Release Notes OP 20.10.2

Office Practicum 20.10.2 Release Notes
All content is subject to change.

Release Dates:

Cloud
December 12, 2020

On-Premise
December 16, 2020 following the standard availability announcement

Before reporting any issues specific to the release, check Post-Release Support Trend Updates for new topics that have already been reported.

Note: If any content in these Release Notes discusses an issue that has medical implications, that heading is displayed in **red**.

Enhancements to Support the 2021 Office Visit E/M Coding & Documentation Changes

OP 20.10.2 features enhancements made to support the 2021 Office Visit E/M Coding and Documentation changes that will be in effect as of January 1, 2021. It is important to note that the details of what “should” and “should not” count are evolving and the developments in OP can only align with what we know to be true at the time of development. We expect that there will be modifications to the enhancements 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. 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.

In the sections below, you will find the enhancements made in OP that support the 2021 Office Visit E/M Coding and Documentation changes.

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❕ **Important**: Because these enhancements are being released prior to when the 2021 guidelines go into effect, January 1, 2021, providers will need to follow a temporary workflow for coding an Encounter. Refer to the following resources for instruction on coding an Encounter before and after January 1, 2021:

- **Prior to January 1, 2021**: Encounter: Legacy Coding
- **After January 1, 2021**: Encounter: Code and Finalize the Visit Note

Resources: The 2021 Office Visit E/M Coding & Documentation Changes Resource Center located in the OP Help Center contains all of the resources that are referenced in the following sections.

Enhancements that Support both Medical Decision Making (MDM)-Based Coding and Time-Based Coding	

Renaming of Assessment and Plan/Orders
Encounter Note > Assess/Plan
 	
Encounter Note > Orders
	• The Assessment section of the Encounter window has been renamed **Assess/Plan** and includes:
	  ○ Diagnoses
	  ○ Assessment
	  ○ Plan
	  ○ Patient Instructions
	• The Plan/Orders section of the Encounter window has been renamed **Orders** and only includes the Order tabs.
	
	While overall personalization will not be affected, this change may display Assess/Plan and/or Orders for users who previously did not have them displayed in the Encounter window.

Template Filter Options Encounter Note > CC/HPI/ROS, Narrative Exam, Detail Exam, Assess/Plan, Orders	The Template filter list located at the top of the window, which defaults to All Templates, now includes an option to filter Templates that are **Author Specific**. Selecting this option allows the user to then choose the author(s) whose templates will be available by selecting the appropriate checkbox(es).
Redesigned Coding Window Encounter Note > Coding	The Encounter Coding window has been redesigned to display **Tracked Time** and **MDM** side-by-side. The Tracked Time side of the window includes: • A **Learn More** button that takes users directly to the Time-Based Coding Resources in the OP Help Center. • An **Add Suggested Code** button used to apply the time-based Suggested Code to the Encounter. The MDM side of the widow includes:

	• A **Learn More** button that takes users directly to the Medical Decision Making-Based Coding Resources in the OP Help Center. • An **Add Suggested Code** button used to apply the MDM-based Suggested Code to the Encounter. • A **Details** button that displays the calculated amount of documentation that supports each level of MDM. The window also includes a **Categories** radio button for users to select their CPT codes from the previously defaulted electronic superbill view if needed.
Ability to Collapse Encounter Navigation Panel Encounter Note	A **collapse/expand** button has been added to the Patient Encounter window to allow users to collapse or expand the navigation panel.

Enhancements that Support Medical Decision Making (MDM)-Based Coding

Resources Specific to Medical Decision Making-Based Coding:

- Where and How MDM is Indicated and What OP Can and Cannot Do
- Definitions and Examples of the Elements of MDM
- Medical Decision Making Calculation Support in OP

