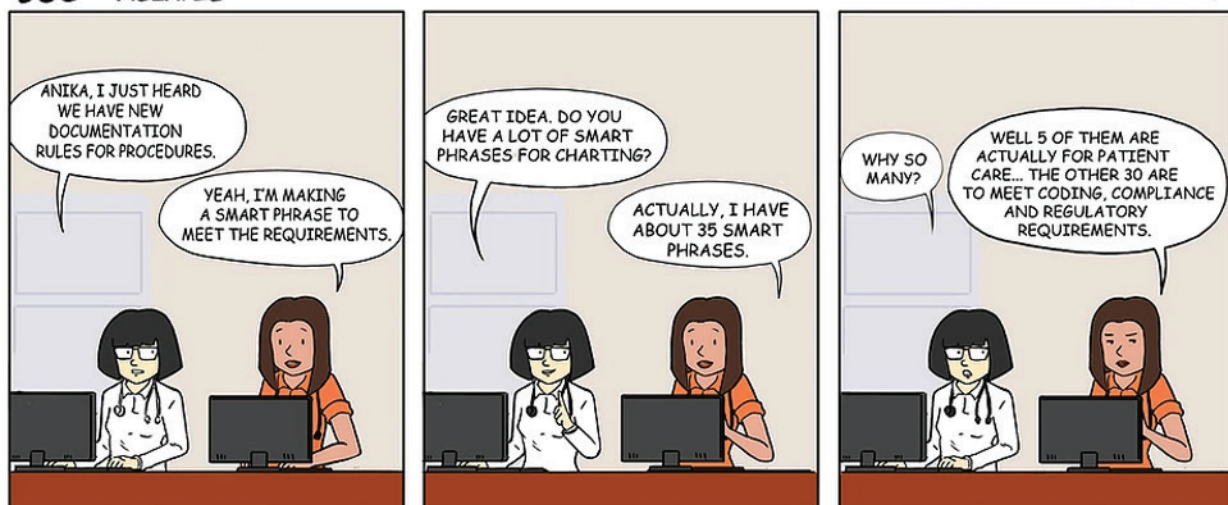


2021 E/M Updates: EHR Workflow and Operational Considerations

How did we end up here?

Physicians are increasingly burdened with administrative duties that either never existed before or were handled by other members of the care team. These new tasks, combined with other stressors, are leading contributors to an epidemic of clinician burnout in the United States.¹ While the cause of burnout among physicians is multi-factorial, the electronic health record (EHR) is a contributor,² as doctors spend a third of their time in the EHR documenting patient interactions.³ Groups such as the American Medical Association (AMA) and others identified the need to reduce the administrative burden associated with writing ambulatory notes, leading to changes in longstanding documentation requirements.

DOC-RELATED



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Easing E/M Documentation Requirements

Current Procedural Terminology (CPT®) codes are used in the United States by clinicians to notify payers of services rendered. A subset of these CPT codes (called evaluation and management and abbreviated E/M) apply to office visits. In the 1990s, the federal government implemented very specific guidelines around documentation requirements for each E/M code that contributed to physician progress notes including much more information than had been previously mandated. To ease physician burden, documentation guidelines were re-evaluated.

In the past few years, the AMA established and applied four guiding principles when redesigning E/M codes for office visits to adhere to the rules outlined by CMS and payers:

- ▶ Decrease administrative burden
 - ▶ Remove counting elements of the history and physical exam
 - ▶ Revise codes to reflect how physicians and other qualified healthcare professionals (QHP) think
- ▶ Decrease the need for audits
 - ▶ Provide more detail in CPT codes and introductory language to promote payer consistency if audits are performed and to promote coding consistency
- ▶ Decrease unnecessary documentation that is not needed for patient care in the medical record
 - ▶ Eliminate history and exam scoring
 - ▶ Promote high-level activities of medical decision-making (MDM)
- ▶ Ensure that payment for E/M is resource-based and has no direct goal of payment redistribution between specialties
 - ▶ Use current MDM criteria (CMS and educational/audit tools to reduce the likelihood of change in patterns)

Changes to E/M Guidelines

The new E/M codes became effective on Jan. 1, 2021 and apply only to outpatient visits.

