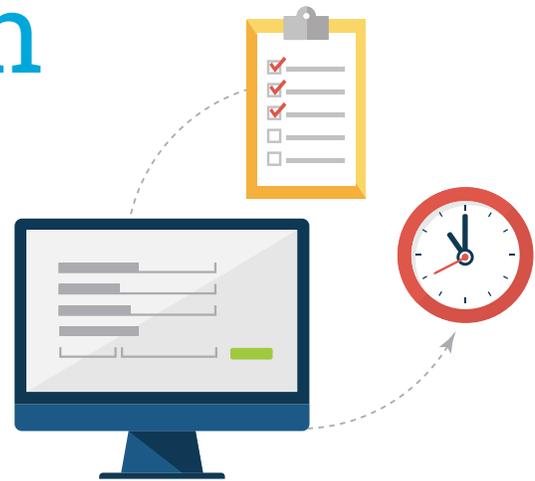


Simplified Outpatient Documentation and Coding

Reduce Workload With Recent Updates To E/M Coding and Team Documentation



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How Will This Toolkit Help Me?

Learning Objectives

- 1 Describe the most recent billing and coding documentation guidelines
- 2 Implement workflow solutions for more efficient documentation
- 3 Provide examples of documentation to help educate physicians and their teams



Introduction

Physicians and supporting team members in medical practices are experiencing burnout at an unsustainable rate. An unmanageable workload, in large part due to the electronic health record (EHR) documentation burden, contributes to physician burnout. Furthermore, a physician sitting at a computer performing the clerical task of data entry and note-taking is a low-value use of a high-dollar resource.

Physicians and advocacy groups have been asking to reduce regulatory requirements for less-meaningful work for the past decade. In recent years, there have been 2 major favorable changes in regulation to decrease documentation burden and redundancy for physicians during ambulatory visits:



1. [January 1, 2019 \(PDF\)](#): allowing ancillary staff members to document certain parts of the clinical note that physicians can then review and verify, rather than independently re-document¹
2. [January 1, 2021](#): changing level of service (LOS) codes to only depend on medical decision-making or time, not history or physical exam elements²

These changes recognized duplication in data collection and recording, helped clarify billing rules, and removed specialty-specific challenges created by the previous guidelines that had been in use for a quarter of a century. While it seemed intimidating to many physicians to understand yet another set of rules, most practicing clinicians agree that these changes “made sense” and made their lives easier because no substantial requirements were added, and many requirements were removed.

Four STEPS to Optimize Documentation and Coding Strategies in Your Practice

1. Understand Current Guidelines and How They Benefit You

2. Engage Key Players

3. Educate Physicians and Other Team Members

4. Develop Team Documentation Workflows

1

Understand Current Guidelines and How They Benefit You

2019 Changes

In 2019, significant and welcome changes were made to the existing documentation guidelines.¹ These changes began addressing unnecessary redundancy in medical charts. Now, physicians can use the documentation of history performed by other clinical team members (eg, medical assistants and nurses) and non-clinical documentation assistants (eg, clerical staff, scribes, students, or patients themselves) for billing requirements. You can find more information on this process in the [AMA STEPS Forward® Team Documentation toolkit](#).

2021 Changes

In 2021, changes to the Current Procedural Terminology (CPT®) Evaluation and Management (E/M) codes went into effect.² This upgrade affected all new (99201-99205) and established (99211-99215) outpatient visit billing standards. Only the medically necessary and appropriate portions of history (including the Review of Systems) and physical exam are required, thus reducing documentation burden.

In other words, **determination of the appropriate level of service no longer includes history and physical exam documentation but rather depends only upon either medical decision making (MDM) or the total amount of time spent providing care for a patient on the day of the visit (including before and after the visit, not just face-to-face time)**—see Table 1.