Supports Element: Problems Addressed **Problem Status Selector** Clinical tab > Encounter Templates Encounter Note > Assess/Plan	A new **Problem Status** column in the Encounter Template Editor allows the selection of a default Problem Status for each diagnosis in the template. The default Problem Status selection is then displayed in the Assess/Plan of the Encounter where it can be changed, if needed, using the drop-down menu located in the Problem Status column. If a default Problem Status was not added in the Template Editor, it may be selected when documenting the visit.
Supports Element: Data Reviewed/Analyzed **Independent Historian and Assisted by Translator Fields** Encounter Note > Visit Info	• The **Independent Historian** drop-down lists the patient's Family Contacts/free-text field to document who is providing the information to the provider. • The **Assisted by translator*** checkbox can be selected to indicate a translator was needed to collect visit information. * As of 11/24/2020, this is under consideration by the AMA as a valid MDM action and therefore will not be counted by OP for MDM at this time.
Supports Element: Data Reviewed/Analyzed	The **Reviewed Today** button, when clicked, indicates that a

Reviewed Today Button for Diagnostic Tests Patient Chart > Diagnostic Tests Encounter Note > Diag Tests	historical test result was on the current day/date of the Encounter, given it is relevant to the patient's current visit or reason for seeking care. * As of 11/24, the decision to exclude in-house tests was made by AMA, and OP plans to deliver the ability to filter these out in a future release. * As of 11/30, the decision to exclude labs previously reviewed by you or another provider in the practice was made by the AMA, and OP plans to deliver the ability to filter these out in a future release.
Supports Element: Data Reviewed/Analyzed **Ability to Mark a Previously Reviewed Document as Reviewed for the Encounter** Patient Chart > Documents Clinical or Practice Management tab > Document Mgmt	The **Mark Reviewed** button in a previously reviewed document of a specific set of categories* counts the document as data reviewed if clicked on the current day/date of the Encounter. The Reviewed by fields in the Document Details are updated to reflect the latest review information. * For a list of valid categories, see: Where and How MDM is Indicated and What OP Can and Cannot Do
Supports Element: Data Reviewed/Analyzed **Care Coordination Fields** Encounter Note > Couns/CoC	The Time Spent and Key Factor fields have been replaced with: • The **Discussed With** field provides a space to document the other qualified health professional with whom care is being coordinated. This field is a free-text field, but can also be populated using the Address Book or Clinical Contacts buttons located to the right of the field. In order for this to be counted, additional details of the coordination must also be entered in the Coordination of Care field. • The **Independent Interpretation of Tests** checkbox can be used to indicate such interpretation. Documentation of the interpretation must also be entered in the Coordination of Care field.
Supports Element: Risk of Complications and/or Morbidity or Mortality **Ability to Mark Risk Questions as Eligible Social Determinants of Health** Clinical tab > More button (Customize group) > Risk Assessments	Risk Questions can be marked as eligible for **Social Determinants of Health** indication by selecting the SDOH checkbox. By default, Food Insecurity, Health Literacy, and Housing Insecurity (new) are selected as eligible for SDOH.
Supports Element: Risk of Complications and/or Morbidity or Mortality **Ability to Mark Risk Factors Pertinent to the Encounter**	Risk Factors that are pertinent to the Encounter can be indicated by selecting the **Pert** checkbox for the risk. These risks are added to the Encounter Summary, but only ones that

Encounter Note > Risk Assess	have been marked as eligible in the Risk Assessments Editor are counted for MDM.
Ability to Add Additional CC/HPI and Toggle Through Added CC/HPI Encounter Note > CC/HPI/ROS	Additional CC/HPI can be layered into the Encounter using two methods: • The **+CC/HPI** button can be used to manually add additional CC/HPI to the Encounter. This button is only used when an additional template is not being applied or a prior note is not being selected. • Selecting another template from the Template drop-down adds additional CC/HPI(s) templates to the Encounter. When an Encounter contains more than one CC/HPI, a new toggle feature gives users the ability to scroll through the CC/HPIs that have been entered.
Suggested Codes Based on MDM Documentation Encounter Note > Coding	E/M Codes are suggested based on the Encounter documentation done when 2 of the 3 elements are met. **See**: Medical Decision Making Calculation Support in OP

Enhancements that Support Time-Based Coding

Resources Specific to Time-Based Coding:

- What Counts as Time for an Encounter and Where Time is Tracked
- Set Intra-Visit and Post-visit Work Visit Stages
- Tracked-Time Code Calculation

Global Preference to Set Encounter Time Category Triggers Admin tab > Global Preferences > Clinic Info. tab	Practices have the option to decide which of their Patient Visit Stages will trigger the categorization of their Pre-visit-Preparation, Intra-visit Work, and Post-visit Work time. This categorization is intended to assist the providers in recalling where they spent time for the patient's Encounter. **Resource**: Set Intra-visit and Post-visit Work Visit Stages
Time-Tracking in the Patient Chart When Accessed on the Date of the Patient's Encounter	All areas of the Patient Chart are time-tracked except for Summary, Claims, Charges, Payments, Credits, Statements, and Disclosures. Time-tracking starts when a Rendering provider accesses a time-tracked window and stops when the provider exits, closes or navigates away from a time-tracked window.

Time-Tracking in the Encounter When Accessed on the Date of the Patient's Encounter	All areas of the Encounter Note are time-tracked. Time-tracking starts when the Rendering Provider accesses a time-tracked window and stops when the provider exits, closes or navigates away from a time-tracked window.
Ability to Manually Enter Attested Time Encounter Note > Coding	Providers have the ability to override the Total Time by entering an **Attested Time** which may also produce a new Suggested Code. An accompanying comment should be entered in the **Comments** field when manually entering Attested Time.
Suggested Codes Based on Time Spent on the Date of the Patient's Encounter Encounter Note > Coding	E/M Codes are suggested based on the Time Tracked on the date of the patient's Encounter: **Resource**: Tracked-Time Code Calculation

Improved Functionality

The following are improved functionalities or enhancements made to the software in OP 20.10.2.

Location	Description and Workflow
Reorganization of CC/HPI/ROS Clinical, Practice Management, or Billing tab > Patient Chart button > Encounters > New or Open Note > CC/HPI/ROS	The following improvements have been made to the CC/HPI/ROS section of the Encounter Note: • The Fever drop-down has been removed from the HPI section as it is not counted toward HPI. Documentation of a fever can be done in the ROS section of the Encounter. • Each CC has an accompanying HPI section to document the history of the individual complaint. This improvement also groups the CC/HPI in the Summary section of the Encounter, making it easier to review.
Reorganization of Prescription Window Clinical, Practice Management, or Billing tab > Patient Chart button > Encounters or Well Visits > New or Open Note > Medications Clinical, Practice Management, or Billing tab > Patient Chart button > Medications	In preparation for 2021 eRx certification, the Prescription window has been slightly redesigned to allow for space for additional prescription information to be included. The changes users see now are: • Relabeling of the diagnosis field from DX to **Primary DX**. • Relocation of the ICD-9 and ICD-10 radio buttons from next to the diagnosis field to between the Primary DX field and the Type field.
Curbside Text Messages	• Appointment Types with the words **Nurse** and **Flu** no longer trigger the sending of the Instamed Payment Link in Curbside texts.

	• Curbside texts now include the practice's Location name, rather than the Practice name.
Apply Default Exam Button Removed from Detail Exam Clinical, Practice Management, or Billing tab > Patient Chart button > Encounters or Well Visits > New or Open Note > Detail Exam	The Apply Default Exam button, which was non-functional, was removed from the Detail Exam section of the Encounter Note.
Portal Tab Visible in Global Preferences Admin tab > Global Preferences > Portal tab	The Portal tab in Global Preferences is now visible to all practices that have an IC_Portal correspondent record. This allows practices who have not yet gone live with their InteliChart portal to set their Sharing preference ahead of time.
Audit Trail Entries for Billing Group and Billing Rule Admin tab > Audit Trail button > Audit Trail of Changes to Records tab	The Audit Trail now contain entries for the following: • New or edited Billing Groups • New or edited OP AWARE Rules

Resolved Issues/Fixes

The following items have been identified as issues in the software and have been fixed in OP 20.10.2.