The updated E/M codes are based on either MDM or time, and no longer take into account discrete documentation of the review of systems (ROS) or physical exam. Extensive clarifications and simplifications were provided in the guidelines to define the elements of MDM. With respect to time, the updated E/M codes include total time spent by the physician on the date of the encounter (before the visit, face-to-face time, and time spent after the visit) and do not require that counseling makes up at least 50% of the time of the visit. Clear time ranges were defined for each code.

It is anticipated that most often, physicians will use the MDM guidelines to calculate the appropriate E/M code. Typically, time will be utilized for visits that were low acuity yet required significant physician time for the following types of activities:

- ▶ Preparing to see the patient (e.g., review of tests)
- ▶ Obtaining and/or reviewing separately-obtained history
- ▶ Performing a medically necessary 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 reported separately)
- ▶ Documenting clinical information in the record
- ▶ Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- ▶ Care coordination (when not reported separately)

Table 2 - CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

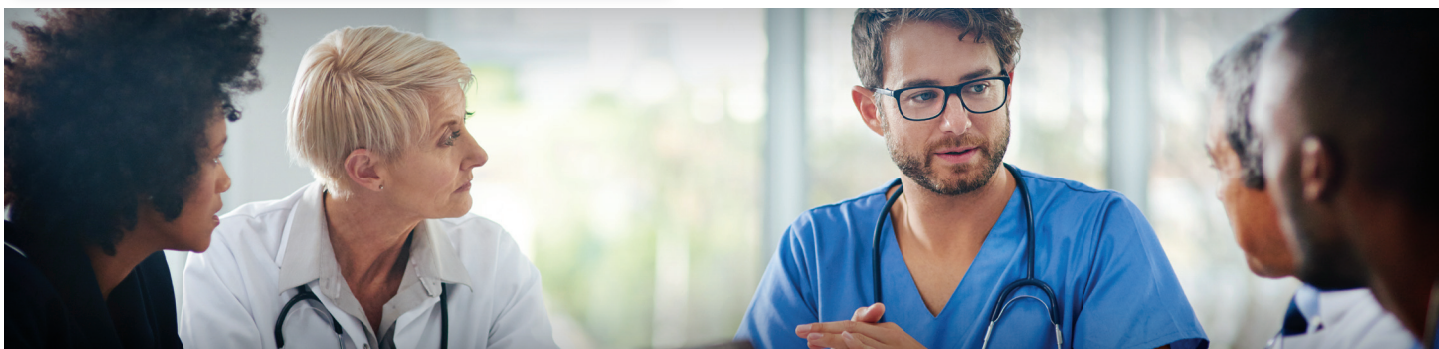
Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release



Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

<https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf>



Workflow and Operational Changes

Before the Clinic Visit

Team-based care involves all clinical members working at the highest level of their license so that synergy can be achieved. Teams can leverage protocols to allow data collection in a timely and efficient manner. These processes have been shown to increase quality and lower unnecessary medical utilization,⁴ while freeing up physicians to focus on tasks that only they can perform.⁵

Teams often first meet at morning huddles⁶ before the first patient of the day is seen. Huddles may last only 10-20 minutes, but it's important to note that any time a physician spends discussing a specific patient can be included if the physician elects to bill that day's encounter based on time.

In the past, various interpretations of CMS guidelines led to requirements that only physicians themselves could meaningfully contribute to progress notes. It is now well-established that there is no need for physicians to re-enter or re-document any part of the chief complaint or history that is recorded by ancillary staff or even the patients themselves.⁷ Hence, support staff and patients should be allowed to directly contribute to documentation.

Support staff can **gather relevant data** found throughout the EHR and highlight information for the physician to

review. If appropriate, the information can be incorporated into the note, ideally in summary form. Reports or similar EHR tools can be configured to surface information automatically that might be of interest to the physician. These tools are more likely to be of value to specialists as the problems, results, medications, and notes that a specialist might find helpful are more easily predicted than for a primary care doctor.

