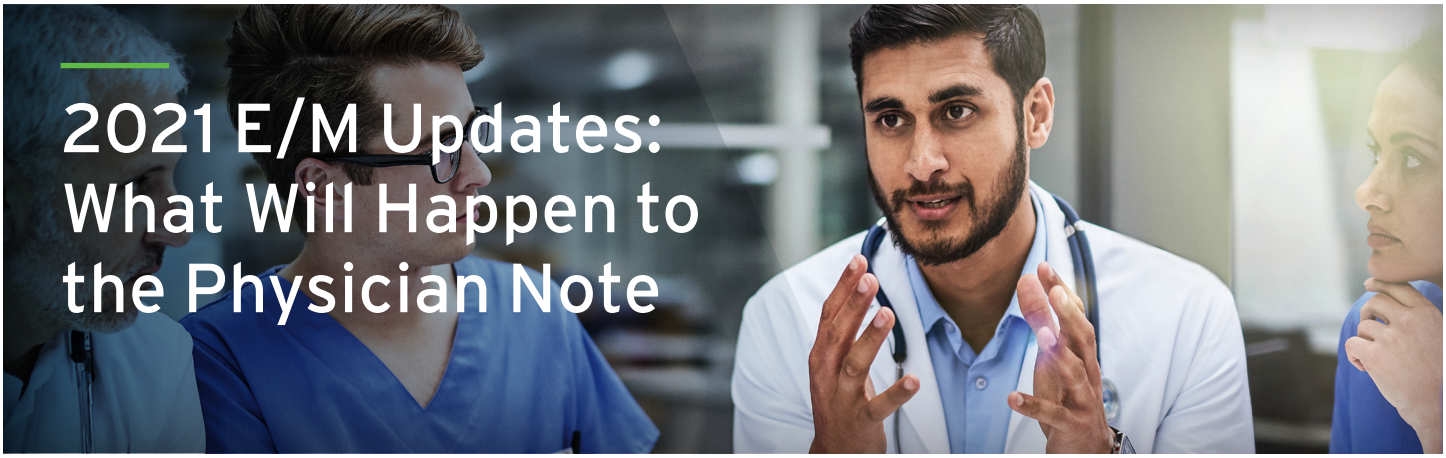
NORDIC™ AMA

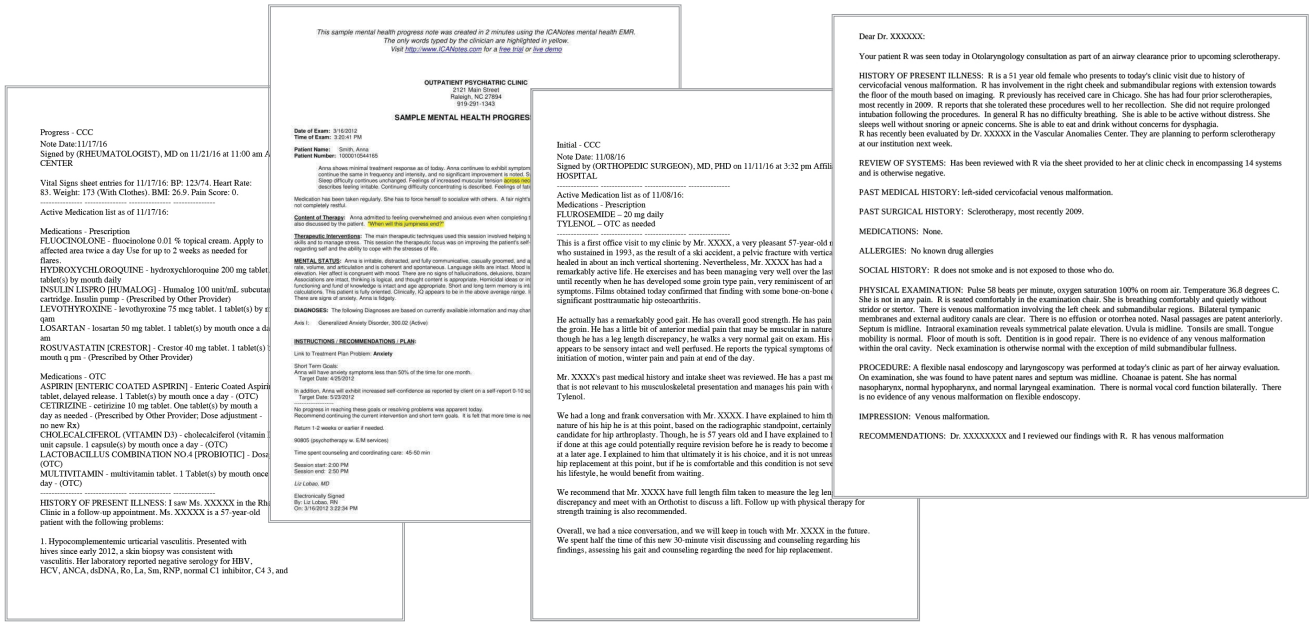


2021 E/M Updates: What Will Happen to the Physician Note

How did we get here?

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:



Progress - CCC
Note Date:11/7/16
Signed by (RHEUMATOLOGIST), MD on 11/21/16 at 11:00 am A
CENTER

Vital Signs sheet entries for 11/17/16: BP: 123/74. Heart Rate: 83. Weight: 173 (With Clothes). BME: 26.9. Pain Score: 0.

Active Medication list as of 11/17/16:

Medications - Prescription
FLUOCINOLONE - fluocinolone 0.01 % topical cream. Apply to affected area twice a day Use for up to 2 weeks as needed for flares.
HYDROXYCHLOROQUINE - hydroxychloroquine 200 mg tablet tablet(s) by mouth daily
INSULIN LISPRO [HUMALOG] - Humalog 100 unit/mL subcutan cartridge. Insulin pump - (Prescribed by Other Provider)
LEVOTHYROXINE - levothyroxine 75 mcg tablet. 1 tablet(s) by qam
LOSARTAN - losartan 50 mg tablet. 1 tablet(s) by mouth once a da am
ROSUVASTATIN [CRESTOR] - Crestor 40 mg tablet. 1 tablet(s) mouth q pm - (Prescribed by Other Provider)

Medications - OTC
ASPIRIN [ENTERIC COATED ASPIRIN] - Enteric Coated Aspirin tablet, delayed release. 1 Tablet(s) by mouth once a day - (OTC)
CETIRIZINE - cetirizine 10 mg tablet. One tablet(s) by mouth a day as needed - (Prescribed by Other Provider; Dose adjustment - no new Rx)
CHOLECALCIFEROL (VITAMIN D3) - cholecalciferol (vitamin unit capsule. 1 capsule(s) by mouth once a day - (OTC)
