2021 E/M Updates: Documentation Challenges

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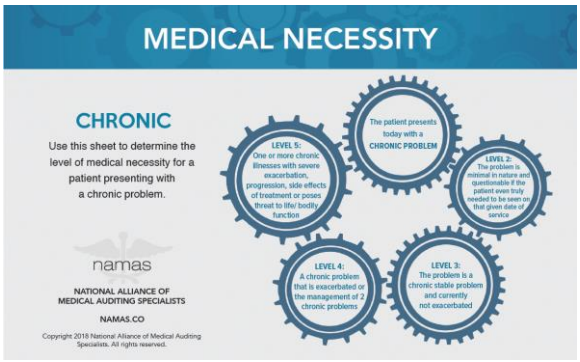
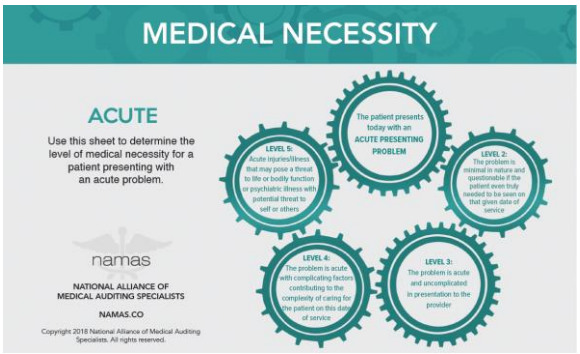
Medical Necessity = Complexity of Care





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These changes impact office and outpatient services only

99202-99215

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Overview of the Changes

- 2021 AMA E&M Guideline Updates
  - MDM ONLY as the key component
    - Revision to wording
    - New scoring of data and complexity
    - All 3 categories of MDM into one table
    - Definitions added
  - Time used in lieu of MDM
    - ALL office-based encounters
    - Time is cumulative on the date of service
    - Time includes non-face-to-face services
    - Revised typical times into ranges of time
  - Deletion of 99201
  - History and exam no longer be scored

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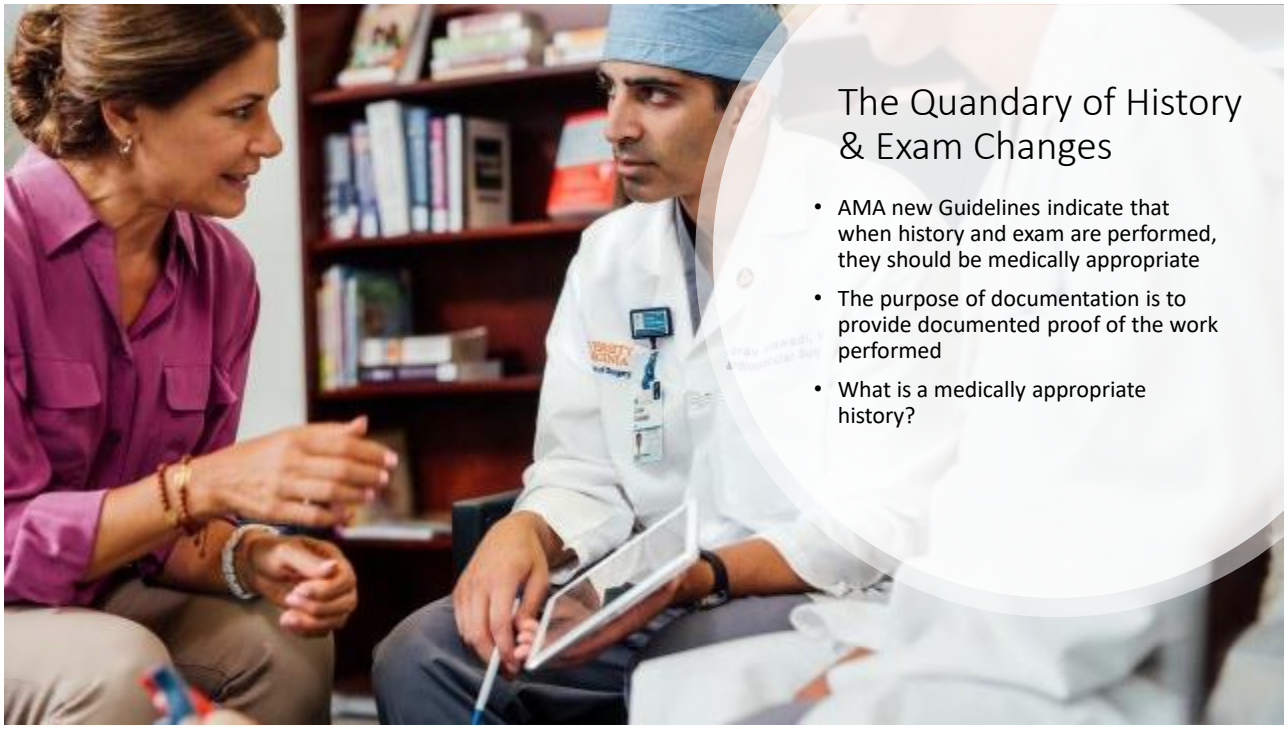

