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SPEAKING: Effective Communication: Non Clinicians Educating Clinicians Effectively

General Training Observations

- Typical stumbling blocks with providers during an education/training/feedback session:
  - You're not a physician
  - It's in the documentation- I know it's there
  - I never do that; the finding must be wrong
  - They don't listen, but go on "autopilot"
  - They ask you questions about what you literally just said
- Sometimes the issues is the trainer:
  - Not relatable
  - Not a provider advocate
  - Getting to caught up in the details important to them in their world and less to that of the provider's role
  - Boring
  - Too juvenile

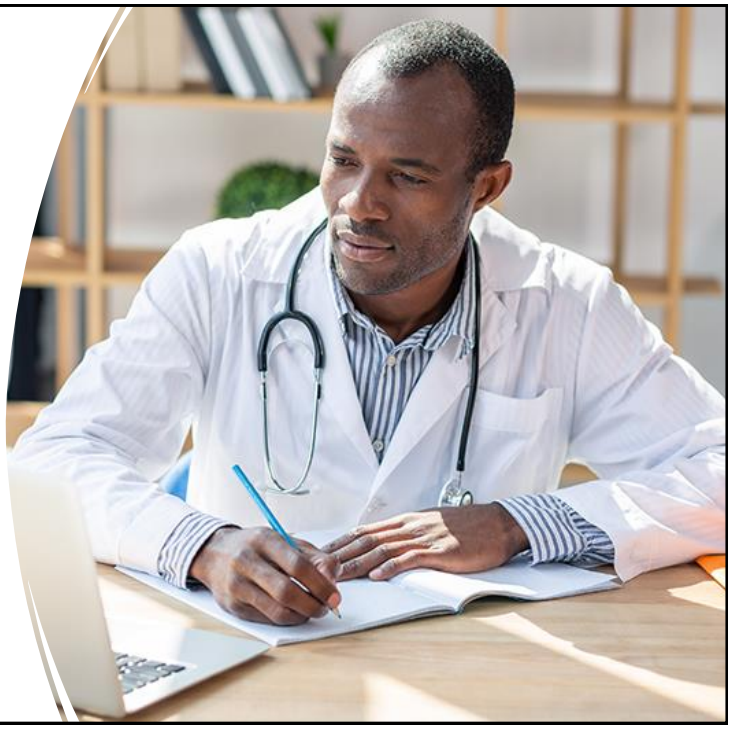
This Session will Address:

- How to approach the training
  - Medical Necessity
  - Time
  - MDM
- Q&A from NAMAS trainings to help you prepare

What to consider for ANY training session…

- Who chooses the codes that are reported to the carrier?
  - If it is a coder are, they reviewing what the provider assigned or cold coding?
  - Will this change in 2021?
  - Do they use an reference tool?
- Does the provider use a scribe?
- When was the last "formal" E&M training been conducted?

Medical Necessity



- Medical Necessity does NOT change for 2021!
- This should be the leading point of 2021 education
- Different meaning to providers than it does coders, auditors, and compliance professionals.
- We must first be relatable by explaining our concept:
  - Complexity of the presenting problem as documented (NOT the treatment plan)
  - Based on what is documented and NOT medical care rendered
  - Complexity should NOT be implied, but must be stated
  - Complexity must be interpreted
  - Diagnoses in and of themselves do not demonstrate complexity

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

AMA AMERICAN MEDICAL ASSOCIATION

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  ◦ Review of prior external note(s) from each unique source*;
			  ◦ review of the result(s) of each unique test*;
			  ◦ ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  ◦ Review of prior external note(s) from each unique source*;
			  ◦ Review of the result(s) of each unique test*;
			  ◦ Ordering of each unique test*;
			  ◦ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• **3** or more chronic illnesses with severe exacerbation, progression or side effects of treatment;
		or
		• **2** or more chronic illnesses with severe exacerbation, progression or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  ◦ Review of prior external note(s) from each unique source*;
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			  ◦ Assessment requiring an independent historian(s)
			or
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
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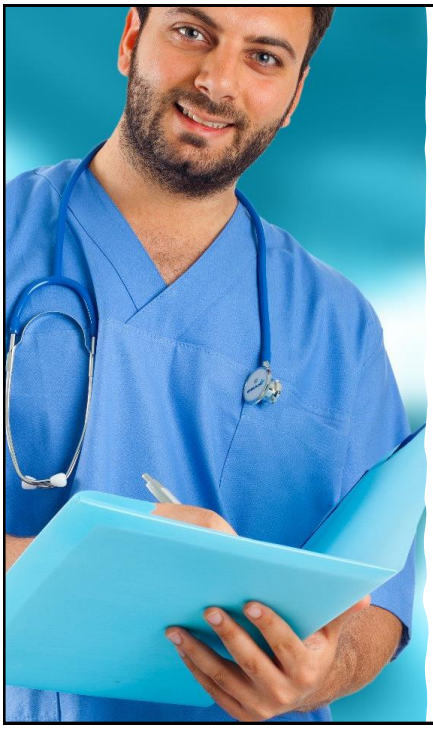
MDM in 2021 plays to Medical Necessity NOT to Documentation Standards