LACTOBACILLUS COMBINATION NO.4 [PROBIOTIC] - Dosa (OTC)
MULTIVITAMIN - multivitamin tablet. 1 Tablet(s) by mouth once day - (OTC)

HISTORY OF PRESENT ILLNESS: I saw Ms. XXXXX in the Rh Clinic in a follow-up appointment. Ms. XXXXX is a 57-year-old patient with the following problems:

1. Hypocomplementemic urticarial vasculitis. Presented with hives since early 2012, a skin biopsy was consistent with vasculitis. Her laboratory reported negative serology for HBV, HCV, ANCA, dsDNA, Ro, La, Sm, RNP, normal C1 inhibitor, C4 3, and

This sample mental health progress note was created in 2 minutes using the ICANotes mental health EMR. The only words typed by the clinician are highlighted in yellow. Visit http://www.ICANotes.com for a free trial or live demo

OUTPATIENT PSYCHIATRIC CLINIC
2121 Main Street
Raleigh, NC 27894
919-291-1343

SAMPLE MENTAL HEALTH PROGRES

Date of Exam: 3/16/2012
Time of Exam: 3:20:41 PM

Patient Name: Smith, Anna
Patient Number: 1000010544165

Anna shows minimal treatment response as of today. Anna continues to exhibit symptom continue the same in frequency and intensity, and no significant improvement is noted. S Sleep difficulty continues unchanged. Feelings of increased muscular tension across rep describes feeling irritable. Continuing difficulty concentrating is described. Feelings of fat

Medication has been taken regularly. She has to force herself to socialize with others. A fair night's not completely restful.