The Quandary of History & Exam Changes

- AMA new Guidelines indicate that when history and exam are performed, they should be medically appropriate
- The purpose of documentation is to provide documented proof of the work performed
- What is a medically appropriate history?

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2021 Impact on Exam

The extent of examinations performed and documented is dependent upon clinical judgement and the nature of the presenting problem(s)

Controversies to be eliminated:

1995 vs. 1997

Relevance to the encounter

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Consider the Following Example To Shape Your Message

Chief Complaint

fever 99.8 F today/confusion/ vomited weekend/ History of Present Illness 4 years old male child here with dad complaining of fever and acting sick at daycare.

He was at daycare today and he was playing. He was asking a question and he was just staring, not answering. No shaking , no LOC.
Daycare checked temperature and was up to 99.1. He was tired and slept on chair.

He was sick past weekend , vomited at home Thursday and Friday , Sunday had fever up too 99.6. Parents gave Tylenol and Ibuprofen.
Monday he was fine and Tuesday was fine but poor appetite.
Yesterday he was back at school and he was fine.

No vomiting, no diarrhea, no rash
Eats and drinks well. Normal UO. Review of Systems Negative except HPI Physical Exam
Vitals & Measurements **T:** 36.4 °C (Axillary) **PPR:** 110 **RR:** 20 **BP:** 104/60 **SpO2:** 100% **HT:** 107 cm **WT:** 18 kg **BMI:** 16 General: Alert, active, no acute distress.
Head: Normocephalic, atraumatic
EENT: External ears normal. Left TM erythematous and bulging and right mild erythematous. TMs clear bilaterally with good light reflexes. PERRL. EOMI. Normal conjunctivae. Nares patent. No discharge. Mucous membranes moist. Normal oral mucosa. No pharyngeal erythema. Tonsils normal.
Neck: Supple. No lymphadenopathy.
Respiratory: Good air entry throughout. Lungs CTA B./L No wheezes/crackles/rhonchi.
Cardiac: Regular rate and rhythm. No murmurs. Peripheral pulses intact. Cap refill <2sec.
Abdomen: Soft, non-tender, non-distended. Active bowel sounds. No hepatosplenomegaly.
Extremities: Warm, well-perfused. No obvious deformities
Musculoskeletal: back straight, full range of motion
GU: normal external genitalia
Neuro: No focal deficits. Cranial nerves II-XII grossly intact
Skin: Warm, dry. No rash.

Assessment/Plan BOM (bilateral otitis media) Both ear infected, he does not complain of ear pain but his acting sick could be to the ear infection.
Amoxicillin 400 mg/5 ml , 9 ml orally twice a day for 10 days.
ibuprofen or Tylenol as needed for pain.