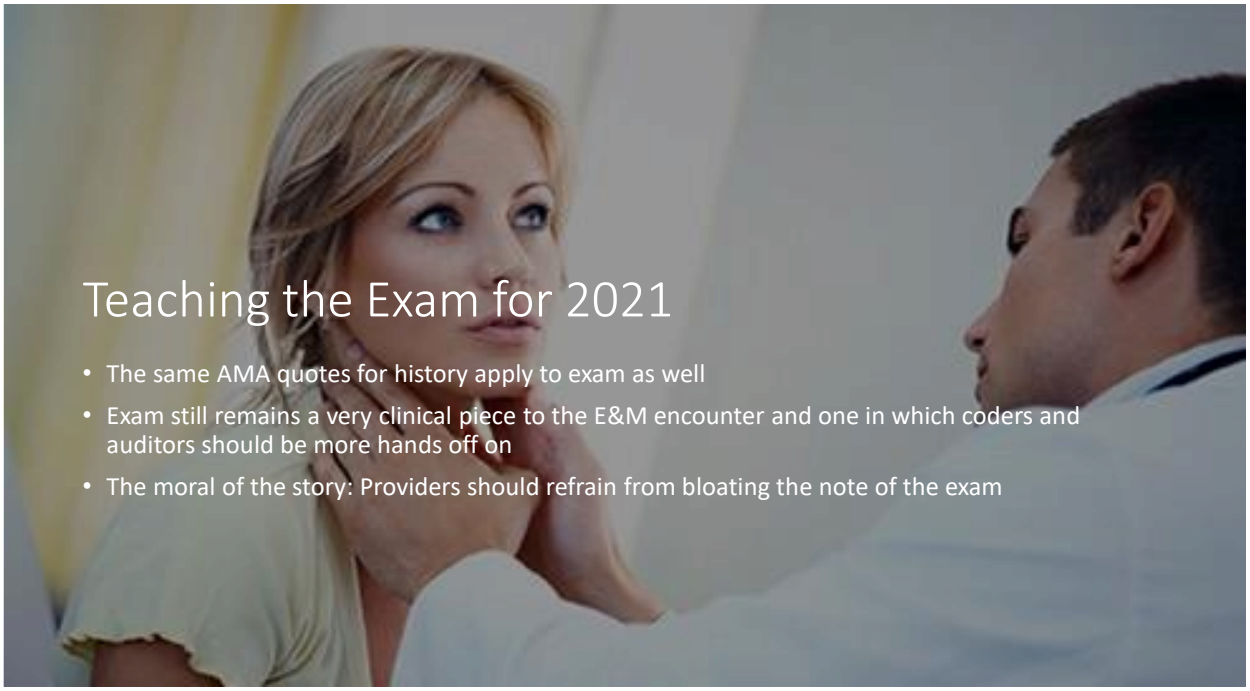


Teaching the Components & Concepts for 2021

- Again, what is important to you when coding/auditing a note is NOT what is important to a provider
- Their job is patient care, documentation validates the care- we must ALWAYS remember this is their perception
- AMA Changes ONLY impact:
  - Office/outpatient E&M services
  - Work of the encounter and NOT reimbursement policies

Teaching History for 2021

- *While the physician's work in capturing the patient's, pertinent history contributes to both the time and MDM these elements alone should not determine the appropriate code level*
- *History and physical examinations should still be performed and/or documented as medically appropriate, but these elements will no longer be sued for code selection*
- *The care team may collect information and the patient or caregiver may supply information directly that is reviewed by the reporting physician or QHP*
- **Morale of the story: Subjective overview of the complexity of why the patient is being seen**



Teaching the Exam for 2021

- The same AMA quotes for history apply to exam as well
- Exam still remains a very clinical piece to the E&M encounter and one in which coders and auditors should be more hands off on
- The moral of the story: Providers should refrain from bloating the note of the exam

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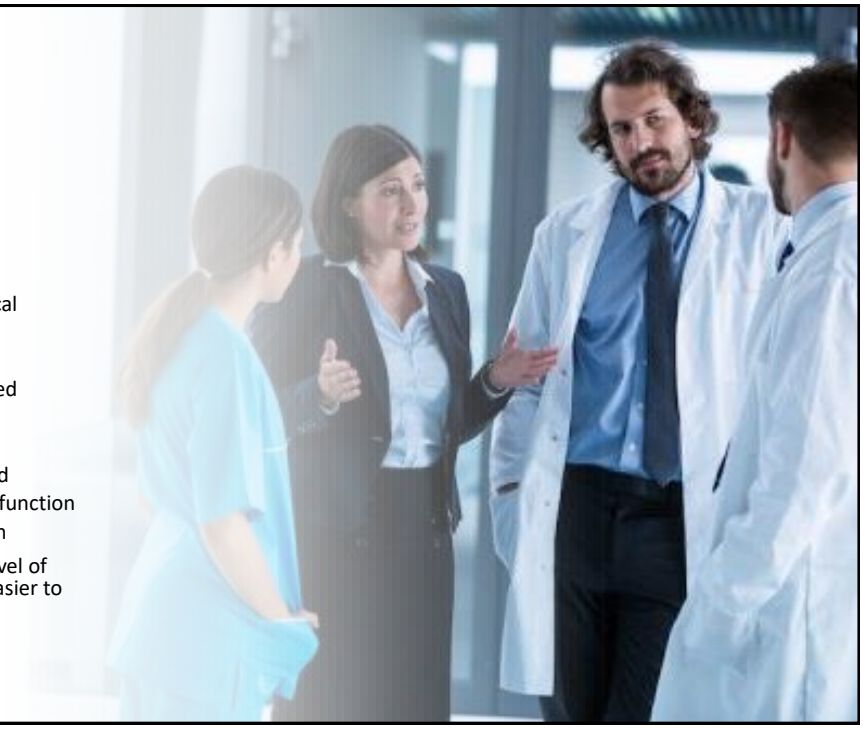
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate *(Must meet the requirements of at least 1 out of 3 categories)* Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: ▪ Review of prior external note(s) from each unique source*; ▪ Review of the result(s) of each unique test*; ▪ Ordering of each unique test*; ▪ Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive *(Must meet the requirements of at least 2 out of 3 categories)* Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: ▪ Review of prior external note(s) from each unique source*; ▪ Review of the result(s) of each unique test*; ▪ Ordering of each unique test*; ▪ Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Teaching the MDM for 2021: Presenting Problem

