HEADS UP: Office Visit E/M Coding & Documentation Changes Coming January 2021

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COVID, COVID, COVID, COVID.....

And Now for something COMPLETELY different....

Office Visit E/M Coding & Documentation Changes: Effective 1/1/2021

Agenda

- Review major changes in office visit E/M coding and documentation
- Discuss the business impact of these changes
- Outline potential workflow/implementation impact of these changes
- Review practice strategies for ongoing education

Why Change Office Visit E/M Coding?

- CMS efforts to promote “Patients Over Paperwork”
- Coding Guidelines have not been updated since ***1997*** (before most people had EHRs)
- Initial CMS proposal was to pay at a “blended rate” for 99212-99215
- These changes are the AMAs counter-proposal to CMS changes (which would have negatively impacted many primary care practices)

Major Changes

- NO LONGER choose E/M based on countable bullet points of HPI, ROS and exam elements
- ONLY two ways can pick E/M Level are
  - **TIME**

    OR
  - **MEDICAL DECISION MAKING**

There is no longer a “difference” between coding levels for new/established patients.

EFFECTIVE 1/1/21: the RVUs for E/M services have been slightly increased!

TIME: Established Patients

- **99212: 10-19** minutes of total time is spent on the date of the encounter
- **99213: 20-29** minutes of total time is spent on the date of the encounter
- **99214: 30-39** minutes of total time is spent on the date of the encounter
- **99215: 40-54** minutes of total time is spent on the date of the encounter

For services 55 minutes or longer, see Prolonged Services 99XXX

TIME: New Patients

- ~~**99201**~~**: Has been deleted**
- **99202: 15-29** minutes of total time is spent on the date of the encounter
- **99203: 30-44** minutes of total time is spent on the date of the encounter
- **99204: 45-59** minutes of total time is spent on the date of the encounter
- **99205: 60-74** minutes of total time is spent on the date of the encounter

For services 75 minutes or longer, see Prolonged Services 99XXX

TIME: What Counts?

PROVIDER doing work the **SAME DAY** as the encounter:

- preparing to see the patient (eg, review of tests)
- 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)

Pediatric Time Wins!

- Wrestling with that 3 year old to take sutures out for 30 minutes....99214
- Have a complex patient and it takes you awhile to document the visit, send a portal message, call the school, finalize your note.....

  ALL of that time counts provided you do it the ***same day as the visit***
- All of those Telehealth visits you couldn't get to a 99214 because of lack of exam elements.....

  ALL of the time counts including struggling with the technology to get connected provided the ***provider is doing the work***!

TIME Takeaways

- **NO ROUNDING** (time frame is explicitly stated in the definition of the CPT code)
- Only **PROVIDER** work counts when choosing an E/M level based on time
- Only time spent **ON THE DAY OF THE ENCOUNTER** counts

TIME Workflow Implications

- Providers who “prep charts” and open notes in advance of that visit: all of that time DOES NOT COUNT if not done on the same day as the encounter
- Providers who document days after the visit: all of that time DOES NOT COUNT if not done the same day as the encounter
- Start changing workflow habits NOW so you can leverage these changes starting in January:
  - May need to give providers ‘prep time’ in AM and expect them to come in 30 minutes prior to first appointment to review old records, etc.
  - May need to give providers ‘documentation time’ at lunch and end of the day or provide ‘catch-up time’ throughout the day
- May need to delay choosing E&M level in case more work later in day

TIME: Business Implications

- If you code based on TIME, how many 99214s can you realistically complete in an hour? In a day?
  - 30-39 minutes = one 99214
  - But also must consider ancillary work not accomplished at the visit
  - Only so many hours in a day (can't say you saw 25 patients at 99214 = over 12 hours working/documenting!)
- Which means pediatricians.....***NEED TO UNDERSTAND MEDICAL DECISION MAKING COMPLEXITY***

TIME Documentation

- Will I have to document *HOW* I got to that total time?
  - Yes, to some degree (much like you had to include language about face-to-face time and >50% of time spent counseling according to the current rules). OP will summarize where the computer was focused
- Can’t OP just TELL me what time to use based on navigation through the EHR?
  - Not completely. How will OP know if you spend 30 minutes wrestling the child to get out the sutures?
  - OP will work on a solution to assist/suggest, but just like the current environment, only the provider knows how much time they ACTUALLY spent on the activity (vs had the chart open but then went to refill their coffee)

MEDICAL DECISION MAKING: 4 LEVELS

- Straightforward (99202, 99212)
- Low (99203, 99213)
- Moderate (99204, 99214)
- High (99205, 99215)

3 Elements of MDM

- The number and complexity of problem(s) that ***are addressed during the encounter***
- The amount and/or complexity of data to be reviewed and analyzed
- The risk of complications, morbidity, and/or mortality of patient based on management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s)

To qualify for a particular level of medical decision making, <u>two of the three elements</u> for that level of medical decision making must be met or exceeded.

