NORDIC AMA

2021 E/M Transition: How Organizations Are Moving Forward Successfully

Before learning how successful organizations are moving forward with the new evaluation and management (E/M) guidelines, it's important to understand how we got here.

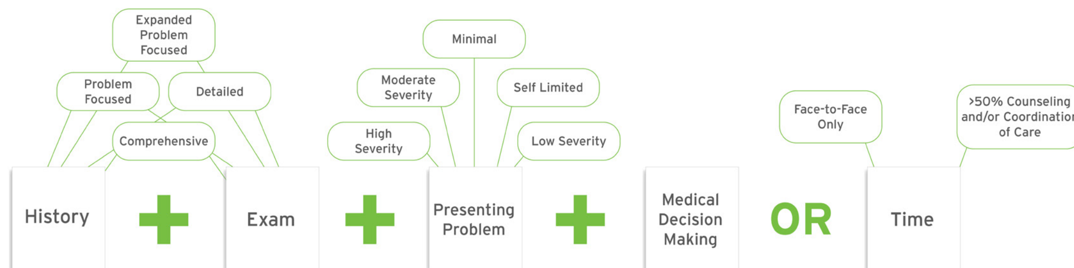
History of Evaluation and Management CPT Codes

Modern uniform billing requirements for physician documentation of outpatient clinic visits came about in the mid-1990s. At the time, notes were often handwritten and had considerable variability from physician to physician with respect to the information that was or was not included. 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.

In 1995, and then again in 1997, CPT Evaluation and Management (E/M) documentation guidelines were put in place by CMS 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.



Changes to Ambulatory E/M Codes

With four goals in mind, the E/M guidelines were created by the American Medical Association (AMA) CPT editorial panel which were then accepted by the Centers for Medicare and Medicaid Services (CMS). The goals were to:

- Decrease administrative burden by removing the scoring of the history and exam and coding the way physicians and other qualified healthcare professionals think

- Decrease the need for audits by putting 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 by eliminating history and exam scoring and by promoting higher level activities of medical decision making

- Ensure that payment for E/M services is resource-based and has no direct goal for payment redistribution between specialties by using current medical decision-making criteria (such as CMS and educational/audit tools) to reduce the likelihood of change in patterns

As of Jan. 1, 2021 evaluation and management level of service for office or other outpatient services can be determined using one of two approaches:

- Medical Decision Making - extensive clarifications were provided in the guidelines to help define the elements of MDM

- Time - the total time spent on the date of encounter which incorporates both face-to-face and non-face-to-face services and has clear time ranges for each code

What Belongs in a Clinic Note?

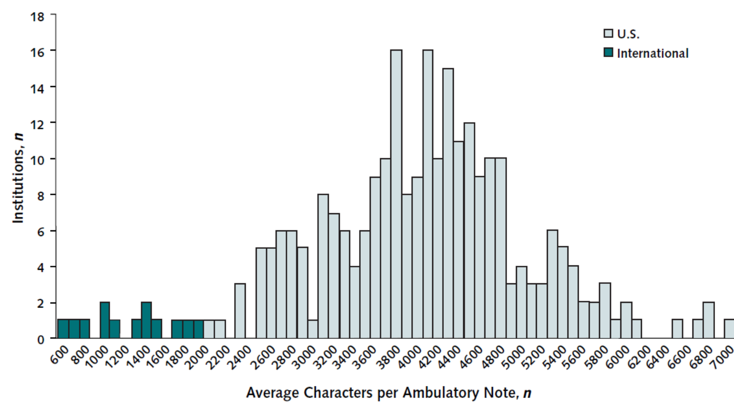
Forward thinking organizations have used the new E/M code descriptions to reconsider why clinicians document and what that documentation should look like.

Physicians write progress notes for many reasons:

- To remind us what we found, said, and did
- To communicate to other clinicians what we found, said, and did (aka continuity of care)
- To allow us to get paid for services rendered
- To engage patients in their care[1]
- To prove that we practiced quality care
- To help defend against a medical liability claim

Progress notes in the U.S. have gotten much longer, yet haven't become much more informative, coining the phrase "note bloat," which can be informally defined as the inclusion of less relevant information for non-clinical reasons. In the U.S., documentation requirements and their adoption into EHR templates have played a significant role in the ever-increasing size of the typical progress note.[2] The updated E/M guidelines encourage more succinct notes which focus on clinically-relevant information presented in a physician-friendly way. Onerous documentation requirements have been cited as a principal cause of burnout due to administrative burden[4]. Hence, adoption of the new note-writing requirements may allow physicians to regain some of the time they have had to spend on documentation.

Figure. Average characters per ambulatory progress note in U.S. and international health systems.



AMA Vice President of Professional Satisfaction Christine Sinsky, MD noted recently that a group of leading healthcare organizations has banded together to reduce physician documentation by 75%. One of their first recommendations is to significantly decrease the use of structured text output. As Dr. Sinsky relates, "If we can document it with smart phrases and dropdown boxes, we should reconsider whether we should document it at all."[3]