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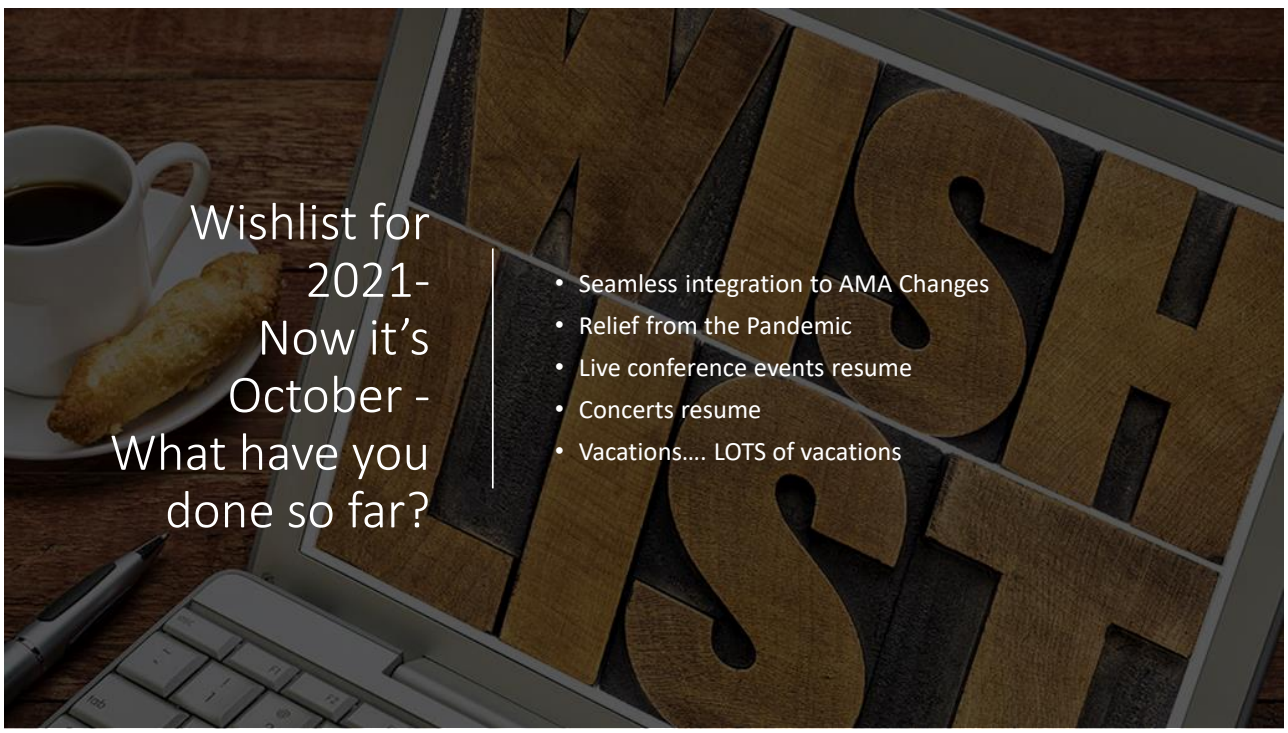

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2021 E&M Compliance Change Concers

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New vs. Established

Current rules for office services no longer give additional “weight” to new patients and new problems for code selection

- Consider this as part of billing/code selection/audit review planning

Do you think this modification will lead to future changes?

- Consolidated reimbursement rate
- Future changes in the new/established criteria

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Compliant Use of Time

- Time for 99202-99215 is all pre/intra/post time on the date of the encounter in 2021
- Consider the mis-uses of time
  - Incorporating staff time
  - Incorporating procedural time
  - Not including time spent later in the day
  - Overestimating time or rounding up
  - Including in time statements things that were not done for this specific patient
- Time must still be medical necessary
  - Total time on the date of the encounter
  - Justification statement
  - Medically necessary

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Time Based Documentation

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

- Define the change in time for 2021
  - Total time on the day of the encounter
  - Allowed regardless of counseling and coordination of care
  - Time range in lieu of typical time

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Time Based Documentation: Total Time

- On the day of the encounter
- Duties may include any time spent "working" on behalf of the patient
  - Think of this like floor/unit time in the inpatient setting
  - Time spent unrelated to the patient is NOT allowed
    - Give examples
- Approved "work" per AMA
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Referring and communicating with other health care professionals (when not separately reported)
  - Documenting clinical information in the electronic or other health record
  - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

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MDM Based Documentation

- Address the change that MDM is the only scorable component
  - Presenting problems and the complexity addressed
  - Data reviewed/analyzed
  - Patient management risk
- MDM over time when MDM supports a higher level of service
  - Time documented is 15 minutes- Level 2
  - Acute uncomplicated problem with RX management- Level 4