By creating **rooming protocols**,⁸ nurses or medical assistants can complete such tasks as:

- ▶ Identify the reason for the visit and help the patient set the visit agenda
- ▶ Perform medication reconciliation
- ▶ Screen for conditions based on protocols
- ▶ Update past medical, family, and social history
- ▶ Provide immunizations based on standing orders
- ▶ Arrange for preventive services based on standing orders
- ▶ Assemble medical equipment, if needed, before the physician enters the exam room



By considering the patient as part of the care team, their thoughts, feedback, and descriptions can be incorporated into the progress note. **Our Notes**⁹ is a movement to encourage patients to submit semi-structured notes from home before their visit, including such things as:

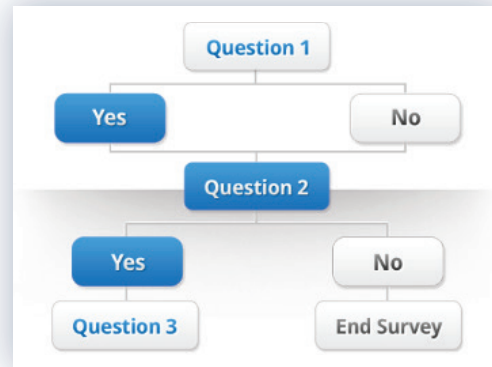
- ▶ Interval history
- ▶ Goals for the visit
- ▶ Specific details such as medication or symptom changes

Initial results from Beth Israel Deaconess Medical Center and the University of Colorado¹⁰ show:

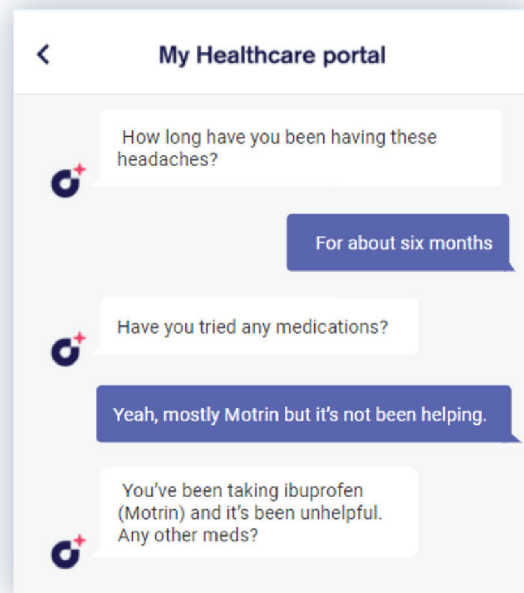
- ▶ 90% of providers and patients who participated chose to continue
- ▶ 15-20% of patients respond to the Our Notes prompt

More structured information can be gathered from the patient prior to the visit and incorporated into the note via formal **patient questionnaires**. Many EHR vendors and third parties offer sophisticated online questionnaires that can collect history of present illness or chronic disease

data points. These questionnaires can use complicated branching logic so patients aren't queried about non-relevant information.



While still in early development, chatbots may prove valuable as ways to elicit structured patient data in a conversational style. A chatbot is a software application that is programmed to simulate human dialog by replying to certain phrases with programmed responses in voice- or text-based conversation. Bots are being investigated to learn how they can elicit and distill clinical histories.^{11,12}



Courtesy of Hyro.ai

During the Clinic Visit

There may be **hard stops** in the EHR or other clinical IT systems that no longer serve a purpose given the more relaxed documentation guidelines for ambulatory visits. It is important to reconsider institutional requirements such as:

- ▶ Discretely documented chief complaint
- ▶ Formal history or physical exam
- ▶ Vital signs documentation
- ▶ Other non-essential parts of the progress note

Note documentation in the EHR should have the option to be **less structured** so the appropriate note can be written for the given encounter and patient. Flexibility is essential given the new E/M requirements.

