



2021 Office Visit E/M Coding Changes: A Closer Look at **Time** in OP

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Agenda

- Brief review of the CPT codes with time descriptions
- Deeper dive of time tracking functionality in OP
- Discuss what time tracking OP **can** help you with
- Discuss what time tracking OP **cannot** help you with
- Overview of visible changes in OP that will be coming your way
- Outline planned additions for early 2021

Sue Kressly Disclaimer

- I am not a certified coder
- I am have no legal credentials
- I do not work for AMA or the AAP
- The information that you are about to see is my personal interpretation of educational materials that are available in the public domain
- There are nuances about coding, documentation and audits that are yet unknown since we are entering uncharted territory
- I do not have a crystal ball
- ***It is the legal responsibility of each provider who sees patients to educate themselves to the fullest extent possible, and choose the most appropriate code that represents the work which they performed***

OP Disclaimer

- We are headed into uncharted waters, and details about what “can count” and what “shouldn’t count” is evolving.
- OP built these tools based on what was believed to be accurate based on subject matter expertise at the time.
- OP expects there will be modifications/changes to this functionality as more is learned from both the industry and our practices.
- All coding recommendations are “suggested” based on information that can be tracked in OP.

CPT Code Definitions: 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

CPT Code Definitions: 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

Time: What Counts?

- Provider time
- Spent the same calendar day as the office visit (00:01am -11:59 pm)
- Clinical time

Time: What Does NOT Count?

- Clinical staff time
- Time spent the day previous or the next day (*only on the date of the face-to-face encounter or virtual face-to-face/Telehealth*)
- Time spent doing work that you are billing for separately with its own CPT codes
 - Time spent reviewing Vanderbilts
 - Time spent performing a procedure you bill for separately (cauterization of an umbilical granuloma, reduction of a subluxed radial head)
- Time of a “non-qualified” other healthcare professional that you supervise
- Time the provider spends doing non-clinical work
 - Scheduling an appointment
 - Processing payment

HOW is OP Keeping Track?

- Patient does ***not*** need to have an appointment in the calendar for the day (prior OP communication set that expectation, it is no longer required)
- Calculates time that a ***provider*** when **logged in** to OP spends on specific sections inside OP with the **focused** patient
- Practice does NOT have a preference where you can log into more than one device at the same time

Time Tracking Assistance: What Your OP Should Look Like

Do **NOT** have this box unchecked or OP cannot track your time appropriately. OP **cannot** keep track of your time if you are logged in to more than one device.

Do **check this box** in order for OP to track your time appropriately.

The screenshot shows the 'System Preferences: Affects all users on the network.' window, specifically the 'Security' tab. The 'ADMIN' menu item is highlighted in the top navigation bar. The 'Global Preferences' button is also highlighted. The 'Security' tab contains several settings, including password validation and auto-logout. A red box highlights the 'Auto Logout' section, specifically the checkbox 'Do not allow simultaneous login on multiple workstations:'. A green arrow points from the text 'check this box' to this checkbox. The 'Apply' button is visible next to the checkbox. Below the checkbox, there is a 'Timed Logout' section with a dropdown menu set to '5'.

System Preferences: Affects all users on the network.

Basic Colors & Font Schedule Special Clinic Info. Billing Maintenance Security Exit

☒ Use strong password validation *If enabled, passwords become case sensitive and the following settings are used in validating passwords.*

Minimum password length: 6

Number of consecutive attempts at setting a password before user is disabled: 5

Number of passwords a user must set before reusing the same password: 2

Minimum # of days user must wait before changing their password again: 2

Maximum # of days a password is valid before it must be changed:

of days in advance to remind user that maximum valid days is approaching:

☒ Password requires characters other than letters

☐ Allow user name to be part of password

Auto Logout:

☐ Do not allow simultaneous login on multiple workstations:
If enabled, every workstation must have a unique designation. See Utilities-> System Administration-> Workgroup-> Administration.