Table 1. Overview of CPT® E/M Coding

CPT®	New 99202	Established 99212	New 99203	Established 99213	New 99204	Established 99214	New 99205	Established 99215
Time (min)	15-29	10-19	30-44	20-29	45-59	30-39	60-74	40-54
MDM	Straightforward		Low		Moderate		High	
History	Medically appropriate		Medically appropriate		Medically appropriate		Medically appropriate	
Exam	Medically appropriate		Medically appropriate		Medically appropriate		Medically appropriate	

Another important addition is the prolonged service codes when billing based on time:

- For non-Medicare payers, the physician can add 1 or multiple 15-minute prolonged service codes (99417) when a visit is billed based on time and they have exceeded the total time associated with the highest level of service (99205 or 99215).
- For Medicare patients, the physician can add the G2212 code for each prolonged 15-minute interval. However, the minimum time required to use the prolonged service code differs from non-Medicare payers—see Table 2.

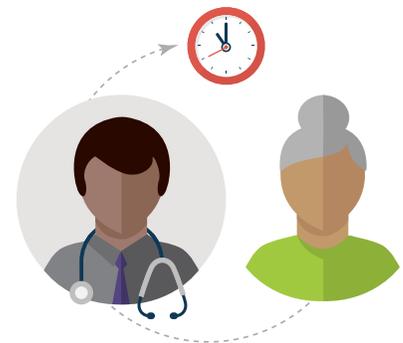


Table 2. New Prolonged Service Codes When Billing Based on Time²

	Time Spent	
	Non-Medicare	Medicare
New Patient	Standard Level 5 (60-74 min) 99205	Standard Level 5 (60-88 min) 99205
	Prolonged (75-89 min) add 99417	Prolonged (89 -103 min) add G2212
	Extra prolonged (90 or more min) add additional 99417 codes as needed for each 15-minute interval	Extra prolonged (104 or more min) add additional G2212 codes as needed for each 15-minute interval
Established Patient	Standard Level 5 (40-54 min) 99215	Standard Level 5 (40-68 min) 99215
	Prolonged (55-69 min) add 99417	Prolonged (69-83 min) add G2212
	Extra prolonged (70 or more min) add additional 99417 codes as needed for each 15-minute interval	Extra prolonged (84 or more min) add additional G2212 codes as needed for each 15-minute interval

Q&A

Do these changes only affect primary care or other specialties too?

These changes are for the service codes themselves, affecting any specialty that bills these service codes.

Should I delete the history and physical sections of my notes?

Documentation of the history and physical examination are still important for excellent patient care. However, they are no longer a requirement for determining level of coding.

Has anything changed with the Level of Service codes themselves? For example, is a Level 4 Established Patient (99214) visit still a Level 4?

For the most part, if the service you provided was a Level 4 service before, it is a Level 4 service now based on MDM. The difference is that you should not have to document certain “required” elements such as PE or ROS to get your documentation to a certain level of service. Now, the Level of Service is based on the total time or MDM only.

Why is there a difference between Medicare and non-Medicare prolonged service times?

When CPT® wrote the description for the prolonged service code, they used the following language:

“Code 99417 is only used when the office or other outpatient service has been selected using time alone as the basis and only after the minimum time required to report the highest-level service (i.e., 99205 or 99215) has been exceeded by 15 minutes. To report a unit of 99417, 15 minutes of additional time must have been attained. Do not report 99417 for any additional time increment of less than 15 minutes.”³

CMS disagreed with the minimum time requirement. They felt that the prolonged service code should be added to the maximum time interval for the base service, so they finalized their own prolonged service code, G2212, with a different base time requirement.

Is there a limit to the number of prolonged service codes I can add?

There is no limit to the number of 15-minute prolonged service codes that can be added.

Do I have to document time spent on each task (eg, chart review, documentation, talking to a patient), or just total time?

The 2021 guidelines do not provide specific documentation best practices for reporting time; however, the primary goal of documenting time is to ensure an accurate record of the total time spent on patient care on the date of the encounter.

How do patients’ social determinants of health (SDOH) affect coding?