Wayfinding tools in the EHR should also be re-examined to ensure that navigators or care pathways do not require information or stops that aren't universally necessary.

While **E/M calculators** aren't new, they may become more important as physicians learn the new requirements

for ambulatory documentation. These calculators use a combination of manual data entry and information discretely recorded in the electronic health record to suggest the proper E/M code. Some suggestions for successful use of code calculators:

- ▶ Make it easy
 - ▶ Embed calculators within workflows and limit manual entry
 - ▶ Update calculators with new requirements
 - ▶ Record the scores/calculations for reference later
- ▶ Educate
 - ▶ Familiarize physicians with tools that assist with time calculation
 - ▶ Enable use of time data or decision making in notes
- ▶ Limitations
 - ▶ Adoption can be challenging
 - ▶ Custom historical EHR build may need to be unraveled before tools work correctly

After the Clinic Visit

While the physician can sign the note soon after the patient leaves, this may be ill-advised given the new E/M guidelines. If coding by medical decision-making, physicians may need to wait to determine whether additional testing will be needed (based on results of tests ordered at the encounter) or waiting to speak with an independent historian. If coding by time, the physician may be searching through medical records after the visit or speaking to a referring physician about the patient. Under any circumstances, physicians might choose to **not routinely sign notes until the end of the day**.

From a coding perspective, there **is no reason to document time unless time is being used to justify the E/M code**. Since most physicians will use MDM to calculate most of their E/M notes, time spent before, during, and after the visit on the day of the encounter will likely be documented a minority of the time.

Physician Coaching

Workflow:

- ▶ Complete prep and follow up on the day of the visit if possible
- ▶ Complete a history and examination as is medically necessary
- ▶ Use a level of service calculator to evaluate code level for medical decision-making and total time

Documentation:

- ▶ Document the rationale (aka “the why”)
- ▶ Document pertinent results and the significance to the patient’s condition/problem
- ▶ Remove unnecessary/duplicate documentation

- ▶ Document the total time spent the day of the visit if coding by time not MDM

Billing code:

- ▶ For each encounter, evaluate level of service based on MDM and total time to select the most appropriate code
- ▶ For services or time that are billed separately, do not include these in your MDM or total time calculation
- ▶ Only count time that is spent on the day of encounter
- ▶ Do not double count time spent with other QHPs
- ▶ If total time exceeds level 5, add appropriate prolonged services code(s)

Tools and Resources

AMA CPT (including E/M) QuickRef calculator

- ▶ <https://apps.apple.com/us/app/cpt-quickref/id426712025> (iOS)
- ▶ https://play.google.com/store/apps/details?id=org.ama_assn.cptquickref&hl=en_US (Android)

For more information:

- ▶ AMA Educational Materials:
 - ▶ <https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>
- ▶ E/M Information:
 - ▶ <https://www.nordicwi.com/services/provider/advisory-services/performance-improvement/strategic-em-transition-services>

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About the authors



Craig Joseph, MD, is Nordic's chief medical officer with over 25 years of healthcare and IT experience. In addition to practicing medicine as a primary care pediatrician for eight years, he worked for Epic for six-plus years

and has served as chief medical information officer at multiple healthcare organizations, using both Cerner and Epic. While at Epic, Craig helped build what is now called the Foundation System. He also assisted in the implementation and optimization of the EHR for Epic customers across the United States and Europe. Craig participates in many healthcare IT industry groups, and he remains actively board-certified in both pediatrics and clinical informatics.



Barbara Levy, MD is an obstetrician gynecologist, past chair of the AMA/ Specialty Society RVS Update Committee (RUC) and served as the vice president for Health Policy at the American College of Obstetricians

and Gynecologists (ACOG). She is a current member of the CPT Editorial Panel. Dr. Levy is clinical professor of Obstetrics and Gynecology at the George Washington University School of Medicine and Health Sciences, an ACOG fellow, and a fellow of the American College of Surgeons. She previously served as a member of the AMA House of Delegates. She also served as the medical director of the Franciscan Health System Women's Health and Breast Center.

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