Apply

Timed Logout:

Set the number of minutes of inactivity before the user is logged out. All forms remain open. Encounter or Preventive exam forms that are open will be auto-saved, (not closed - but saved) after 15 minutes. Office Practicum will be automatically closed after 3 hours of inactivity. Inactivity is time since last key stroke or mouse click. 0 = disabled.

5

Starting Checklist

- Provider is logged into OP ✓
- Global preference is checked to not allow simultaneous logins ✓

OP Will “Follow” the Provider Wherever They Go

- Uses the focused/highlighted patient on the OP form

The screenshot displays the OP software interface. At the top, a patient chart header for 'MAX TESTBABY (8700)' is visible. Below it, a message form is open, with the patient name highlighted in a red box. The form includes fields for 'From' (SUSAN KRESSLY [305]), 'To' (MAX TESTBABY (8700)), and a 'Send' button. The top ribbon shows various tabs like CLINICAL, PRACTICE MANAGEMENT, BILLING, ADMIN, TOOLS, PERSONALIZE, and HELP. The message form also includes a 'Current Message' tab and a 'Send' button.

- Does not use the highlighted patient on the top ribbon

The screenshot shows the top ribbon of the OP software interface. The patient name 'EMMA TESTBABY (8700)' is highlighted in a red box on the top ribbon. The ribbon includes tabs for CLINICAL, PRACTICE MANAGEMENT, BILLING, ADMIN, TOOLS, PERSONALIZE, and HELP. Below the ribbon, the message form for 'MAX TESTBABY (8700)' is visible, showing a discrepancy between the highlighted patient on the ribbon and the patient in the message form.

- Specific forms will be tracked because likely reflect “clinical work”

Forms in OP Which Will Be Tracked

What Is and Is Not Tracked for Time

Tracked in the Encounter <small>Note: All sections are time-tracked.</small>	Tracked in the Patient Chart		Not Tracked in the Patient Chart
<div><div>Visit Info</div><div>CC/HPI/ROS</div><div>Problem List</div><div>Allergies</div><div>Medications</div><div>Immunizations...</div><div>History</div><div>Risk Assess</div><div>Surveys</div><div>Vitals/Growth</div><div>Implantables</div><div>Narr Exam</div><div>Detail Exam</div><div>Graphic</div><div>Couns/CoC</div><div>Diag Tests</div><div>Referrals/TOC</div><div>Assess/Plan</div><div>Orders</div><div>Care Plans</div><div>Asthma Plans</div><div>Coding</div><div>Summary</div></div>	<div><div>CLINICAL</div><div>Clinical Overview</div><div>Care Plans</div><div>Encounters</div><div>Well Visits</div><div>Referrals/TOC</div><div>Problem List</div><div>Allergies</div><div>Medications</div><div>Immunizations (*)</div><div>History</div><div>Vitals/Growth</div><div>Implantable Devices</div><div>Diagnostic Tests</div><div>Risk Assessment</div><div>Surveys</div><div>Development</div><div>Asthma Plans</div><div>General Notes</div></div>	<div><div>DEMOGRAPHICS</div><div>Basic Information</div><div>Notes/Addl Info</div><div>Privacy/Sharing</div><div>Family Contacts</div><div>Clinical Contacts</div><div>Consent Forms</div></div> <div><div>ACCOUNT</div><div>Insurance</div></div> <div><div>COMMUNICATION</div><div>Messages</div><div>Tasks</div><div>General Letters</div></div> <div><div>REPORTS</div><div>Documents</div><div>Medical Records</div><div>School/Camp</div></div>	<div><div>ACCOUNT</div><div>Summary</div><div>Claims</div><div>Charges</div><div>Payments</div><div>Credits</div><div>Statements</div><div>Disclosures</div></div> <div><div>- Schedule (Calendar or Tracking)*</div><div>- Message Center*</div><div>- Clinical Work window*</div><div>- Billing Center*</div></div> <div><div><i>*While these areas can be used to navigate to a Patient Chart, the act of viewing these windows does not trigger time-tracking. It is not until you actually go to the Patient Chart that time-tracking begins.</i></div></div>

What About Logouts?