Pediatric MDM Wins!

- Getting history from someone other than the patient: an ***"independent historian"*** (for example, parent or babysitter) increases MDM
- Need for use of an interpreter increases MDM
- Social determinants of health will add to risk ***if documented***
- Complex patients whom you know well, even if you can do the visit in 10 minutes, can be a 99214 based on MDM ***if you document appropriately***

MDM Workflow Implications

- Will need to thoughtfully review ***and document*** chronic/contributory problems
- Templates with bulleted items will no longer be relevant. “Thinking out loud in the plan” ***with explicit documentation*** is what will get you a higher level of MDM. **TEMPLATES WILL NEED TO BE ADJUSTED!**
- Sloppy documentation of the plan will be problematic in an audit
- Providers will need to decide whether they can code higher with time or MDM: **OP will assist!**

MDM Documentation: Problems Addressed

- Fully describe as: acute, stable, increased, recurring, or considered but ruled out.
- Document symptoms that are present but not typically characteristic of a condition, that indicate an increased severity of disease, or that indicate need for further evaluation.

MDM Documentation: Data Reviewed/Analyzed (1/3)

- Document sources of history (“mother reported no family hx of GI disorders including celiac disease”)
- Document external records and reports reviewed
- Document a rationale for tests ordered if not easily inferred
- Include notes on any discussion with other health care professionals external to the practice or with appropriate sources, such as teachers or social workers. The level of MDM is not increased by discussions with health care professionals in the same group practice and same specialty but is increased by discussion with a physician of a different specialty in the same or other group practice.

MDM Documentation: Data Reviewed/Analyzed (2/3)

- Include notes on any discussion with other health care professionals external to the practice or with appropriate sources, such as teachers or social workers.
- The level of MDM is ***not*** increased by discussions with health care professionals in the same group practice (running by your partner) and same specialty but is increased by discussion with a physician of a different specialty in the same or other group practice.

MDM Documentation: Data Reviewed/Analyzed (3/3)

- Document findings of informal test interpretation (eg, viewed image and agree with radiologist that there is no apparent fracture).
- If separately reporting a code for interpretation and report or communication with an external health care professional, do not count this toward the amount and/or complexity of data reviewed or analyzed.

MDM Documentation: Risk

- Risk of complications and/or morbidity or mortality of patient management

Remember to the insurance company/auditor:

if it's NOT documented, it's NOT done.

MDM Business Implications

- Providers will need to more accurately document what they were thinking about, what they considered, what else they discussed in order to meet higher MDM
- “Sloppy documenters” are going to result in significantly less 99214s (and in some cases 99213s)
- Providers who see a high volume of patients per day are likely not going to be able to bill at the same level that they had been using templates to quickly get to a 99214. ***May negatively impact your bottom line*** unless you have a strategy to change templates/documentation habits to support higher MDM.

Next Steps

More Information

- The AAP already has great resources and is developing an PediaLink module so your providers can get CME while they become better informed about these changes
- See resources provided
- Stay tuned for more granular updates from OP Subject Matter Experts
- Stay tuned for OP changes that will assist your providers

Practice Action Items

- Subscribe to the AAP Coding Newsletter
  - July 2020 edition has much of this information
  - More to come in upcoming editions
- Make sure the right people in your organization are getting OP informational updates/emails to take advantage of new information
- ***Make sure you are not behind on OP versions in January!***
- Develop a PLAN to disseminate ongoing educational information to ALL of your providers
  - Include protected time to DO THIS IMPORTANT WORK
- Develop a PLAN for internal practice audits of notes starting in January
- Analyze the impact to your business and make sure everyone understands their part

FAQs

- Can we start using these changes prior to 1/1/21?
  - Only MEDICARE has allowed providers to start using these new rules prior to January. Auditors will look at your notes through 12/31/2020 using the CURRENT documentation guidelines

- Is there a chance this will be delayed?
  - NO. Medicare already went there.

- Can the insurers refuse to follow these new rules?
  - No. The documentation rules are written into the definition of the CPT code itself.
  - The AAP including Payer Advocacy Advisory Committee (PAAC) already has a strategy to track/report problematic payers.

Resources

- AMA CPT Guideline Changes
- AAP News Article on Upcoming Changes
- AAP Coding Newsletter
- AAPC Article about 2021 Coding Changes
- E/M University 2021 Changes online course

For your time & attention