- Presenting problem of the patient
  - Chronic problems
    - Treatment goals within chronic patients
    - Stable vs. exacerbated
  - Acute problems
    - When an acute problem becomes a chronic problem (1 year or until death)
    - Uncomplicated vs. complicated
- Consider the commonality in teaching these concepts
  - Use a single specialty specific example and walk it through the definitions of stable, exacerbated, severe exacerbation according to the AMA definitions
  - Consideration of hospitalization or high risk of morbidity within the near term
- Undiagnosed new problem- controversy here, but refrain from addressing during your training

Simplify the Presenting Problem in 2021

- Notice how this correlates with Medical Necessity
- Help your providers understand:
  - Level 3: Acute Uncomplicated
    Chronic Stable
  - Level 4: Acute Complicated
    Chronic Exacerbated
  - Level 5: Threat to life/body function
    Severe Exacerbation
- If we teach providers the individual level of MDM for the categories, it makes it easier to put it together



Teaching the MDM for 2021: Data & Complexity

- Caution how you train your providers here
- This is confusing enough for coders/auditors whose primary role E&M leveling is, imagine for a provider that doesn't want document at all
- Minimal changes in the content requested. The largest change is how we score it
- Consider refraining from teaching the scoring process
- Rather, teach them what we need them to include in a greater lesser type of concept
    1. Usual Service: order & review testing, review notes (and whose notes), & independent historian
    2. More work: viewing an image, tracing, specimen (not report) already read and render your opinion
    3. Extensive work: discussion with another provider about the patient

Simplify the Data & Complexity in 2021

- If Category one is used, then the encounter is typically a level 3
- If Category two OR three are used the encounter could represent a level 4
- When multiple categories are documented, then the encounter may be a 4-5

1. Usual Service: order & review testing, review notes (and whose notes), & independent historian
2. More work: viewing an image, tracing, specimen (not report) already read and render your opinion
3. Extensive work: discussion with another provider about the patient

Teaching the MDM for 2021: Management Risks

- This section has not changed except for the addition a few different management options
- AMA Comment during symposium: Document considered management options for inclusion in overall risk (proceed with caution)
- New for 2021:
  - Social determinants of health impacting patient treatment
  - Decision regarding hospitalization
  - Updated definition of high-risk medication monitoring

Simplify the Management Risks for 2021

- Teach the changes in an escalating scale
- Example:
  - Over the Counter Meds: Level 3
  - Prescription Meds: Level 4
  - High Risk Med Monitoring: Level 5

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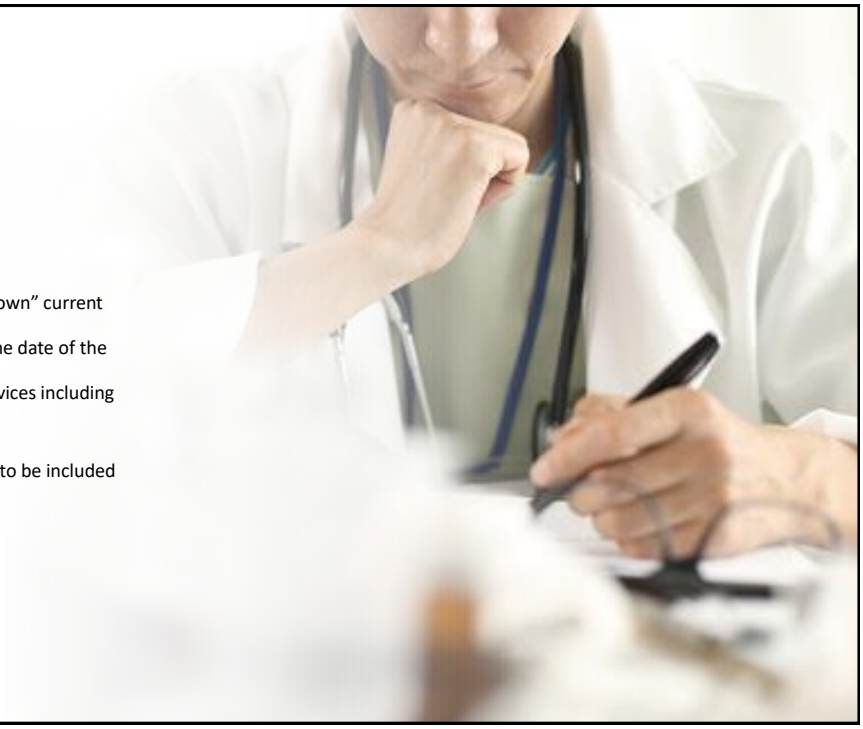
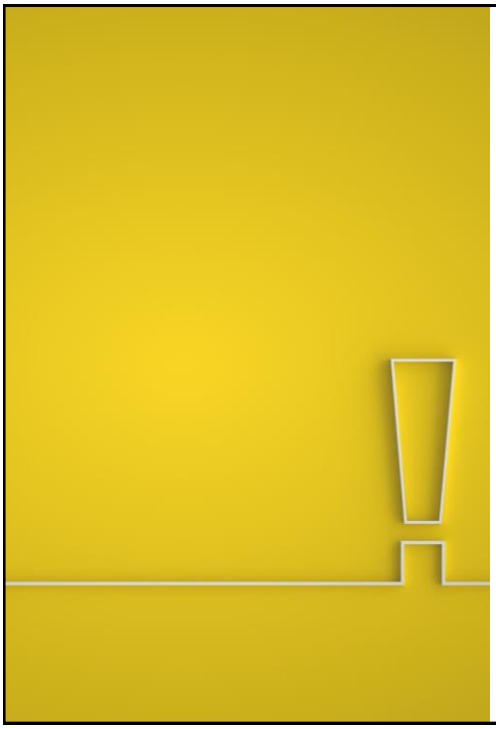
Teaching Time for 2021