Social determinants of health can contribute to the complexity of patient issues and, as a result, may affect both the time spent during an encounter coordinating care and the level of MDM. Getting in the habit of adding any ICD-10 SDOH diagnoses on the claim being used in MDM will demonstrate the SDOH impact. These ICD-10 SDOH diagnoses will also help support medical necessity for higher levels of service. Examples of SDOH Z codes can be found in this [infographic from CMS](#) (PDF).

Here is an example of an EHR shortcut to document SDOH issues:

The screenshot shows a text editor interface with a toolbar at the top containing icons for star, up, search, undo, redo, insert smart text, copy, left arrow, right arrow, list, refresh, and share. Below the toolbar, the text reads: "Patient's care may be negatively impacted by {SDOH list shortcut}. Based on these, patient will not be able to ***." To the right of this text, a drop-down menu is open, titled "List shortcut drop-down menu options". The menu contains the following items: housing inadequacy/insecurity, food insecurity, poverty, access to care, medical literacy, incarceration, environmental conditions, quality of housing, and ***.

Are tests counted for the data component of MDM when they are ordered or resulted?

The data component of MDM includes the thought processes for diagnosis, evaluation, or treatment. Any ordered test is presumed to be analyzed when it results; therefore, the test is counted in the encounter when it was ordered. Tests ordered outside of an office visit (eg, with pre-visit labs) may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter when it is analyzed.

2 Engage Key Players

Many organizations have not yet applied these new time-saving billing and coding changes because of the strain and distraction of the COVID-19 pandemic. However, because of the pandemic toll on physicians, it is more important than ever before to reduce unnecessary burdens.

Any change in workflow, particularly if there is any association with licensure or accreditation, must be approached with the involvement of the key players (Figure 1).

Figure 1. Key Players to Engage



Compliance Officer

Your compliance office needs to work closely with you to plan and implement these new rules. A compliance officer or department is responsible for ensuring you and your organization operate within the regulatory guidelines of federal, state, and local authorities.

Revenue Cycle Management Billing and Coding Experts

Your revenue cycle billing and coding experts are likely auditing your charts and adjusting charges as needed behind the scenes. Billers and coders in most healthcare organizations are further removed from the point of care delivery than they might prefer, making it challenging for them to provide the level of support that could benefit clinical teams. Reach out to them early in the process to leverage their knowledge.

Information Technology (IT) and Health Information Management (HIM) Teams

Your IT and HIM teams can optimize changes, so you work smarter, not harder. They can “turn on” access to the medical record for ancillary staff and patients. Often these elements of history are entered by team members but not accessible to the physician, leading to duplication of work. Some EHR systems have embedded tools that support billing and coding documentation requirements. Examples include Level of Service (LOS) selection support, a Medical Decision Making (MDM) calculator, and system links or phrases to easily document the amount of time spent on various care-related tasks.

Clinician Champions or Clinical Documentation Improvement Specialists

An interested physician who is knowledgeable about the documentation workflow and how the medical record works for clinicians is an asset. Provide relative value unit (RVU) support or protected time for this important work for themselves and their peers.

Operations and Nursing Leadership

It is imperative to involve operations leadership and nursing leadership early on, particularly if you plan to have medical assistants or nurses perform any new tasks related to documentation of patient encounters. Work with practice managers and nursing education to develop any training and competencies needed to prepare team members for new responsibilities. Adding documentation responsibilities will require buy-in from those who supervise the ancillary team members (eg, practice managers) and assurance that those care team members will not be asked to perform duties beyond their training and scope.

3

Educate Physicians and Other Team Members

The 2021 CPT E/M documentation guidelines for billing represent the most significant changes in how clinicians code visits since 1995. In light of this, practices and organizations should dedicate considerable time and effort to educating physicians, advanced practice providers (APPs), and other clinical team members about the updates. This training should be valued and provided during regular hours. *Providing compensation and/or blocking time to attend is critical.*

Consider which opportunities and settings would be best for sharing the important content and how the individuals on your team learn most effectively. Sending a mass email with all the information may take less time than a group learning session followed by individual, at-the-elbow support. However, it is also less likely to bring about the desired transformation.