- OP ***cannot*** track your time when you are not logged in to OP on the computer (for example, reviewing paper records, phone time)
- OP will be ***inaccurate and overcount*** your time if you are logged in, and a patient is focused but you walk away from your computer
- Be aware of what your timed logout preference is: if you are with the patient and the computer auto-logs you out, time will be ***undercounted***

Where is My Timed Logout Preference?

The screenshot shows a software interface with a top navigation bar containing 'ADMIN', 'TOOLS', 'PERSONALIZE', and 'HELP'. Below this is a sidebar menu with items like 'Administration', 'EPCS Access Control', 'Logged In Users', 'Backup Log', 'HL7 Error Log', 'Global Preferences', 'Audit Trail', 'Monitor SQL', 'Reports', and 'Customize'. The 'Global Preferences' option is highlighted with a red box. The main content area is titled 'System Preferences: Affects all users on the network.' and has tabs for 'Basic', 'Colors & Font', 'Schedule', 'Special', 'Clinic Info.', 'Billing', 'Maintenance', 'Security', and 'Exit'. The 'Security' tab is selected and highlighted with a red box. Inside the 'Security' tab, there are several settings: 'Use strong password validation' (checked), 'Minimum password length' (6), 'Number of consecutive attempts at setting a password before user is disabled' (5), 'Number of passwords a user must set before reusing the same password' (2), 'Minimum # of days user must wait before changing their password again' (2), 'Maximum # of days a password is valid before it must be changed' (empty), '# of days in advance to remind user that maximum valid days is approaching' (empty), 'Password requires characters other than letters' (checked), and 'Allow user name to be part of password' (unchecked). Below these are 'Auto Logout' settings: 'Do not allow simultaneous login on multiple workstations' (checked) and an 'Apply' button. At the bottom, the 'Timed Logout' section is highlighted with a red box. It includes instructions: 'Set the number of minutes of inactivity before the user is logged out. All forms remain open. Encounter or Preventive exam forms that are open will be auto-saved, (not closed - but saved) after 15 minutes. Office Practicum will be automatically closed after 3 hours of inactivity. Inactivity is time since last key stroke or mouse click. 0 = disabled.' and a spinner control set to '5'.

ADMIN TOOLS PERSONALIZE HELP

Administration
Administration
ze LOINC Codes
Activities

EPCS Access Control
EPCS Provider Dashboard

Logged In Users
Audit Trail

Backup Log
HL7 Error Log
Monitor SQL

Global Preferences

Reports Customize

System Preferences: Affects all users on the network.

Basic Colors & Font Schedule Special Clinic Info. Billing Maintenance Security Exit

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of days in advance to remind user that maximum valid days is approaching:

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☐ Allow user name to be part of password

Auto Logout:

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If enabled, every workstation must have a unique designation. See Utilities-> System Administration-> Workaroup-> Administration.

Apply

Timed Logout:
Set the number of minutes of inactivity before the user is logged out.
All forms remain open.
Encounter or Preventive exam forms that are open will be auto-saved, (not closed - but saved) after 15 minutes.
Office Practicum will be automatically closed after 3 hours of inactivity.
Inactivity is time since last key stroke or mouse click.
0 = disabled.

5

Time Tracking is **Guidance Only!**

- OP Time tracking is meant to assist you and offer guidance
- OP Time tracking ***should not be taken as absolutely accurate***
- OP uses time tracking to offer coding ***recommendations***
- OP Time tracking should be used to “sanity check” the approximate time you believe you spent
- OP currently is only tracking time for the ***rendering*** provider
- ***It is the responsibility of the provider who did the work to adjust the time and choose the most appropriate code based on the clinical work performed***

Reviewing the New Coding Tab in OP

- New tab Assess/Plan
- Order tab separate
- Defaults to new E/M radio button
- ***Use Legacy*** until 1/1/21
- Learn More: takes you to resources on OP Help
- Total time for reference
- PROVIDER enters their attested time
- Comments show on note summary