- Teach the changes as compared to the "known" current rules
  - Visit time changed to total time on the date of the encounter
  - Face-to-face only changed to ALL services including non-face-to-face
  - Typical times changed to time ranges
- Provide the AMA list of allowed work time to be included
- Discuss time of "other staff":
  - Medical assistants
  - Residents
  - NP/PA (NPP/QHP staff)
- Documentation expectation of time
  - Total time
  - Justification of the total time



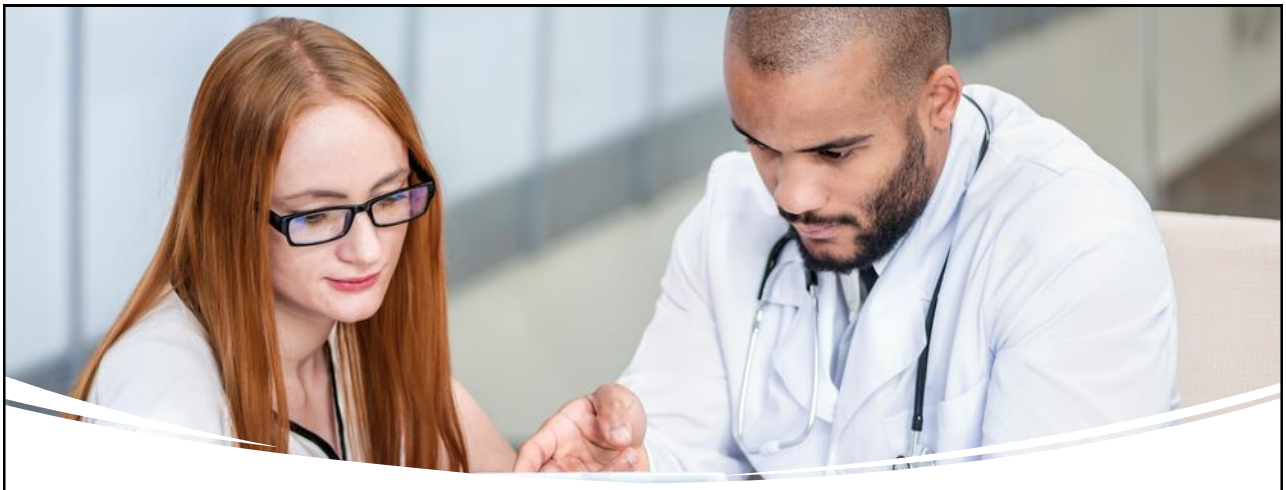
Time Range Comparison

2020 Time Requirement	Code	2021 Time Requirement
20	99202	15-29
30	99203	30-44
45	99204	45-59
60	99205	60-74
10	99212	10-19
15	99213	20-29
25	99214	30-39
40	99215	40-54



Prolonged Services Add-On

- MAX out the time of the code. In other words- it only adds-on to 99205 or 99215
- Codes only apply to office/outpatient code set- otherwise use the “old” prolonged times
- 99417 and the AMA interpretation vs. G2212 and the CMS interpretation



Time or MDM: Who wins?

- This is where medical necessity help to determine the level of service
  - Documentation of MDM supports a 99213
  - Time of the encounter supports a 99215
    - Total time documented?
    - Statement of time spent?
    - Justification of the time?