Taking the time to explain the individual and practice-wide benefits of the revised documentation requirements, particularly those related to reducing redundancy and “note bloat,” will likely lead to greater clinician interest and adoption. **Using clinical vignettes, such as those provided as part of this toolkit, is often the most effective way of sharing this information with clinicians.** Additionally, continue to provide easy access to billing and coding support within the organization for questions.

Use the following clinical vignettes to help clinicians understand how to use the updated CPT coding guidance.

Clinical Vignette 1. Sample Progress Note, Level 4 MDM



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HPI

60 y/o male here for follow up HTN and HL.

Doing well, no complaints.

Meds reviewed.

See A/P for remainder of HPI.

PFX

Vital signs: normal including blood pressure - 120/72

Heart: RRR, no murmurs

Lungs: clear to auscultation

A/P

1. HTN - well controlled on lisinopril 20 mg and thiazide diuretic 25 mg daily. Continue current medications.

2. HL - on atorva 20 mg daily. No side effects. Last lipid panel 6 mo ago at goal. Continue current treatment.

Next visit in 6 mo for follow up and wellness check.

Notes for the coding and documentation exercise:

Each element (number of diagnoses, complexity of data, and risk) can be classified as straightforward, low, moderate, or high.

For CPT coding, 2 of 3 MDM elements need to meet the moderate level to be considered Level 4 MDM.

Number of Diagnoses	Complexity of Data	Risk	CPT Code
<p>This case meets criteria for moderate number of diagnoses (any criteria below met)</p> <ul style="list-style-type: none"> <input type="radio"/> ≥1 chronic condition with exacerbation <input checked="" type="radio"/> ≥2 stable, chronic conditions <input type="radio"/> 1 acute illness or injury with systemic manifestation or uncertain prognosis 	<p>This case meets criteria for straightforward complexity of data (minimal or no data)</p>	<p>This case meets criteria for moderate risk of morbidity from additional diagnostic testing or treatment</p> <p>Example:</p> <ul style="list-style-type: none"> <input checked="" type="radio"/> Prescription medication management (can be prescribing new medication, continuing same dose of current medication, or changing dose of current medication) 	<p>This case meets Level 4 criteria for number of diagnoses and risk</p>
Moderate/99214	Straightforward/99212	Moderate/99214	OVERALL CODE: 99214

Clinical Vignette 2. Sample Progress Note, Level 4 MDM



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HPI

40 y/o female with diet-controlled diabetes and obesity presents to establish care after moving from another state. No meds. States she had a visit with her old PCP about 6 mo ago, and blood work was done at that time.

Currently living with her cousin while looking for jobs. She is a single parent to 2 teenagers. She has not found many grocery stores in the neighborhood and is not comfortable with public transportation. She sometimes can borrow a car from her cousin, but mostly uses this for job hunting, or transporting her children to school events. Asks to defer lab testing until her next visit due to possible out-of-pocket costs.

PFX

BP 120/72 P 74 BMI 35.12

A/P

1. Diet-controlled DM. States had labs done 6 mo ago, does not recall last A1c. Will work on transfer of records and defer testing until next visit.
2. Obesity - discussed daily exercise, adding more vegetables to her diet.
3. SDOH - Patient's care may be negatively impacted by food insecurity due to her current lack of income. Based on this, patient will not be able to access healthy foods to manage her diabetes and obesity. Will consult SW for community resources and social support.

Notes for the coding and documentation exercise:

Each element (number of diagnoses, complexity of data, and risk) can be classified as straightforward, low, moderate, or high.

For CPT coding, 2 of 3 MDM elements need to meet the moderate level to be considered Level 4 MDM.