The screenshot displays the 'Services and Procedures Coding' interface. A red arrow points to the 'Services and Procedures Coding' title. Below it, the 'Diagnostic/Procedure Codes' tab is active, and the 'E/M' radio button is selected. A red box highlights the 'E/M' radio button. The 'Tracked Time' section shows 'Pre-visit Preparation', 'Intra-visit Work', and 'Post-visit Work' all at 0 minutes and 0 seconds. A red arrow points to the 'Learn More' button next to 'Tracked Time'. The 'Total Time' section shows 'Attested time' with a dropdown menu and a red box around it, and a '20 minutes' value in a red box. A red star is placed over the 'Comments' text area. The 'MDM' section includes dropdowns for 'Problems' (Low), 'Data Review/Analysis' (Minimal or None), 'Risk of Complications', and 'MDM Summary' (Straightforward), each with a corresponding 'Comments' text area. A red star is placed over the 'Comments' text area for 'MDM Summary'. At the bottom, the 'Visit type' is set to 'Estab', and the 'CPT Codes' section shows a table with columns for 'CPT Code', 'Mod', 'CPT Description', and 'Procedure Note'. A red star is placed over the 'Assess/Plan' tab in the left sidebar.

Flag as incomplete

Services and Procedures Coding

Diagnostic/Procedure Codes Coding Decision Support (Legacy)

☒ E/M ☐ Categories ☐ Templates

Tracked Time

Pre-visit Preparation 0 minutes 0 seconds

Intra-visit Work 0 minutes 0 seconds

Post-visit Work 0 minutes 0 seconds

Total Time

Attested time: [dropdown] minutes

20 minutes

Comments

CPT code suggestion: 99213 Add Suggested Code

MDM

Problems Low

Data Review/Analysis Minimal or None

Risk of Complications

MDM Summary Straightforward

CPT code suggestion: 99212 Details Add Suggested Code

Visit type: ☒ Estab ☐ New pt

CPT Codes Add CPT Code: [input]

CPT Code	Mod	CPT Description	Procedure Note	
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OP Time Tracking “Buckets”

- In order to help providers “sanity check” their total time, OP will divide tracked time into the following 3 buckets:
 - Pre-visit preparation: clinical time the provider spends before the beginning of the visit (starting at 00:01 am)
 - Intra-visit work: clinical time the **rendering** provider spends during the course of the visit
 - Post-visit work: clinical time the provider spends after the completion of the visit (up to and including 11:59 pm)

OP Time Tracking “Buckets”

- Time can only be broken into “buckets”
 - When preferences are set for intra-visit and post-visit appointment stages
- If preferences are not set, or the patient does not have an appointment in the schedule, OP will only track ***total*** time

OP Time “Buckets”

- Pre-Visit Preparation
- Intra-Visit Work
- Post-Visit Work

Services and Procedures Coding

Diagnostic/Procedure Codes Coding Decision Support (Legacy)

☒ E/M ☐ Categories ☐ Templates

Tracked Time

[Learn More](#)

Pre-visit Preparation 4 minutes 44 seconds

Intra-visit Work 5 minutes 42 seconds

Post-visit Work 3 minutes 4 seconds

Total Time 13 minutes

Attested time: 12 minutes

Comments

Showing comments in note

CPT code suggestion: 99212

[Add Suggested Code](#)

MDM

Problems

Minimal

Data Review/Analysis

Minimal or None

Risk of Complications

MDM Summary

Straightforward

CPT code suggestion: 99212

[Add Suggested Code](#)

[Learn More](#)

Comments

Comments

Comments

Comments

How Does OP Sort By Buckets?