Reminders Before We Start

01

No need to score history and exam for documentation content purposes

02

Score EVERY note for the MDM level of service

03

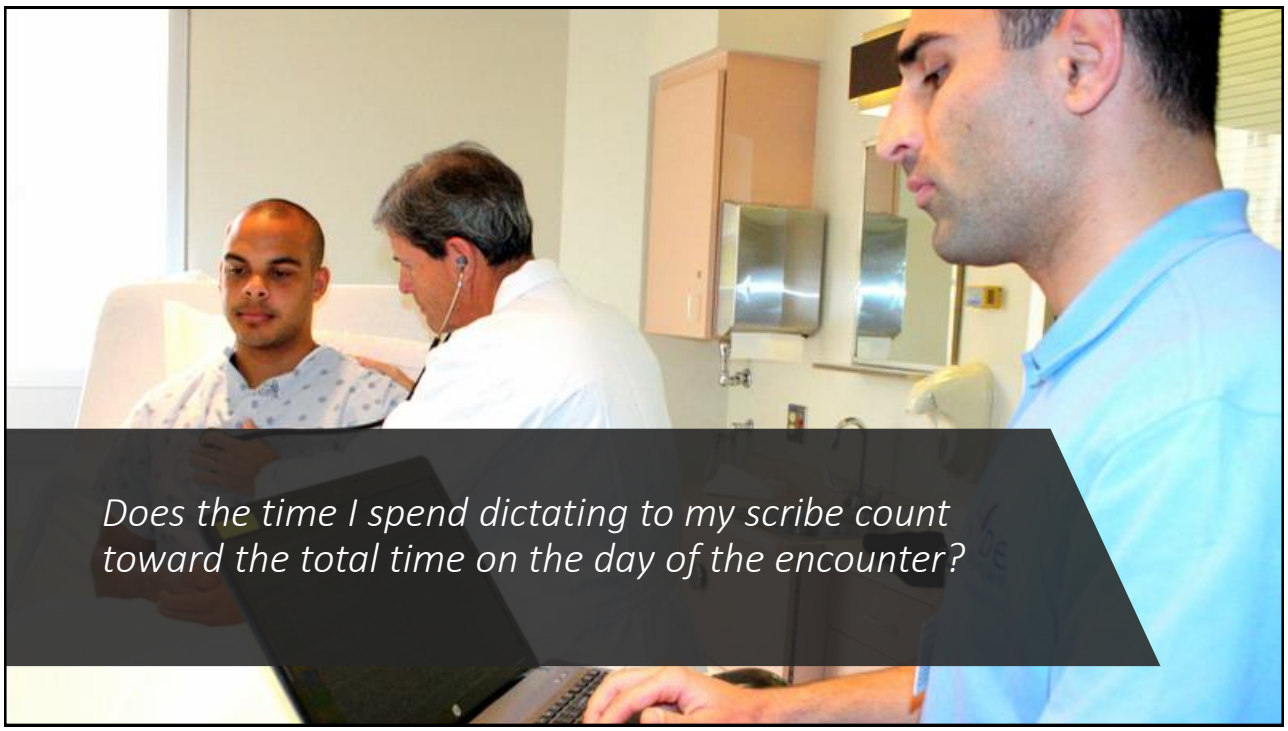
If time is documented, score EVERY note for time supported level of service