Successful Adoption of New Ambulatory E/M Guidelines

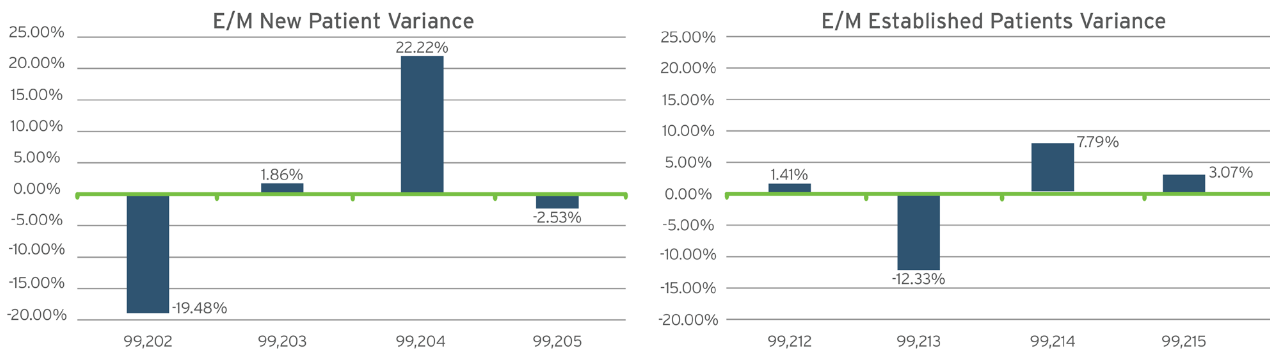
Organizations that have enthusiastically embraced and adopted the updated E/M documentation guidelines have followed a similar tract. They prepared their clinicians using multiple learning opportunities along with frequent reinforcement of the new concepts. Specific actions include:

- Requiring education and training for physicians prior to the Jan. 1 go-live
- Providing live, interactive sessions with ample time for questions and answers
- Hosting regular "lunch and learn" conferences whereby physicians and coders can interact and understand how the changes affect documentation
- Conducting concurrent and real-time reviews of charts with ample bidirectional feedback between clinicians and auditors

While seemingly obvious, a crucial success strategy is to offer education by leveraging adult learning theory. Clinicians need to hear, view, and process the new information at defined intervals over the weeks and months that follow. Further, explaining the rationale ("the why") behind the changes is an essential part of moving to the new documentation paradigm. Physicians must understand the goals of the new guidelines and realize that their coders, auditors, and organizational leadership support the move to decrease unnecessary clinical documentation.

Early Results of Top Performers

After examining initial results from the first quarter of 2021, some trends are starting to emerge. Well-prepared organizations are showing a shift to level four visit utilization based on the new E/M guidelines. Here are initial results from one organization:



While there may be multiple reasons for these changes, including new usage patterns due to the COVID-19 pandemic, we think the new E/M guidelines for outpatient visits is the leading cause.

It should be noted that a move to higher acuity codes will bring along with it higher wRVU realization for E/M-related services. If this turns out to be a more definitive trend, implications for physician contracts will need to be taken into account. New benchmarks for provider productivity will not be available for at least another year, making it even more challenging at the organizational level to manage provider compensation.

Common Challenges and Opportunities

Appropriate documentation of **prescription drug management** continues to be an opportunity for many physicians. Doctors need to know that simply adding the current medication list to the progress note is not adequate. Prescription drug management is based on documented evidence that the physician has evaluated medications as part of a service that is provided. Physicians should make a direct connection between the medication that is prescribed to the patient and the work that was performed on the day of the clinic visit, such as: "Stable hypertension; continue valsartan 10 milligrams, will refill for 4 months until next follow-up visit." Simply stating that the medication list was reviewed will not meet the definition of prescription management.

Physicians should be aware that, for the purposes of medical decision making, they cannot count labs at both the time of the order and the follow-up appointment when reviewed. These tests should be counted on the date that they are ordered only, and not when the patient returns.

From the documentation perspective, it's important to include specific words and phrases that tell the story of the care that the physician is providing.

DOCUMENT THIS	NOT THIS
▶ I spent 32 minutes today (include activities to justify what was time consuming, as needed) caring for Mildred	▶ 50% of the time spent in today's visit was counseling and coordination of care
▶ Patient returns for follow-up of hypertension and diabetes	▶ Patient returns for follow-up
▶ Due to the patient's extreme fatigue, I will order a thyroid panel	▶ Will order labs for further workup
▶ Decrease Lipitor as patient has lost 75 lbs and through diet modifications has reduced cholesterol levels	▶ Med list reviewed

Conclusion

In summary, embracing the updated E/M guidelines can reduce note bloat and unnecessary clinician burden. To achieve these goals, physicians should emphasize their rationale for care decisions during the clinic visit and avoid boilerplate language that doesn't add value to the patient "story." Organizations should endeavor to educate their physicians and coders about the new guidelines in multiple ways and with regular feedback. Further, it's important to audit notes to ensure that physicians are coding appropriately and in line with the updated recommendations.

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, a member of the CPT Editorial Panel, co-chair of the RUC CPT E/M Workgroup, 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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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

[1]. Walker J, Leveille S, Bell S, et. al. OpenNotes after 7 years: patient experiences with ongoing access to their clinicians' outpatient visit notes. J Med Internet Res. 2019;21(5):e13876. DOI: 10.2196/13876.

[2]. Downing NL, Bates DW, Longhurst CA. Physician burnout in the electronic health record era: are we ignoring the real cause? Annals Intern Med. 2018;169(1):50-2. DOI: 10.7326/M18-0139

[3]. Berg, S. 3 ways to begin to reduce clinical documentation by 75% by 2025. Retrieved on 25 April 2021. https://www.ama-assn.org/practice-management/sustainability/3-ways-begin-reduce-clinical-documentation-75-2025

[4]. Halamka JD, Tripathi M. The HITECH era in retrospect. N Engl J Med. 2017;377(10):907-9. DOI: 10.1056/NEJMp1709851