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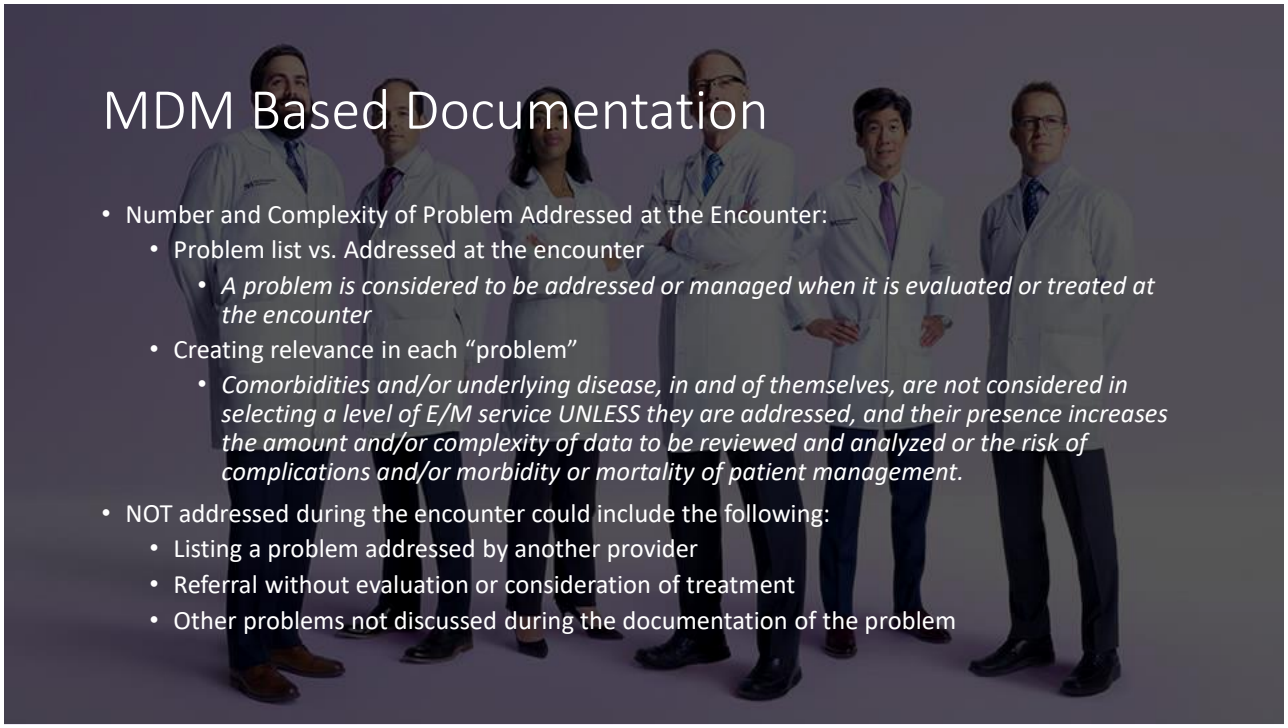

MDM Based Documentation

- Number and Complexity of Problem Addressed at the Encounter:
  - Problem list vs. Addressed at the encounter
    - *A problem is considered to be addressed or managed when it is evaluated or treated at the encounter*
  - Creating relevance in each "problem"
    - *Comorbidities and/or underlying disease, in and of themselves, are not considered in selecting a level of E/M service UNLESS they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.*
- NOT addressed during the encounter could include the following:
  - Listing a problem addressed by another provider
  - Referral without evaluation or consideration of treatment
  - Other problems not discussed during the documentation of the problem

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MDM Based Documentation

- Definitions addressed for 2021:
  - Chronic Problem- a problem with an expected duration of at least 1 year or until death
    - Stable: Not better or not worse
      - Treatment goals optimized
      - Well-controlled hypertension or cataract
    - Exacerbated: Worsening, poorly controlled, progressing, or severely impacted
      - Treatment goals have not been reached
      - Level of exacerbation
      - Asthma exacerbation, COPD exacerbation
  - Acute Illness/Injury Problem Variations- recent or new short-term problem
    - Uncomplicated: little to no risk of mortality with treatment
      - Self-limited problem not solving
      - Cystitis, allergic rhinitis, simple sprain
    - Complicated: systemic involvement creating a complication (moderate or high)
      - High risk of morbidity without treatment
      - Significant systemic involvement
      - Pyelonephritis, pneumonitis
  - Undiagnosed New Problem with uncertain prognosis

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MDM Based Documentation

- Data & Complexity:
  - The policy should address the variance in the categories and provide a solid resources
  - Unique test
    - Consider listing categories of test
    - Use CPT codes to create consistency
  - External record/provider
  - Interpretation and visualization
  - Discussion with another provider
    - Acceptable forms of documentation
    - Documentation of discussion

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MDM Based Documentation

- Risk of Management & Treatment Options
  - Treatment options considered
  - Straightforward and Low Complexity examples
  - Moderate
    - Prescription drug management
    - Minor vs. Major procedure
    - Identified risk vs. Non-Risk
  - High
    - Drug therapy- High risk
    - Decision regarding hospitalization

