Embrace E/M coding changes to cut doctors' clerical burdens

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Changes for evaluation and management (E/M) office-visit documentation and coding developed by the AMA and adopted by the Centers for Medicare & Medicaid Services took effect this year and provide opportunities to refocus attention on patient care by reducing clinically irrelevant administrative burdens.

Two new white papers produced jointly by the AMA and Nordic, a Madison, Wisconsin-based health care consulting firm, offer guidance on taking advantage of opportunities to improve patient care and boost physician satisfaction by making operational changes and integrating the new documentation guidelines into a practice's electronic health record (EHR).

The papers, "2021 E/M Updates: What Will Happen to the Physician Note" and "2021 E/M Updates: EHR Workflow and Operational Considerations," were written by Barbara Levy, MD, a former chair of the AMA/Specialty Society RVS Update Committee (RUC) and Craig Joseph, MD, a pediatrician and Nordic's chief medical officer.

Dr. Levy, an ob-gyn, also served as co-chair of the work group convened by the AMA in 2108 that was responsible for the changes that were made to the AMA Current Procedural Terminology (CPT®) code set pertaining to E/M office visits.

New E/M office visit code-selection criteria remove complex counting systems for history, exam and data that sometimes varied by payer. While these simpler and more flexible guidelines only apply to the office visit codes, they are a big part of most practices.

Drs. Levy and Joseph also appeared in a series of webinars produced by the AMA and Nordic in which she emphasized that the code changes apply only to E/M in outpatient and office settings—but not to inpatient, home care or nursing home E/M. She noted that the AMA continues to work on proposals for those settings.

Both papers begin with a "How did we get here?" segment outlining how physician administrative burdens have grown along with corresponding rates of physician burnout. They then discuss the

goals and principles that led to the E/M reforms and describe the changes now in place.

Seize opportunity for change

The paper on the physician note describes how these changes may trigger a need for adjustments in level-of-service benchmarks and compensation as physician and coder efficiency and productivity rise and workflows improve.

Risks and opportunities are identified. While there is a potential for more coding errors as clinicians and coders adjust to the changes, a key risk is that change is not embraced.

“Physicians may continue to document as they have for the last 25 years, leading to unnecessary documentation and wasted time by physicians and coders,” the paper warns.

Sharpening physician focus

The workflow paper describes how practices can develop team-based care protocols to collect patient information, so physicians can focus “on tasks that only they can perform.”

In rooming protocols, for example, staff can be assigned tasks such as:

> Identifying the reason for the visit and help the patient set the visit agenda.
> Performing medication reconciliation.
> Screening for conditions based on other protocols.
> Updating past medical, family and social history.
> Arranging preventive services based on standing orders.

Tips are given on engaging patients to become part of their own care team by submitting structured notes prior to the visit which outline visit goals and symptom changes.

There are also recommendations on workflow, documentation and coding, as well as links to AMA tools and resources to help practices transition to the new reporting guidelines.