Modern uniform billing requirements for physician documentation of outpatient clinic visits came about in the mid-1990s. At the time, notes were generally handwritten with copious obscure abbreviations which were often meaningless to all but the author. Doctors included whatever information they thought was relevant, often focusing on what they needed to remember for the next visit or what they thought a colleague might need to know if covering on call.

Sample notes:

2021 E/M Updates: What Will Happen to the Physician Note

How did we get here?

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How did we get here?
In 1995, and then again in 1997, CPT Evaluation and Management (E/M) documentation guidelines were put in place which strictly defined requirements for each code. Seven components were used to judge which code was appropriate for a given outpatient E/M service:

- History
- Physical exam
- Medical decision making (MDM)
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

Based on complicated rules strictly defining characteristics of the problem at hand, review of systems, physical exam, and MDM, the proper E/M code could be elicited.

**Current State**

Complicated E/M requirements for documentation of clinic visits, combined with other factors such as increased litigiousness and development and growing ubiquity of electronic health records (EHRs) lead to progressively longer and more detailed notes (in other words, note bloat). While ambulatory progress notes outside the United States averaged less than 2000 characters, documentation by American physicians average more than twice that number.

At the same time, an epidemic of clinician burnout is occurring in the United States. While the cause of burnout among physicians is multi-factorial, the EHR is a contributor, and doctors spend a third of their time in the EHR documenting patient interactions. Groups such as the American Medical Association (AMA) and others identified the need to reduce the administrative burden associated with writing ambulatory notes, and a revision to the E/M guidelines was undertaken.

**Easing E/M Documentation Requirements**

The AMA worked toward four guiding principles when redesigning E/M rules:

- Decrease administrative burden
  - Remove scoring by history and physical exam
  - Code the way physicians and other qualified healthcare professionals (QHP) think
- Decrease the need for audits
  - More detail in CPT codes 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 MDM
- Ensure that payment for E/M is resource-based and has no direct goal for 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

It’s important to note that E/M changes apply only to outpatient office visits. Further, these changes do not go into effect until Jan. 1, 2021.

The new E/M level of service codes are based on either MDM or time, and do not 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 medical decision-making 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 (not reported separately)

What This Means for Healthcare Organizations

Impacts:

- With changing documentation requirements, clinicians will need to determine when to code using MDM vs. total time on the day of the encounter
- Physician and coder efficiency and productivity will be affected
- Level of service benchmarks might have to be adjusted
- Compensation changes may be in the works based on the potential for higher acuity codes to be generated

Risks:

- Physicians may continue to document as they have for the last 25 years leading to unnecessary documentation and wasted time by physicians and coders
- There is the potential for increased coding errors and clinicians and coders adjust to the new guidelines
- Risk adjustment reductions and revenue take backs might occur if acuity levels decrease significantly

Opportunities:

- Increased physician satisfaction via more meaningful, streamlined documentation
- Improved clinical workflows that allow the patient and care team to contribute directly to the documentation
- Patient throughput may be streamlined given fewer requirements for clinically-unnecessary documentation
- Physicians may see increased reimbursement given the clarified documentation guidelines
What Belongs in the Physician Note?

Doctors write notes to:

- Remind us what we found, said, and did
- Communicate to other clinicians what we found, said, and did (aka continuity of care)
- Allow us to get paid for services rendered
- Engage patients in their care (a new reason related to the 21st Century Cures Act, but a great reason)
- To prove that we practiced quality care
- To help defend against a medical liability claim

The physician need not be the only contributor to the clinic note. The patient and the clinic’s support staff can start the progress note and add important information. The patient knows the history of present illness, any interval history if appropriate, and the medication they are taking. The clinic medical assistant or nurse can review the patient’s history, record appropriate vital signs, and do any necessary screening. Ultimately, the physician reviews the information, documents appropriate elements like the physical exam, assessment, and plan, and signs the note.