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Scoring the Encounter

- Medical necessity and how it is addressed in the documentation
- Documentation scoring process
  - 2-3 rule of MDM
  - Compare time and MDM
  - Medical necessity vs. Documentation

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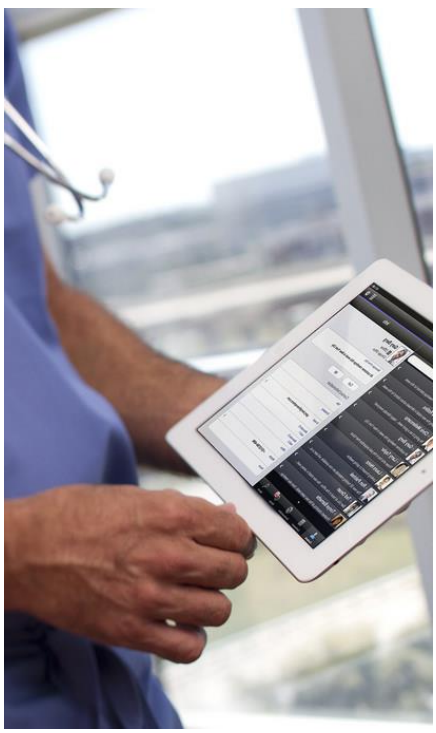
Gray Areas for 2021

- Time vs. MDM
- Split-Shared time and MDM visits
- Defining chronic presenting problems
- Review of each unique test
- Order of each unique test
- Discussion with an external provider
- Minimal management risk
- Low management risk



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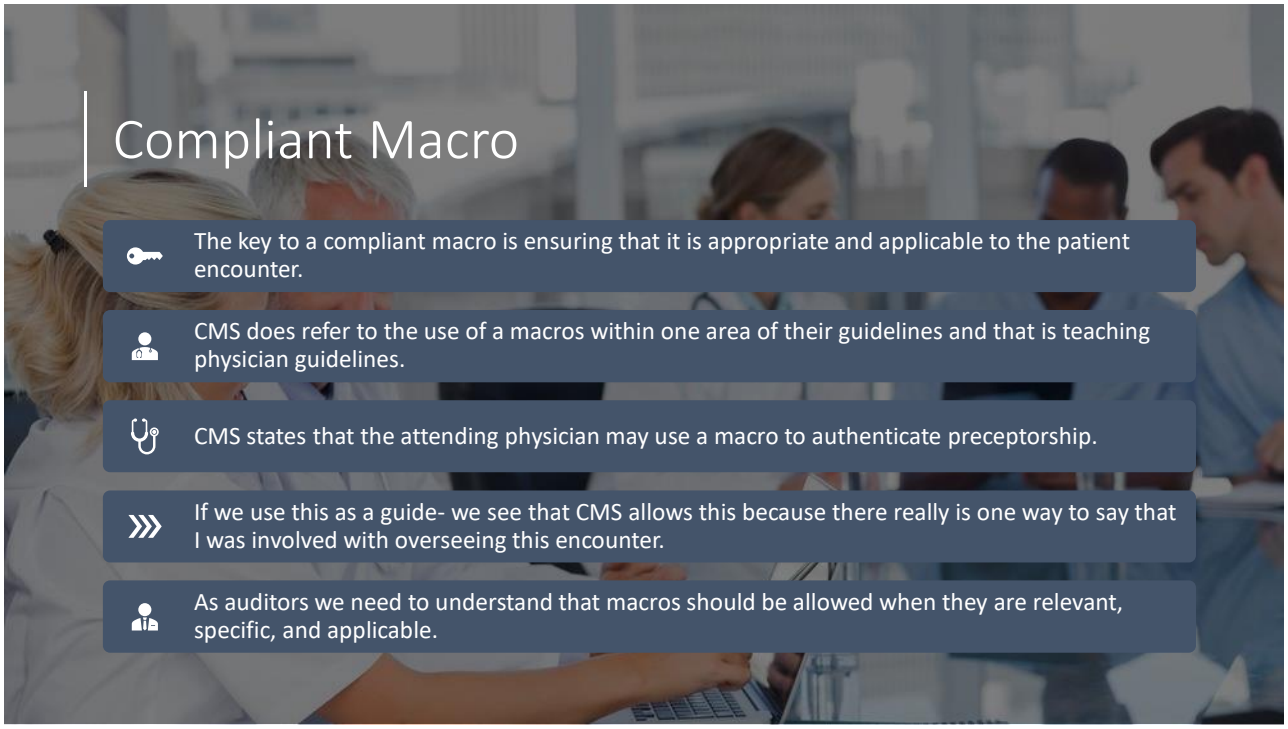