- A global practice preference setting will allow the practice to determine a specific visit stage that indicates “start intra-visit counting here”
 - This MUST be one of your *provider* stages in OP
- A second global practice preference can be set to determine the end of the intra-visit work
 - This can be a provider stage
 - This does not have to be a provider stage
 - Practice may want to create a new OP stage to indicate provider is finished with visit

Practice Preferences

The screenshot shows the 'Practice Preferences' window. At the top, the 'ADMIN' menu is highlighted with a red box. Below it, the 'Global Preferences' option is also highlighted with a red box. The 'Clinic Info.' tab is selected and highlighted with a red box. The window contains several sections of settings:

- Electronic Billing Transmission (print image only):**
 - ☐ Physicians registered under multiple corporate names
This will allow individual MD billing. Electronic claims clearing houses require separate batch billing for each corporation.
- Default Date Settings:**
 - 14 Referral Flag Days
- Time Tracking:**
 - ☒ Start tracking intra-visit time when the doctor stage is MD: InProgress
 - ☒ Start tracking post-visit time when the stage is Checked Out

Two red stars are placed next to the 'MD: InProgress' and 'Checked Out' dropdown menus.

What Happens if We Don't Set Preferences?

- If you don't set any preferences: everything will be tracked in the total bucket
- Does this matter?
 - Makes it more difficult to sanity check your time spent
 - Does not have any implication on total time (which is what you are attesting to)
 - Does not get sent to payers
- If you don't set up a "stop" time for intra-visit work, there will be no "post-visit" bucket time
- OP will only fill the "buckets" which you delineate by setting preferences

What Does it Mean to “Attest” to Time?

- The provider is acknowledging that they are choosing a CPT code that reflects the total amount of time they actually spent that “counts” according to the AMA rules
- OP only **suggests** the code
- The rendering provider who did the work, must attest to its accuracy (not the biller who was not in the room). It is the rendering provider’s legal responsibility.
- If the provider does not fill in the “attested time” but chooses the “Add Suggested Code” button in Tracked Time, OP will auto-fill the attested time with the value in the tracked total time field

What About Extra Unanticipated Time?

- If you choose a CPT code and finalize your note:
 - Any additional time spent afterward will not be counted or reflected in your note
 - Best practice is to document the extra time as an addendum and inform your biller of the additional time so the CPT can be adjusted if appropriate
- What if my note is *not* finalized?
 - OP will recalculate any additional clinical time a provider spends
 - You can return to your note and use the recalculation to choose an updated CPT coding level if appropriate

What Gets Documented in the Note?

- It's always great to leave no doubt for auditors
- Consider language such as “I attest the total time spent by the provider doing clinical work including previsit, intravisit and postvisit work was x minutes.”
- May also want to put additional details in the note somewhere such as “spent 15 minutes preparing for visit reviewing old records as well as ER report from visit on 11/1/20”
- Coding details/attestation will be part of the audit note (which is what you should supply to payers in an audit)
- Can choose to add coding details to encounter summary note

What Happens to those “Comments” I Make?

- Displays in *audit note summary* if you write a comment
- **Also** displays in standard note summary *if* you include it in your note criteria