04

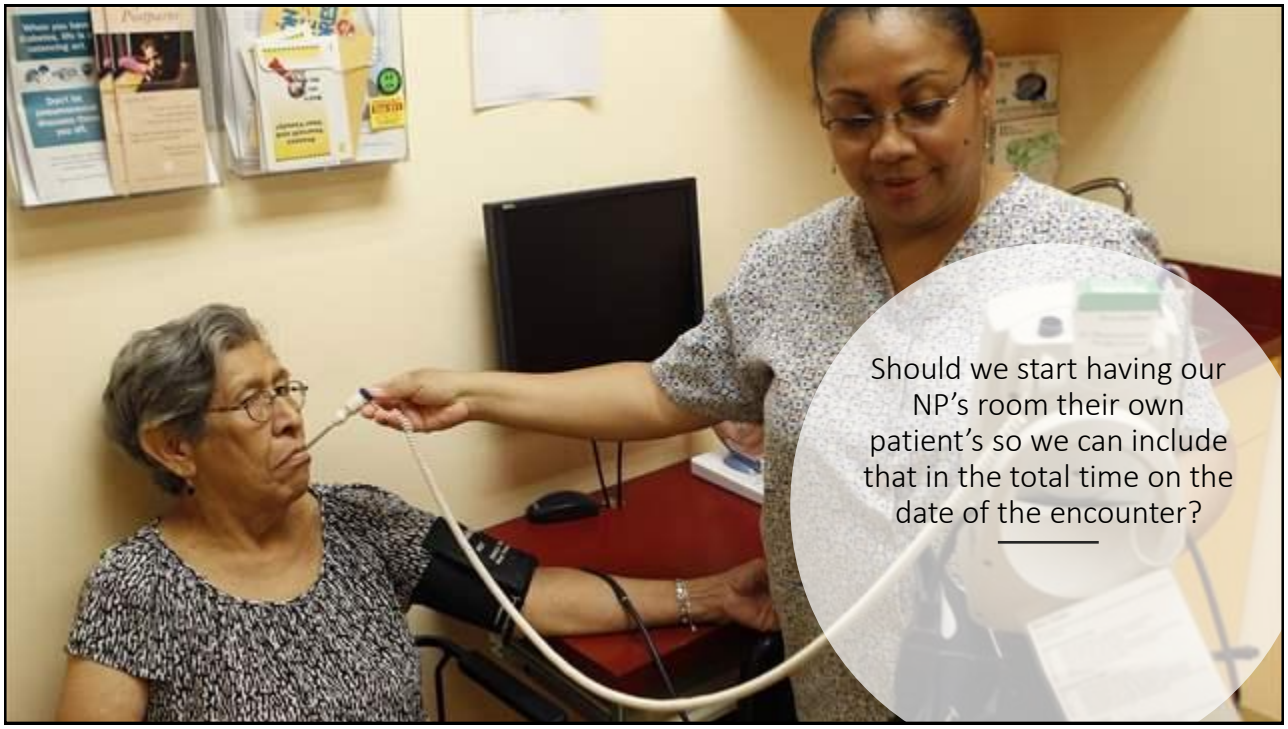
Score medical necessity in EVERY note

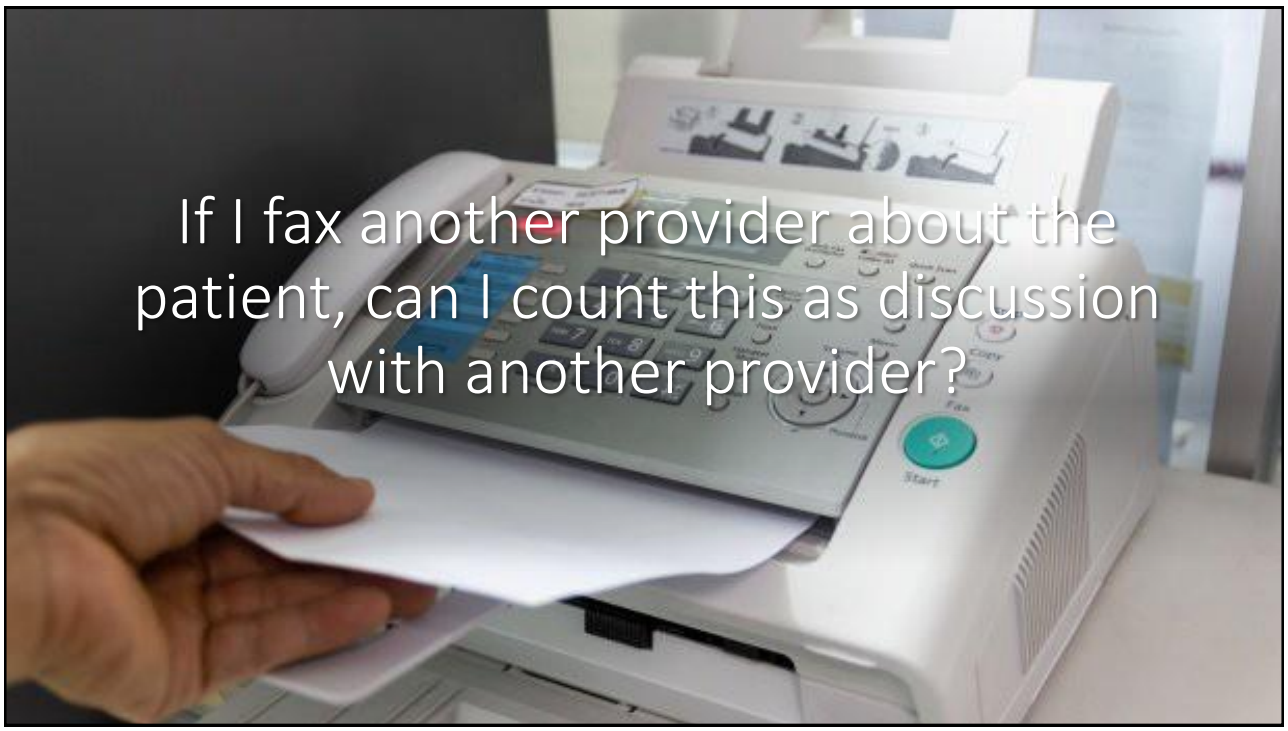
Q&A Session to Help

The following are actual physician questions our team has fielded during 2021 E&M Training Sessions