Number of Diagnoses	Complexity of Data	Risk	CPT Code
<p>This case meets criteria for moderate number of diagnoses (any criteria below met)</p> <ul style="list-style-type: none"> <input type="radio"/> ≥1 chronic condition with exacerbation <input checked="" type="radio"/> ≥2 stable, chronic conditions <input type="radio"/> 1 acute illness or injury with systemic manifestation or uncertain prognosis 	<p>This case meets criteria for minimal complexity of data (minimal or no data)</p>	<p>This case meets criteria for moderate risk of morbidity from additional diagnostic testing or treatment</p> <p>Example:</p> <ul style="list-style-type: none"> <input checked="" type="radio"/> Diagnosis or treatment significantly limited by social determinants of health 	<p>This case meets Level 4 criteria for number of diagnoses and risk</p>
Moderate/99204	Straightforward/99202	Moderate/99204	OVERALL CODE: 99204

Clinical Vignette 3. Sample Progress Note, Level 5 MDM



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HPI

63 y/o male with 5 days of worsening cough productive of yellow sputum, SOB, and wheezing, as well as temp to 100.4 at home.

Hx COPD on daily LABA and inhaled steroid, former smoker, not on home oxygen. Last visit with me 2 mo ago for routine follow up - stable at that time. Most recent PFTs showed FEV1 55% of predicted. He has been hospitalized 2 times in the past 2 years for COPD exacerbation.

No known sick contacts, had a negative covid PCR test yesterday. Has been using albuterol rescue inhaler 3-4 times daily for the last 2 days.

PFX

VS - O2 sat 90% on RA, baseline is 92-94%
other VSS and unchanged from baseline

CV - RRR

Lungs - fair air movement, diffuse inspiratory and expiratory wheezes

A/P

COPD exacerbation with possible pneumonia - albuterol neb given in clinic. He felt a bit better, but O2 sat still lower than baseline. Discussed directly admitting him to observation status, but he is adamant about returning home.

Will rx Prednisone 40 mg daily for 5 days, first dose today, as well as oral antibiotics.

Follow up in clinic in 2 days, stressed need to go to ED if worsening symptoms; he understands and agrees.

Notes for the coding and documentation exercise:

Each element (number of diagnoses, complexity of data, and risk) can be classified as straightforward, low, moderate, or high.

For CPT coding, 2 of 3 MDM elements need to meet the high level to be considered Level 5 MDM.

Number of Diagnoses	Complexity of Data	Risk	CPT Code
<p>This case meets criteria for high number of diagnoses (any criteria below met)</p> <ul style="list-style-type: none"> ● ≥1 chronic condition with severe exacerbation or threat to life ○ 1 acute illness or injury with threat to life or bodily function 	<p>This case meets criteria for low complexity of data (any criteria below met)</p> <ul style="list-style-type: none"> ● Review or order any combination of 2 unique notes, results, or tests: ○ Gather information from independent historian (other than patient) 	<p>This case meets criteria for high risk of morbidity from additional diagnostic testing or treatment</p> <p>Example:</p> <ul style="list-style-type: none"> ● Potential need for hospitalization or sending patient to ER for rapid evaluation/higher level of care 	<p>This case meets Level 5 criteria for number of diagnoses and risk</p>
High/99215	Low/99213	High/99215	OVERALL CODE: 99215

Clinical Vignette 4. Sample Progress Note, Level 5 Time-Based



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HPI

48 y/o female with T2DM and migraine HA here for routine f/u - last visit with me 3 mo ago.

Not doing well today. Tearful. States teenage son having difficulties in school and she just found out 2 wks ago that he may be using illegal drugs. Her husband has not been coping well and has increased his alcohol consumption. She is working with the school counselor and other resources for her son. She cannot sleep and this is making her feel very anxious and emotionally labile, crying frequently and having difficulty functioning at home and at work. Weight is stable. Denies SI/HI. Has never experienced symptoms like this in the past - has never been on prescription medications for depression or anxiety.