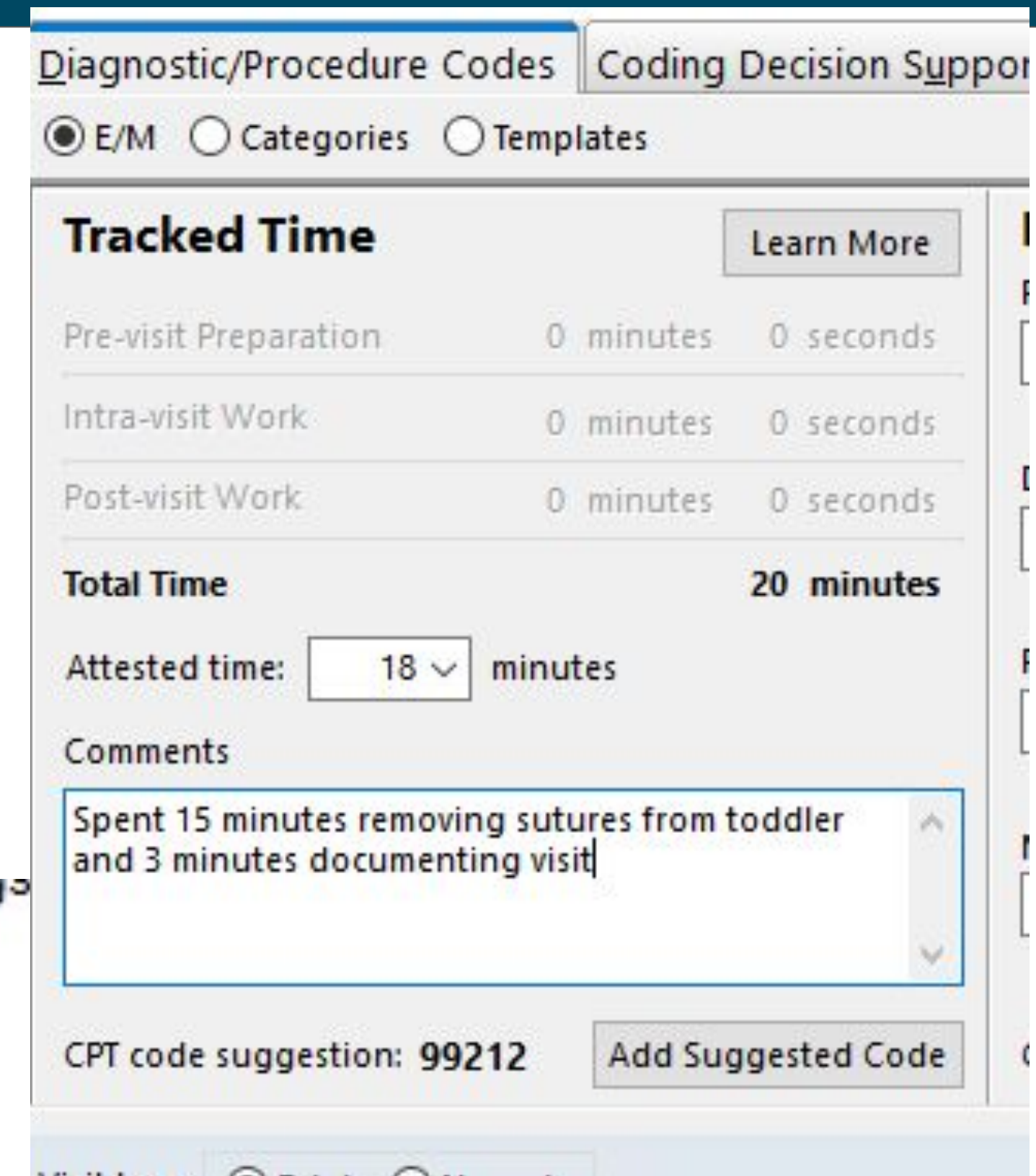


The screenshot shows a sidebar on the left with icons for 'Care Plans', 'Coding', and 'Summary'. The 'Summary' icon is selected. The main content area displays the following information:

Procedures:
99212 OFFICE/OUTPATIENT VISIT, EST

Coding/Audit
Attested Time: 18 minutes -- Spent 15 minutes removing sutures from toddler and 3 minutes documenting visit

Providers:



The 'Coding Decision Support' window has two tabs: 'Diagnostic/Procedure Codes' (selected) and 'Coding Decision Support'. Below the tabs are three radio buttons: 'E/M' (selected), 'Categories', and 'Templates'. The 'Tracked Time' section includes a 'Learn More' button and a table with the following data:

Activity	Minutes	Seconds
Pre-visit Preparation	0	0
Intra-visit Work	0	0
Post-visit Work	0	0
Total Time	20	minutes

Below the table, 'Attested time:' is shown with a dropdown menu set to '18' and the word 'minutes'. A 'Comments' text area contains the text: 'Spent 15 minutes removing sutures from toddler and 3 minutes documenting visit'. At the bottom, 'CPT code suggestion: 99212' is displayed next to an 'Add Suggested Code' button.

Including Coding Audit info in Summary Notes

- Optional preference
- Will be available to all
(including external entities who receive/read notes)

The screenshot shows the 'Report Criteria' window with the 'Encounter Sections' tab selected. The window has a table of criteria and a section for selecting report options.