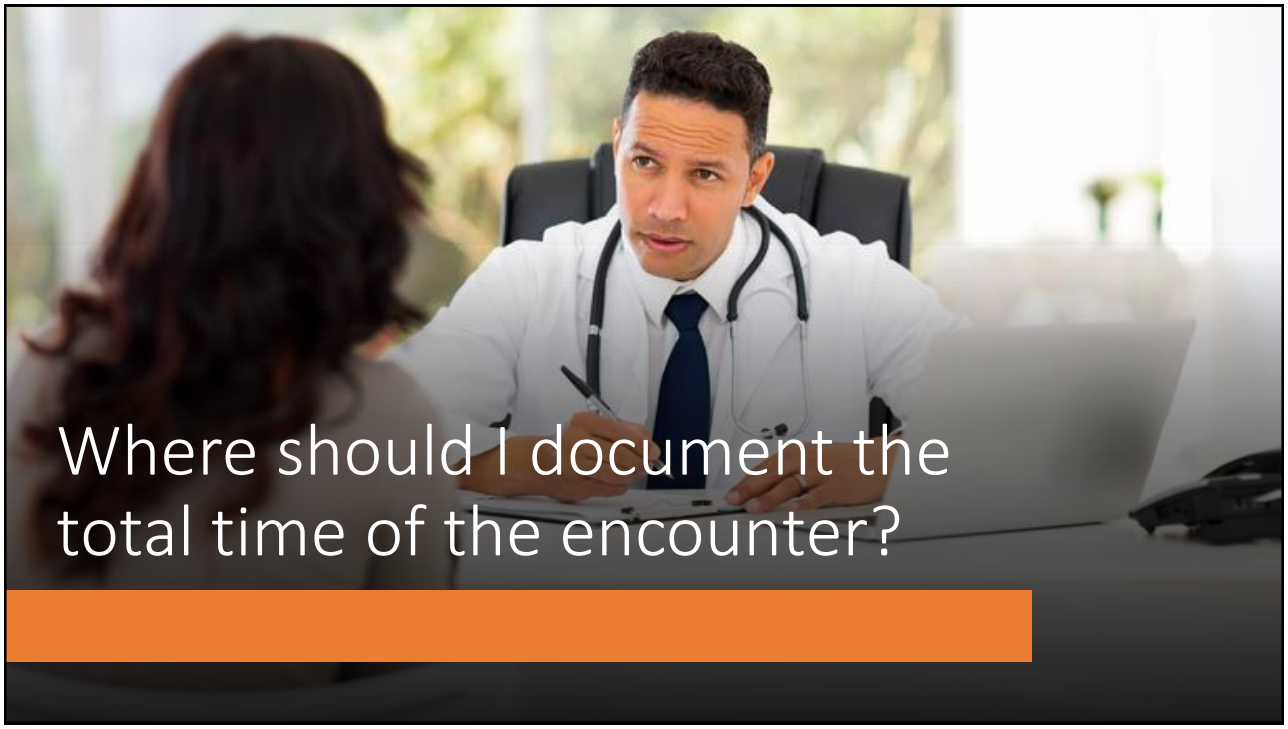
Does the time I spend dictating to my scribe count toward the total time on the day of the encounter?


Should we start having our NP's room their own patient's so we can include that in the total time on the date of the encounter?


If I fax another provider about the patient, can I count this as discussion with another provider?

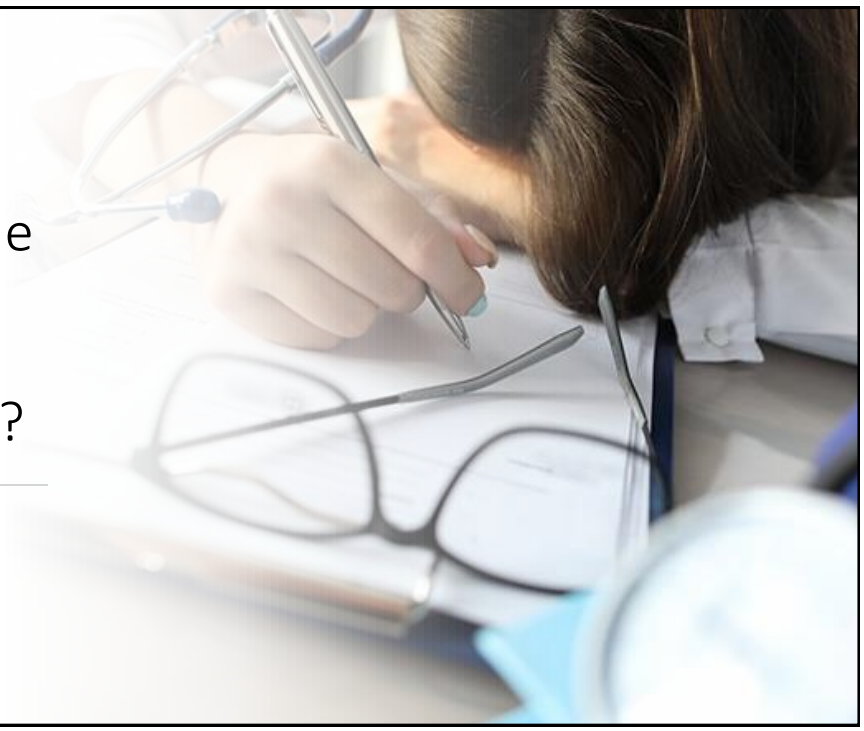
According to the AMA, an “independent historian” is “an individual (eg. parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history due to developmental state or because a confirmatory history is judged to be necessary.