PHQ9 - 10 points (moderate depression)

GAD7 - 12 points (moderate anxiety)

A/P

1. Mood disorder, mixed depression/anxiety, reactive. Start sertraline 25 mg, increase to 50 mg in 1 week. Refer to crisis counseling via social work. I personally spoke with Dr. Smith, PhD who can see her in 1 week. She contracted for safety.
2. Type 2 Diabetes with peripheral neuropathy. Continue current medications. BG running in 150-180 range at home. Lab testing deferred to next visit.
3. Migraine HA. Stable.

F/u in 3 weeks.

My total time on this date and for this encounter was 60 minutes which included the following activities: preparing to see the patient, performing a medically appropriate examination and/or evaluation, counseling and educating the patient/family/caregiver, ordering medications, tests, or procedures, referring to and communicating with other health care professionals about management, and documenting clinical information in the electronic or other health record. This time is independent and non-overlapping.

Notes for the coding and documentation exercise:

Each element (number of diagnoses, complexity of data, and risk) can be classified as straightforward, low, moderate, or high.

For CPT coding, 2 of 3 MDM elements need to meet the high level to be considered Level 5 MDM. Alternatively, time-based coding can qualify for Level 5 independent of MDM.

Number of Diagnoses	Complexity of Data	Risk	CPT Code
<p>This case meets criteria for moderate number of diagnoses (any criteria below met)</p> <ul style="list-style-type: none"> <input type="radio"/> ≥1 chronic condition with exacerbation <input checked="" type="radio"/> ≥2 stable, chronic conditions <input checked="" type="radio"/> 1 acute illness or injury with systemic manifestation or uncertain prognosis 	<p>This case meets criteria for moderate complexity of data (any criteria below met)</p> <ul style="list-style-type: none"> <input type="radio"/> Review or order any combination of 3 unique notes, results, or tests: <input type="radio"/> Gather information from independent historian (other than patient) <input checked="" type="radio"/> Discuss case with external physician/qualified health professional about management or test interpretation 	<p>This case meets criteria for moderate risk of morbidity from additional diagnostic testing or treatment</p> <p>Example:</p> <ul style="list-style-type: none"> <input checked="" type="radio"/> Prescription medication management (can be prescribing new medication, continuing same dose of current medication, or changing dose of current medication) 	<p>This case meets Level 4 criteria for number of diagnoses and risk</p> <p>This case meets Level 5 criteria for time (40 minutes) PLUS an additional 99417 prolonged service code (15-minute)</p>
Moderate/99214	Moderate/99214	Moderate/99214	MDM CODE: 99214 TIME CODE: 99215 + 99417

Clinical Vignette 5. Pediatric Sample Progress Note, Level 4 MDM



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HPI

3 y/o male (pt of Dr Smith) with 2 days of right ear pain, worse at night. Not sleeping well, frequently awakening and crying due to pain. Mom thought he felt warm this morning, she checked temperature with a temporal thermometer, and it was 101.3. She gave him a dose of acetaminophen about 3 hrs ago and called the office for a same day appointment.

No trouble breathing.
 He didn't want to eat his favorite breakfast this morning.
 Mild rhinorrhea, no cough, no new rash.
 No significant PMH. No smoke exposure.
 Allergies: None

PFX

VS - W 17.7kg, T 100.4, P 115, R 16
 GEN: Sitting on Mom's lap, looks uncomfortable, but did smile for me
 HEENT: L ear normal, right TM erythematous with loss of light reflex
 CV - RRR
 Lungs - Clear

A/P

1. R AOM, febrile. Start amoxicillin, 800mg 2 times a day for 7 days. APAP/Ibuprofen as needed for pain/fever, provided dosage card. Discussed importance of maintaining hydration and changes which should prompt a call to the office or escalation in care. Follow-up in 2 weeks for ear recheck.