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Office/Outpatient Macro

- Considering the 2021 AMA Guidelines, time statements will be a highly effective macro in the office setting.
- 2021 also allows us to consider all of the time spent in relation to that patient encounter on a given date.
- This allows us to increase our time allowances in the office to that of the inpatient but would also necessitate our need to identify the actions or work performed to occupy the total time.
- Example- Primary Care Exception Teaching Physician Macro: *While the patient was in clinic or immediately following the patient leaving the clinic, I reviewed the patient's medical history, the resident's findings on physical examination, and the patient's diagnosis and treatment plan with the resident and agreed with the information documented.*
- Recommended Inpatient Uses of a Macro include:
  - Time statement
  - Scribe statement
  - Teaching physician statement
  - Critical Care statement
  - Consult statement

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Compliant Templates

Over time, templates have become overpopulated and more generic in quality as opposed to be patient and visit specific documentation.

This is not always easily found on audit, and when noted it oftentimes appears more like copy/paste and/or cloning concerns.

However, overpopulated errors can be identified by frequent contradictions in areas of more general type of documentation such as the review of systems and the exam findings.

Again, templates can be used and can be effective and appropriate, but the better concept of a template is when we consider them to be outlines of the encounter.

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Office/Outpatient Template

- Examples of effective use:
  - New & Established Patient Encounters: Due to the relaxed guidance for 2021, it might be encouraged that templates are eliminated in the office setting. However, keeping in mind that a template is an outline of an encounter- it may be resourceful to use with the new E&M changes.

    Example:

    History: Chief complaint and medically appropriate history to define the patient's complexity today

    Exam: As medically appropriate based on clinical relevance

    Diagnosis: Include problems addressed only

    Data: Include work done such as review/order testing and notes or other active discussions

    Treatment: Enter ALL treatment options considered and ordered

    This sort of a template is NOT overpopulated but does work to aid in the documentation process.
  - Consult Encounters: While not widely reimbursed, enough carriers still reimburse for the consult codes and therefore worth the documentation and work associated with the guidelines. These codes are NOT impacted by the new E&M changes, and therefore must still utilize the core key components. However, the most common deficiencies noted upon audit is the lack of an initial statement consultation. Therefore, using a template that includes a prompt for this required element will best support the services billed.
  - Preventive Encounters: These services also are NOT impacted by the 2021 AMA changes to E&M. Preventive services whether we are talking about Medicare approved, pediatric, well-women, or any preventive can be well supported through a template reminding the provider of the individual requirements.

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Compliant Copy & Paste

Copy and paste typically refers to portions of the documentation being inserted from other notes, while cloning refers to utilizing the record in its entirety

CMS strongly warns providers about record "cloning," and this is certainly something that should receive additional scrutiny during the audit process for EHR-generated notes.

Record cloning is the use of duplicate documentation such that each patient record looks the same for multiple days of service regardless of the patient's presenting problems and status on each specific day.

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Compliant Copy & Paste

- The use of C&P represents the same cause and effect in either the IP or the OP place of service.
- However, regardless of the place of service, C&P must be performed correctly, or it will create an audit risk for the encounter.
- Correct Uses of C&P:
  - Minimal use of copy and paste as opposed to a quick text substitute to meet the necessary requirements.
  - Site and source large excerpts that are copy and pasted due to the quality
  - Use of originally authored content
- Incorrect Uses of C&P:
  - Notes that include large volumes of copy and pasted documentation that has not been appropriately updated.
  - Copy and past of another providers documentation as this is clinical plagiarism and not allowed.
- The hope of 2021 is that the relaxation included in the E&M office based updates there will be less use of C&P as the need to include copious volumes of irrelevant documentation have been relieved.
- In the inpatient and facility settings, copy and paste struggles will likely persist until changes to documentation requirements are updated to this place of service as well.