Content of Therapy: Anna admitted to feeling overwhelmed and anxious even when completing t also discussed by the patient. "When will this jumpiness end?"

Therapeutic Interventions: The main therapeutic techniques used this session involved helping t skills and to manage stress. This session the therapeutic focus was on improving the patient's self- regarding self and the ability to cope with the stresses of life.

MENTAL STATUS: Anna is irritable, distracted, and fully communicative, casually groomed, and a rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Mood is elevation. Her affect is congruent with mood. There are no signs of hallucinations, delusions, bizarr Associations are intact, thinking is logical, and thought content is appropriate. Homicidal ideas or in functioning and fund of knowledge is intact and age appropriate. Short and long term memory is int Calculations, the patient is fully oriented. Clinically, IQ appears to be in the above average range. There are signs of acuteness. Anna is lidgety.

DIAGNOSES: The following Diagnoses are based on currently available information and may char

Axis I: Generalized Anxiety Disorder, 300.02 (Active)

INSTRUCTIONS / RECOMMENDATIONS / PLAN:

Link to Treatment Plan Problem: Anxiety

Short Term Goals:
Anna will have anxiety symptoms less than 50% of the time for one month.
Target Date: 4/25/2012

In addition, Anna will exhibit increased self-confidence as reported by client on a self report 0-10 sc
Target Date: 5/23/2012

No progress in reaching these goals or resolving problems was apparent today.
Recommend continuing the current intervention and short term goals. It is felt that more time is nee

Return 1-2 weeks or earlier if needed.

90805 (psychotherapy w. E/M services)

Time spent counseling and coordinating care: 45-50 min

Session start: 2:00 PM
Session end: 2:50 PM

Liz Lobao, MD

Electronically Signed
By: Liz Lobao, RN
On: 3/16/2012 3:22:34 PM

Initial - CCC
Note Date: 11/08/16
Signed by (ORTHOPEDIC SURGEON), MD, PHD on 11/11/16 at 3:32 pm Affili HOSPITAL

Active Medication list as of 11/08/16:
Medications - Prescription
FLUROSEMIDE – 20 mg daily
TYLENOL – OTC as needed

This is a first office visit to my clinic by Mr. XXXX, a very pleasant 57-year-old m who sustained in 1993, as the result of a ski accident, a pelvic fracture with vertica healed in about an inch vertical shortening. Nevertheless, Mr. XXXX has had a remarkably active life. He exercises and has been managing very well over the las until recently when he has developed some groin type pain, very reminiscent of ar symptoms. Films obtained today confirmed that finding with some bone-on-bone significant posttraumatic hip osteoarthritis.

He actually has a remarkably good gait. He has overall good strength. He has pain the groin. He has a little bit of anterior medial pain that may be muscular in nature though he has a leg length discrepancy, he walks a very normal gait on exam. His appears to be sensory intact and well perfused. He reports the typical symptoms of initiation of motion, winter pain and pain at end of the day.

Mr. XXXX's past medical history and intake sheet was reviewed. He has a past m that is not relevant to his musculoskeletal presentation and manages his pain with Tylenol.

We had a long and frank conversation with Mr. XXXX. I have explained to him th nature of his hip he is at this point, based on the radiographic standpoint, certainly candidate for hip arthroplasty. Though, he is 57 years old and I have explained to if done at this age could potentially require revision before he is ready to become at a later age. I explained to him that ultimately it is his choice, and it is not unreas hip replacement at this point, but if he is comfortable and this condition is not seve his lifestyle, he would benefit from waiting.

We recommend that Mr. XXXX have full length film taken to measure the leg len discrepancy and meet with an Orthotist to discuss a lift. Follow up with physical therapy for strength training is also recommended.