Notes for the coding and documentation exercise:

Each element (number of diagnoses, complexity of data, and risk) can be classified as straightforward, low, moderate, or high.
 For CPT coding, 2 of 3 MDM elements need to meet the moderate level to be considered Level 4 MDM.

Number of Diagnoses	Complexity of Data	Risk	CPT Code
This case meets criteria for moderate number of diagnoses (any criteria below met) ○ ≥1 chronic condition with exacerbation ○ ≥2 stable, chronic conditions ● ○ 1 acute illness or injury with systemic manifestation or uncertain prognosis	This case meets criteria for low complexity of data (any criteria below met) ○ Review or order any combination of 2 unique notes, results, or tests: ● Gather information from independent historian (other than patient)	This case meets criteria for moderate risk of morbidity from additional diagnostic testing or treatment Example: ● Prescription medication management (can be prescribing new medication, continuing same dose of current medication, or changing dose of current medication)	This case meets Level 4 criteria for number of diagnoses and risk
Moderate/99214	Low/99213	Moderate/99214	OVERALL CODE: 99214



Clinical Vignette Packet

Use this handout of all 5 clinical vignettes during in-person training sessions

4

Develop Team Documentation Workflows

In many practice settings, the physician has historically written most, if not all, of the progress note and entered information into discrete data fields in the EHR while also placing all the orders associated with the visit. A common myth is that CMS or the Joint Commission requires the physician to document all components of E/M services; however, [this is not true](#). Now that you and your team understand the rules and have practiced using them, it's time to work together to complete documentation associated with patient encounters. Team documentation is a cornerstone of efficient documentation and effective team-based care.

You can find detailed definitions and workflows in the [AMA STEPS Forward Team Documentation toolkit](#).

Q&A

Where do I begin with team documentation?

You might start with licensed or certified team members already working in your practice, such as MAs or RNs. For example, the MA doesn't need to stop at the chief complaint. Medical assistants can also complete the history of present illness (HPI), past medical history (PMH), social history (SH), and family history (FH) before the physician reviews and verifies.

Once your existing team contributes directly to the chart, consider expanding who can contribute, especially if your current team is unable or the practice is short-staffed. Ancillary staff such as transcriptionists, health care undergraduate students, and medical students can be a great source of assistance when appropriately trained. Learning team documentation is a great experience for medical students.

What about patient-entered data?

In some ways, the most important person on the team is the patient. No one knows their history better. With a template (eg, timing, location, etc.), many patients can provide a detailed history, including answering prompts a physician would ask as part of a differential diagnosis.

An increasing number of practices and health systems utilize their EHR's patient portal to have patients review, update, and add information to their own medical record. Patients can use the patient portal to update personal demographic data, review medications and problem lists, and answer questions related to the History of Present Illness (HPI) and Social Determinants of Health (SDOH), among other things. In some instances, EHR functionality can automatically link patient-entered information to progress notes and other encounter documentation, helping complete clinical documentation—many health organizations are working towards this goal.

Conclusion

Two fundamental changes to practice that can decrease documentation burden for physicians are to:

1. Minimize unnecessary documentation by understanding current E/M coding requirements
2. Share the necessary documentation by implementing team documentation workflows

These changes enable physicians to give more of their undivided attention to patients while decreasing their after-clinic charting time.





AMA Pearls

- The 2021 E/M changes took away many unnecessary documentation requirements and are considered a “win” for physicians in the ambulatory setting
- Start by cleaning up your note templates to reduce note bloat and time spent on unnecessary documentation
- Training medical assistants or other non-clinical staff to participate in team documentation is an additional key to increasing documentation efficiency

Further Reading

Journal Articles and Other Publications

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The AMA Professional Satisfaction and Practice Sustainability group is committed to making the patient–physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past. We are focused on improving—and setting a positive future path for—the operational, financial, and technological aspects of a physician’s practice. To learn more, visit <https://www.ama-assn.org/practice-management>.

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