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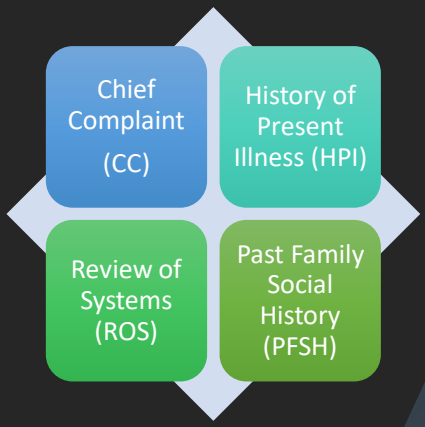
The Overall History:

Severity of the Patient According to the Patient



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Is a condition considered to be chronic or acute?

- Per the AMA: A chronic illness is “A problem with an expected duration of at least a year or until the death of the patient.”

- How do we know this to be true?
  - The condition is inherently chronic, such as diabetes, hypertension, chronic kidney disease
  - The provider’s documentation defines the condition as chronic, either by virtue of the amount of time it has lasted (current duration) or by stating the condition is chronic by the AMA’s definition. Sources can include the history of present illness, the past medical history or any aspect of the note.
  - Remember: The ‘default’ position of the audit is to the less intense option. In other words, a condition that is not established as chronic in the documentation is considered to be acute.
  - Acute vs. Chronic: Back pain, Achilles tendonitis, plantar fasciitis, shin splints
  - More definitively chronic: Degenerative disc disease, osteoarthritis

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Is a condition considered to be chronic or acute?

- Improved, Worsening or Stable?

- The AMA weighs under the new guidelines: “A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short term threat to life or bodily function.” Note that the risk of morbidity without treatment is significant.

- This ‘solves’ the historical audit problem of how to credit a condition that is essentially stable, but under poor overall control due to patient non-compliance or other reasons.

- How do we know the patient is not stable?
  - The provider paints a picture in the documentation of the history/exam/assessment (remember the “SOAP”) that shows clear instability or worsening.
  - The provider has documented clear, attainable treatment goals in the record and noted that the patient it not at these goals and documented why.

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What are systemic symptoms?

- From the AMA: “An illness that causes systemic symptoms *and has a high risk of morbidity without treatment.”*

- The guidelines clarify that systemic general symptoms such as fever, body aches or fatigue in a minor illness would not be considered systemic symptoms for purposes of this definition. Examples given include pyelonephritis, pneumonitis and colitis.

- How do we define a systemic symptom?
  - The provider’s note demonstrates how the symptoms pose a risk to the patient’s morbidity at a high risk.
  - It’s not that fever, or body aches or fatigue can’t be systemic symptoms by this definition, but the burden is on the rendering provider to demonstrate that risk.

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What is an undiagnosed new problem with uncertain prognosis?

- When I audit, I'll see a provider state this for any instance where the patient has symptoms requiring additional workup to establish a definitive diagnosis.

- The AMA states: "A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast."

- How do we define it?
  - The note should demonstrate the provider's concern over the overall risk/concern to the patient.
  - The risk conveys from the provider through the note – as a reviewer, if the provider isn't concerned, then I'm not concerned (i.e., rule-out, just to be safe). If the provider is concerned (get test ASAP, seek immediate treatment), then as the auditor I credit that concern.

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Uncomplicated vs. Complicated vs. Threat to Life or Bodily Function?

- Uncomplicated: Low risk of morbidity without treatment (i.e., simple sprain), little to no risk from treatment, full recovery without impairment is expected.
- Complicated: Requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive or the treatment options are multiple and have risk. Example: Head injury with loss of consciousness. Orthopedic examples: Open fractures, injuries with documented impacts on mobility.
- Threat to Life or Bodily Function: Exacerbation/progression/side effects of treatment that pose a threat to life or bodily function *in the near term without treatment*. Severe musculoskeletal injuries, osteoarthritis – establishing this is dependent on the provider's documentation.

- How do we define it?
  - The history and exam areas of the documentation are often the most critical aspects of establishing whether an injury is complicated or poses a threat to life or bodily function. While these areas no longer have specific requirements in the office setting beyond the provider's discretion, the note must still definitively establish these things.

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Data – Compliance Challenges within the Documentation

- Data under the 2021 E/M Guidelines is divided into three categories, which raises some compliance concerns based on what the provider documents:
  - Category 1: Tests and documents
    - Review of prior external note(s) from each unique source
    - Review of the results of each unique test (does NOT include tests for which the same group/provider is credited with the order).
    - Order of each unique test
    - Assessment requiring an independent historian (this is its own category when the documentation DOES NOT support anything from category 2 or category 3
  - Category 2: Independent interpretation of tests (review of the images/tracing of a test performed/reported by another provider).
  - Category 3: Discussion of management or test interpretation with external physician/qualified health professional.