Location	Description	Fix
Pharmacy Refills Create an Error when there are Multiple Insurance Plans Main Navigation Panel > Refill Req > Refill/Change Requests tab	Users received an error message when completing pharmacy-initiated refill requests that included multiple insurance plans.	Users no longer get an error when completing pharmacy-initiated refill requests that include multiple insurance plans.
Tdap Not Forecasted Clinical, Practice Management, or Billing tab > Patient Chart button > Immunizations	The adolescent Tdap vaccine dose, given between the ages of 11-12, was not being forecasted if the patient received a Tdap at age 10.	VacLogic is updated to forecast Tdap appropriately according to the CDC's catch-up series. **Resource**: Td of Tdap Vaccine Dosing
CHADIS Survey Validation Patient Portal	Contacts attempting to complete a CHADIS Survey on the portal that did meet the Contact Algorithm between OP and InteliChart were being presented with the following: "email is not registered for this patient with the practice, please	Contacts who enter a valid email address and meet the Contact Algorithm requirements can complete CHADIS Surveys through the portal with no issue. If requirements are not met, the parent will be notified on-screen to contact

	contact the practice".	the practice. **Resource**: InteliChart Contacts
CHADIS Surveys Not Importing into OP Clinical, Practice Management, or Billing tab > Patient Chart button > Surveys	An error when processing newly received results for survey queues that are missing the staff who ordered the survey was preventing further results from being processed.	CHADIS Survey results sent to OP that are missing the staff who ordered the survey will no longer prevent further results from being processed. An additional check has been put into place to prevent individual errors from stopping further processing. Results will not be stopped from being pushed into OP from CHADIS.
Internal (OP) Surveys Shown as Completed in Patient Portal Patient Portal	Surveys sent to the Patient Portal were being shown as already completed when the parent attempted to complete the Survey.	Parents can access and complete Surveys in the Patient Portal, as expected.
Error Received when Searching for a Patient with an Apostrophe in their Name Clinical, Practice Management, or Billing tab > Patient Chart button > Patient Search	An error was received when searching for a patient whose name included an apostrophe.	Patient searches for names including apostrophes are completed as expected and without error.
Ability to Type in Appointment Type Field Clinical, Practice Management, or Billing tab > Patient Chart button > Encounters or Well Visits > New or Open Note > Visit Info	Users were able to type into the Appointment Type field in the Visit Info section of the Note. This was saving incorrectly named Appointment Types.	The Appointment Type field is no longer a free-text field. Users must use the ellipsis button to select a different Appointment Type, if necessary.
Ability to Override Survey Categories Clinical, Practice Management, or Billing tab > Patient Chart button > Surveys > New button	In the Survey Forms Explorer window, users were able to type over the Survey categories, thus changing the name of the category.	The Survey category names are no longer editable by clicking the category name. To edit the category name, the user must use the Edit button.
Ability to Edit Questions in Surveys that have been Administered Clinical tab > More button (Customize group) > Surveys	Users were able to edit questions in Surveys that were already administered to patients.	Questions in Surveys that have been administered to patients cannot be edited.

Unable to Archive or Unarchive Coded Values Practice Management tab > Coded Values button	When clicking the checkbox in the Archived column to either archive or unarchive a table row, an error message was displayed “Duplicate values for Description and Guidelines are not allowed, aborting save.”.	Users are now able to archive and unarchive any row from a table that allows edits in the Coded Values table, without receiving the error message.
Auto-Modifier -25 E/M w/ Procedures Billing tab > Payers button > Add or Edit Insurance Payer > Payer Coding Rules tab	The following CPT codes triggered the -25 modifier to be added to the E/M code when the Auto Modifier -25 E/M w/ Procedures checkbox was selected: • 0xxxx through 6xxxx • 92550-92588 • 99173-99177 • 961xx • 94760	The list of CPT codes that trigger the -25 modifier to be added to the E/M code has been updated to: • 00001-36409 • 36417-69999 • 96100-96199 • 94760 The following CPT codes no longer trigger the auto-modifier -25: • 36410 • 36415-36416 • 92550-92558 • 99172-99177