Report Group Name	Notes	Owner
-Encounter Note	Standard encounter note	48F824E5, DD7482F
-Event Chronology, ALL	Event Chronology, all patient records	48F824E5, DD7482F
-Event Chronology, abbreviated	-Event Chronology, abbreviated	48F824E5, DD7482F
2011 PCMH ADD/ADHD	Encounters for ADD	Wiggin, Demosther
2011 PCMH eczema	Encounters for eczema	Wiggin, Demosther
Audit Report Note	Audit Report Note that excludes confidential info	User, Administrative
CPT coding summary	List of CPTs for visits	Wiggin, Demosther
Chart Note Review	Generate and print chart note problem review	
Diagnostic Test Result	Individual diagnostic test	Wiggin, Demosther
Encounter Dx List	Lists all ICD of visits/dates	Wiggin, Demosther

Report Options | Report Sections | **Encounter Sections** | Encounter Section Names | Demographics | Formatting

☐ All

☒ Patient Demographics

☒ Visit Information (date/location)

☒ Chief Complaint / Interval History

☒ History of Present Illness

☒ Review of Systems

☒ Personal/Family/Social History

☒ Advanced directives

☒ Risk assessment

☒ Surveys

☒ Vital Signs

☒ Examination

☒ Assessment/Medical Decision Making

☒ Counseling

☒ Plan

☒ Patient Instructions

☒ Medications

☒ Diagnostic Tests

☒ Checklist Tasks

☒ Coordination of Care

☒ Care Plans / Goals

☒ Followup

☒ Procedures

☒ Providers

☒ Addenda

☒ **Coding / Audit Support**

What About Scribes?

- Scribes are not providers, so their time will not be tracked
- If the provider is logged in and doing pre-visit, intra-visit or post-visit work that time will be counted
- The scribe can help track intra-visit work and document such in the comments on the E/M coding tab and make appropriate adjustments to the calculated time
- OP considering future enhancements to support Scribes

What Changes May Be Headed our Way?

- OP may remove the time you spend on the coding tab (it's not clinical work, but it is documentation??)
- More details about where OP tracked your time
- Tracking time for other people (not just rendering providers) and other purposes (such as care coordination, etc.) not just for office visit E/M coding
- Consideration for practice specific wording about “attested time” in note
- Scribe role support

Learn More

- Will take you to OP Help Center
- Will give you additional resources
- Will display known discrepancies between what OP's calculator is computing and current SME understanding/AMA updated guidance

Services and Procedures Coding

Diagnostic/Procedure Codes | Coding Decision Support (Legacy)

☒ E/M ☐ Categories ☐ Templates

Tracked Time

Pre-visit Preparation 0 minutes 0 seconds

Intra-visit Work 0 minutes 0 seconds

Post-visit Work 0 minutes 0 seconds

Total Time 20 minutes

Attested time: minutes

Comments

CPT code suggestion: 99213 [Add Suggested Code](#)

MDM

Problems Low [Learn More](#)

Comments

Data Review/Analysis Minimal or None [Learn More](#)

Comments

Risk of Complications

Comments

MDM Summary Straightforward

Comments

CPT code suggestion: 99212 [Details](#) [Add Suggested Code](#)

Visit type: ☒ Estab ☐ New pt

CPT Codes Add CPT Code:

CPT Code	Mod	CPT Description	Procedure Note	...
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Resources

- [AMA Guidance](#)
- [AAP Guidance](#) including
 - [Summary of Time Changes](#)
 - [New Prolonged Service Code](#)
 - [FAQs](#) (updated frequently)
 - [Coding Newsletter](#) (subscription required but well worth it!)
 - [Coding for Pediatrics 2021 Edition](#) (purchase but a must have!)
 - [Pediatric Evaluation and Management: Coding Quick Reference Card 2021](#) (\$21.95 for non members, \$16.95 for AAP Members)
- Section on Administration and Practice Management AAP FAQs: <http://bit.ly/faq2021cpt> (and while you are there, [join SOAPM!](#))



For your time
& attention