Overall, we had a nice conversation, and we will keep in touch with Mr. XXXX in the future. We spent half the time of this new 30-minute visit discussing and counseling regarding his findings, assessing his gait and counseling regarding the need for hip replacement.

Dear Dr. XXXXXX:

Your patient R was seen today in Otolaryngology consultation as part of an airway clearance prior to upcoming sclerotherapy.

HISTORY OF PRESENT ILLNESS: R is a 51 year old female who presents to today's clinic visit due to history of cervicofacial venous malformation. R has involvement in the right cheek and submandibular regions with extension towards the floor of the mouth based on imaging. R previously has received care in Chicago. She has had four prior sclerotherapies, most recently in 2009. R reports that she tolerated these procedures well to her recollection. She did not require prolonged intubation following the procedures. In general R has no difficulty breathing. She is able to be active without distress. She sleeps well without snoring or apneic concerns. She is able to eat and drink without concerns for dysphagia. R has recently been evaluated by Dr. XXXXX in the Vascular Anomalies Center. They are planning to perform sclerotherapy at our institution next week.

REVIEW OF SYSTEMS: Has been reviewed with R via the sheet provided to her at clinic check in encompassing 14 systems and is otherwise negative.

PAST MEDICAL HISTORY: left-sided cervicofacial venous malformation.

PAST SURGICAL HISTORY: Sclerotherapy, most recently 2009.

MEDICATIONS: None.

ALLERGIES: No known drug allergies

SOCIAL HISTORY: R does not smoke and is not exposed to those who do.

PHYSICAL EXAMINATION: Pulse 58 beats per minute, oxygen saturation 100% on room air. Temperature 36.8 degrees C. She is not in any pain. R is seated comfortably in the examination chair. She is breathing comfortably and quietly without stridor or stertor. There is venous malformation involving the left cheek and submandibular regions. Bilateral tympanic membranes and external auditory canals are clear. There is no effusion or otorrhea noted. Nasal passages are patent anteriorly. Septum is midline. Intraoral examination reveals symmetrical palate elevation. Uvula is midline. Tonsils are small. Tongue mobility is normal. Floor of mouth is soft. Dentition is in good repair. There is no evidence of any venous malformation within the oral cavity. Neck examination is otherwise normal with the exception of mild submandibular fullness.

PROCEDURE: A flexible nasal endoscopy and laryngoscopy was performed at today's clinic as part of her airway evaluation. On examination, she was found to have patent nares and septum was midline. Choanae is patent. She has normal nasopharynx, normal hypopharynx, and normal laryngeal examination. There is normal vocal cord function bilaterally. There is no evidence of any venous malformation on flexible endoscopy.

IMPRESSION: Venous malformation.

RECOMMENDATIONS: Dr. XXXXXXXX and I reviewed our findings with R. R has venous malformation

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.[1] While the cause of burnout among physicians is multi-factorial, the EHR is a contributor,[2] and 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, 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[4] (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.

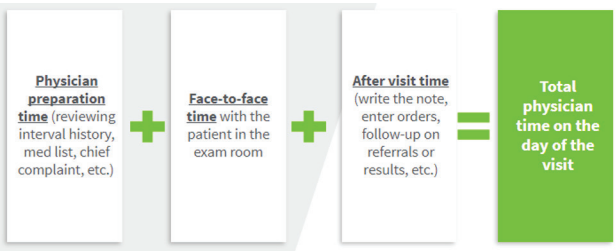
The typical clinic note follows the SOAP format: subjective, objective, assessment, and plan. Indeed, this is the order in which most office visits occur. The patient offers up a history of any health problems and might answer questions about signs or symptoms (subjective). The physician performs a physical 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.[5] APSO formatting creates more usable notes by presenting essential information in ways that make it more easily consumed.[6]

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

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.

ABOUT NORDIC

Healthcare organizations are challenged to deliver higher quality care at a lower cost. Our award-winning team provides health IT staffing, advisory consulting, and managed services that result in a stronger business with better patient outcomes.

ENDNOTES

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