Reimagining the Ambulatory Physician Progress Note

Key components of a typical note, today vs. the future:

**Today**
- Reason for visit
- History of present illness
- Review of symptoms
- Vital signs
- Physical exam
- Test results (often via cut/paste)
- Assessment and plan

**Future**
- History of present illness (with reason for visit and review of symptoms)
- Vital signs summarized
- Physical exam (as needed)
- Important test results noted and “interpreted”
- Detailed assessment and plan including differential and workup

As we move to a less dogmatic system for assigning billing codes for outpatient documentation, physicians are free to incorporate clinical information in a way that makes the most sense to them. There need not be a discrete section called “reason for visit” or “chief complaint,” but instead this sort of clinically-relevant data can be included in the history of present illness. Since physical exam is no longer a requisite part of the note for billing purposes, documentation of exam can be as comprehensive or focused as is called for by the patient’s condition.
Six Ways to Evolve the Clinic Note

1. Remove unnecessary information and duplication

One of the great things about the EHR is that it allows (and perhaps even encourages) clinicians to bring data into the ambulatory progress note. Gone are the days when physicians used abbreviated “fishbone” diagrams to recopy and summarize lab data in order to incorporate it into the progress note. Now with a few keystrokes, the entire list of lab results can be entered into the documentation, including much more than just the important results.

Physicians should only include relevant information in their notes, incorporating specific results when appropriate or simply referencing them in summary form. For example, instead of bringing in a plethora of unnecessary data points with a complete blood count result, simply noting that “the CBC is significant for worsening thrombocytopenia” will likely add more value to the note itself.

2. Embrace the encounter report

In the pre-EHR days, the progress note was the end-all and be-all of the office visit documentation. If information wasn’t included in the progress note, it didn’t exist. This need not be the case using many modern EHRs. Today, many vendors have a concept of an encounter or visit report, which can be thought of as a grouping of building blocks, each of which brings in certain data points relevant to the visit.

The encounter report can be stored statically when the physician closes or signs off on the visit, thereby representing a holistic accounting of what happened. In this case, the physician’s progress note becomes just one part (albeit the most important part) of the record of the visit.

3. Upend the SOAP note with the APSO format

While the workflow of an office visit will virtually always involve the same information-gathering techniques in the same order, the clinic progress note doesn’t need to follow that same sequence.

The typical clinic note follows the SOAP format: subjective, objective, assessment, and plan. Indeed, this is the order in which most office visits occur. The patient offers up a history of any health problems and might answer questions about signs or symptoms (subjective). The physician performs a physical exam, reviews any lab or other results (objective), summarizes the findings (assessment), and the next steps (plan).

Given the way most EHRs function, it can make sense to put the assessment and plan part of the note at the top (APSO). This format allows clinicians to quickly scan notes...
and find the information that is most frequently being sought. APSO formatting creates more usable notes by presenting essential information in ways that make it more easily consumed.

4. Add documentation for time...if appropriate

If time is to be used to calculate the E/M code, physicians should include all the time they spend associated with that visit on the day of the encounter. Besides face-to-face time in the exam room or online chat, this includes prep time and work after the patient is seen. Note that there is no requirement to document the time spent if the physician is not using time to calculate the appropriate E/M code.

5. Consider the patient as the audience

The 21st Century Cures Act was intended to make clinical data more transparent and liquid. Initial rules set forth by the federal government require progress notes to be made easily available in an electronic format via standard interfaces. Hence, we anticipate that patients will view their clinic notes much more frequently than in the past.

Physicians should consider the patient when they are writing notes. Technical language may still be appropriate, of course, but it may be prudent to avoid potentially-confusing abbreviations. Further, medical groups and hospitals may want to create etiquette guides to assist their clinicians if they are concerned about how their notes may be viewed by patients.

6. Focus on The Why

While many members of the clinical team can and should contribute to the ambulatory progress note, the physician alone is responsible for creating and documenting the assessment and plan. Physicians are solely responsible for The Why. Leverage the EHR to collect and display The What (e.g., vital signs, smoking status, orders entered, and medications changed). Ensure that the tools needed by physicians to document the assessment and plan are available, such as voice recognition and common templates.

Eyes on the Prize

The updated E/M codes offer the opportunity to:

- Revisit documentation best practices
- Improve documentation templates and tools
- Create documentation etiquette guides
- Educate physicians on documentation recommendations

With more clinically-relevant guidelines to calculate the appropriate billing codes, we can:

- Improve the focus on patient care
- Increase physician satisfaction
- Expect appropriate reimbursement
- Boost patient throughput
- Reduce compliance burden
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.

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ENDNOTES