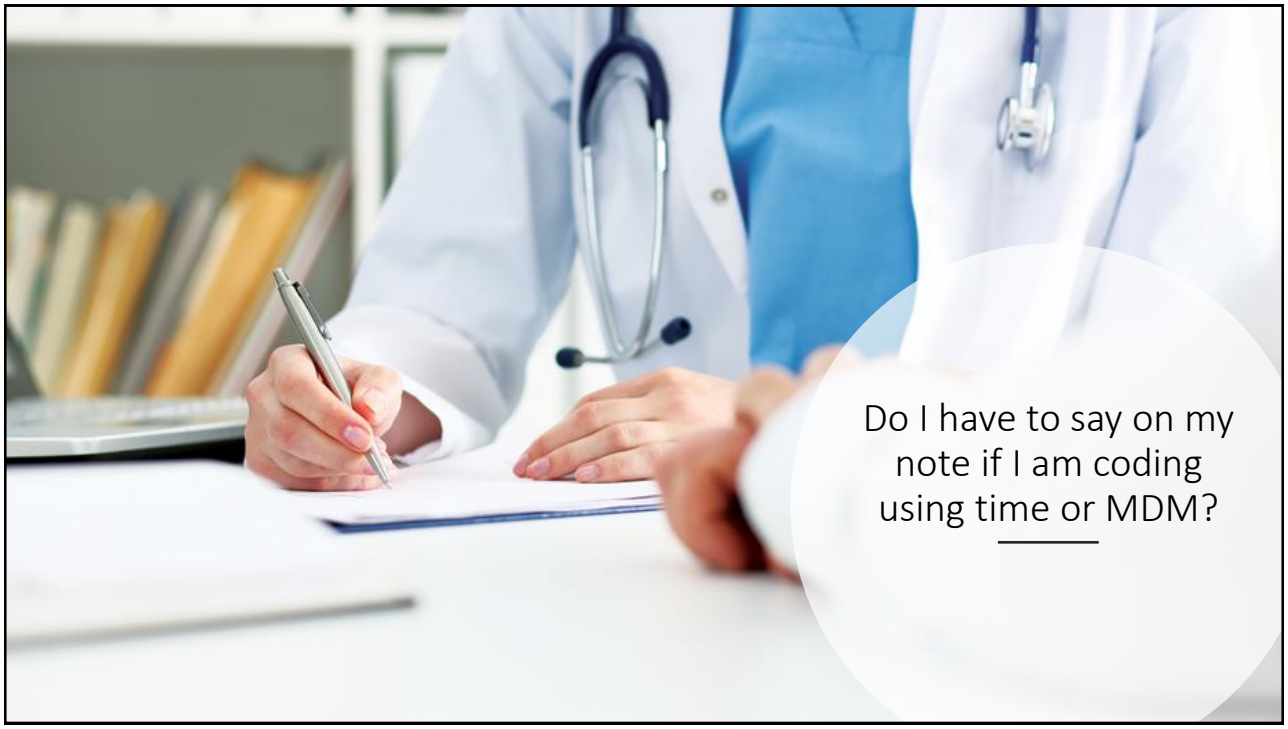
Does that mean a newborn whose mom gives the history is NOT an extra data point, but a kid who says, “my leg hurts,” but can’t tell you if they had fever, etc., then we CAN count an extra historian?



Where should I document the total time of the encounter?

Can I include the time of completing disability forms?



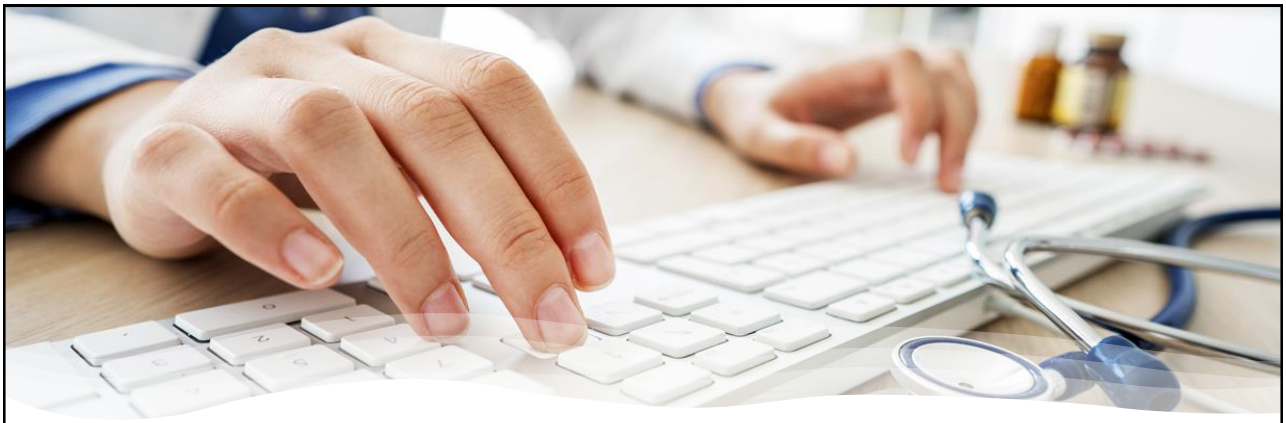


Can I still code a level 5 service if I was worried about a high-risk diagnosis, and I work it up on that assumption, but it turns out to be negative?

For example, I hear a heart murmur that I worry could be threatening, maybe there is relevant family hx like congenital issues in mom/dad, or kid has some SOB, failure to thrive, chest pain, peripheral cyanosis, I do ECG and full workup and explain everything to the family who is worried, then the results show it's innocent/functional.

Based on what you're explaining, it sounds like I am under-coding because I do almost all level 3 new patients…

Should I be worried if I start coding many of them as level 4s because of payers analyzing my utilization?



Do I really have to change anything I am doing?

It sounds like I shouldn't change my templates for 2021 because a.) we do a lot of consults and those codes aren't affected, b.) for new pediatric patients I find it's important to do full history and exam, especially PFSH due to hereditary problems but also home/living situation, potential for parental abuse, school issues, etc.

I prefer to use MDM rather than time, because it seems like too much work to write down what I spent face-to-face and especially non-face-to-face time on.

Often, I will spend the non-face-to-face time the next day, which you say doesn't count because it must be on the same date of service.

So really, I don't like the idea of using time and worrying if I have too much time for one workday based on the codes.

Can I code a higher level if I keep documenting comprehensive hx and exam, like I always do PFSH?

Questions?

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