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Data – Compliance Challenges within the Documentation

- Low credit data (99203/99213): Any combination of two items from tests and documents OR assessment requiring an independent historian

- Moderate credit data (99204/99214): Any combination of three items from tests, documents, independent historian OR independent interpretation of a test OR discussion of management or test interpretation with external provider

- High credit data (99205/99215): Documentation that meets the requirements of two of the three categories of moderate vs. one category

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Data – Compliance Challenges within the Documentation

• Compliance Challenge: If the documentation includes the review of labs/diagnostic test reports, does the provider get credit for that review?

- Were the labs or diagnostic test reports brought from another group practice/location? If so, then YES.
- Were the labs or diagnostic tests ordered by this provider or another provider within the same specialty/group practice at a previous visit? If so, then NO. The provider should have been credited for the order at the previous visit and under the 2021 rules this includes the result.
- Were the labs or diagnostic tests ordered by this provider or another provider within the same specialty/group practice in advance of this visit so the results could be reviewed? If so, then YES, because the provider has not been credited for the order.

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Data – Compliance Challenges within the Documentation

• Compliance Challenge: How are labs and diagnostic tests credited when the provider is also being paid for the test?

- Is it a lab test or a test that does not have a provider interpretation component? If so, then the provider is credited for an order, which includes the review.
- Is it a diagnostic test with a provider interpretation? If so, then the provider does NOT get credit for an order or a review under the 2021 E/M Documentation Guidelines. The separate payment is considered in lieu of this credit.
- Is the diagnostic test ordered and sent to an external provider? If so, then credit is given for the order, which will include the review. It is not an independent interpretation when the ordering provider reviews an external result, as it is not independent.

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Data – Compliance Challenges within the Documentation

- Compliance Challenge: How is an independent interpretation of a diagnostic test credited?
  - The test must have been ordered and interpreted by an external group, which was paid for that work. This does NOT include another provider of the same specialty/group.
  - The documentation must be clear that the provider reviewed the images/tracing and documented his or her own interpretation, rather than reviewing the report.
  - The default is to assume the review was of the report as it credits at lower intensity, so the documentation should be clear on this point.

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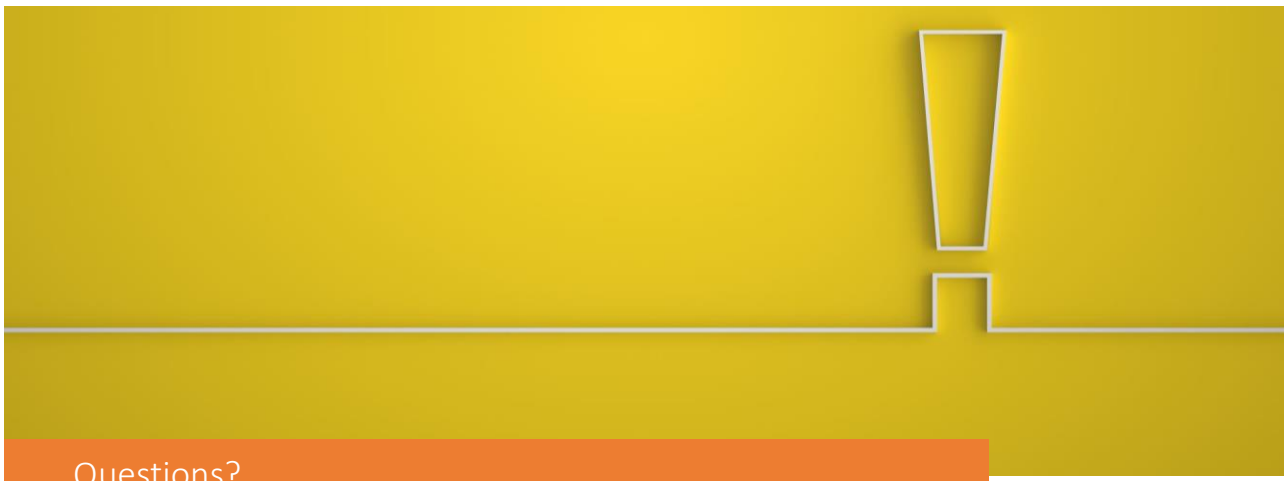

Questions?

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