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Evaluation and Management Office/Clinic Visit Documentation Detour: A Bumpy Road Ahead *(Medicare and Medicaid)*

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Change is frequently difficult; however, without it, progress is stifled. As part of the Medicare Physician Fee Schedule Final Rule, in 2019 The Centers for Medicare and Medicaid Services ("CMS") announced significant revisions are coming for reporting physician time and effort as it pertains to office / outpatient Evaluation and Management ("E/M") visit services. These changes are tied to the 2018 'Patients over Paperwork' initiative and they bring the biggest shift in documentation and reporting visit services since the early 1990s. Below we will discuss these changes and how to manage the necessary adjustments.

The COVID-19 public health emergency ("PHE") took center stage in 2020. As a result, CMS has more widely embraced telehealth, phone visits, and other distanced healthcare options in the name of public safety. Despite the upheaval, changes impacting the new 2021 E/M guidelines for coding and reporting did become effective January 1, 2021, with very little fanfare. Despite being overshadowed by the PHE, the new rules finalized and published by CMS require physicians implement these important changes now.

Documentation and coding guidelines have not changed for E/M services in the past twenty-three (23) years. To put this into perspective, if we consider a physician's career averages thirty-five to forty (35-40) years, providers who began their career in 1992 could realistically be facing retirement soon and must learn yet another major change in how to document their most frequently billed services! On November 1, 2018, CMS finalized bold proposals addressing provider burnout and their intent to provide clinicians immediate relief from excessive paperwork tied to outdated billing practices. Healthcare professionals impacted by these processes will find this requires a significant shift in their methodology. Though this change will have a major impact on almost every specialty practice in the United States, other than in coding and auditing circles, little attention has been given to the anticipated changes in documentation, code assignments, and the corresponding reimbursements for these commonly utilized codes. Unless the provider organization has taken the initiative to prepare for these changes, providers may still be unaware of the change and impact this may have on their coding and documentation practices.

E/M visits are reimbursed less than many diagnostic and procedure codes; however, E/M codes are by far the most common charges submitted regardless of medical specialty or billing provider type. According to CMS' interim final rule ("IFR") outlining changes through CY2020 and those planned for CY2021, in total, E/M visits of all types represent approximately 40% of allowed charges for physician fee schedule ("PFS") services; and office/outpatient E/M visits, in particular, comprise approximately 20% of allowed charges for PFS.

A notable change includes reducing the impact of the history and examination component for office / outpatient E/M code selection. This change allows the E/M level to be selected solely upon medical- decision-making or time. Without being in the trenches of coding, billing, and auditing it can be difficult to grasp how these changes could significantly impact revenue, compliance, quality, and even patient care. To some degree, every provider offering outpatient / office services will be affected.

What effects are we talking about exactly? These new guidelines will have far-reaching effects in outpatient professional-fee clinics, and offices. The new documentation rules establish new concepts and can be confusing to those who practice in more than the office / outpatient area, since the 'old-school' E/M documentation and coding logic will remain in place for all settings except outpatient clinics and office settings. Now providers must learn a new way to document and value their services in their office / clinic but continue to apply old rules when delivering services outside of their office. Imagine a provider review during which both office / outpatient and inpatient services are scored for accuracy. If the provider fails to remember to adjust their code selection based on the service area, it will result in decreased quality scores,

provider frustration, possible missed revenue, additional staff time to make corrections and time spent on additional education efforts.

Since there are no guarantees other carriers will follow suit, it is almost certain to lead to some level of confusion for providers. Potential hazards include providers over- or under-valuing their visits, providing inadequate documentation, overcompensating to meet new guidelines – and all while trying to treat a patient and keep their care first and foremost. CMS' recognition of the need to decrease paperwork burdens and allow greater focus on patient care is to be commended. However, if providers lack the time or resources to prepare for the change it could have the polar-opposite effect.

Information Highlights and What Next?

Stepping Back: Reducing the Documentation Burden after January 1, 2019. In 2019, CMS released documentation guidelines indicating when relevant information is already documented in the medical record, practitioners may choose to focus their documentation on what has or has not changed since the last visit. Providers need not re-record the defined list of required elements if there is evidence the practitioner reviewed the previous information and updated it as needed.

New and established patient office / outpatient E/M visits do not require the practitioner to re-document the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner must document in the medical record that he or she reviewed and verified this information.

Stepping Forward: Reducing the Impact of History and Exam in 2021. Continuing CMS' 2019 focus on providing guidelines to reduce physician burden, 2021 rules indicate ancillary staff may document relevant history and providers may include an examination pertinent to the current encounter; however, using the new "MDM-only method," the history and exam would not be counted towards the level reported. This will allow practitioners to focus their documentation on what has or has not changed since the last visit and code based on MDM or time.

Without diving into coding jargon, the new 2021 medical-decision-making methodology simply disperses the former, separate table of risk throughout the diagnosis and data portions, resulting in one table with three (3) columns instead of three (3) distinct tables for medical decision making. This is a significant change from the prior table structure and will be used differently.

CMS will engage in further conversations with the public over the next two (2) years to further refine policies.

Other Changes to CMS Payment Rates and Logic in 2021. There was discussion CMS would finalize a single payment rate for E/M levels two through four (2-4) for office/outpatient visits: one rate for new patients and one rate for established patients; however, that currently appears to be on hold. For 2021, CMS has removed the lowest level new patient visit code and slightly increased the values of the others; in addition, there will be new codes and requirements for related prolonged services. All of the time requirements for each of the codes have been altered in the code definitions to accommodate billing on time, clarify what time can be counted and how it must be documented.

What should you do now to implement the change? Start by reviewing the final rule at the link below. Review or attend Medicare Administrative Contractors ("MAC") education sessions or review their published information for providers. Focus on how the medical-decision-making scoring and documentation requirements must appear in the record and what documentation may no longer be needed by reviewing the new MDM table using the American Medical Association link below. Ensure coding and auditing staff have access to the appropriate resources and hold provider preparation meetings. We have spoken to several providers who were unaware of the E/M changes described as of the writing of this article!

The 2021 E/M rules are now the new standard, changing how office/outpatient E/M code levels are reached and the corresponding reimbursement for these codes.

What Changes?

- Logic and leveling will affect all medical specialties
- Old E/M guidelines to remain in place for all other settings, e.g., inpatient visits
- New codes and requirements for related prolonged services
- Ancillary staff may document relevant patient history
- Billing providers may include an examination pertinent to the current encounter
- Documented history and examination of E/M office/outpatient visit not counted towards visit leveling
- Code selection solely based on medical decision making or time
- Disperses the table of risk throughout the diagnosis and data portions, resulting in one table with three (3) columns instead of three (3) distinct tables for medical decision making
- CMS removes the lowest level new patient visit code and slightly increases values of the others

Challenges

- Providers and coders will need to know when (and where) to use these new E/M guidelines versus old E/M guidelines
- While the codes and definitions change in CPT text, it is unclear if all other payers will follow the new CMS scoring and leveling requirements
- Preparing for major change during a health care crisis, e.g., orienting providers to the guidelines, providing staff education and additions / revisions to some documentation templates depending on how and which requirements will be followed across payors

For further discussion, questions, or information about our provider coding and documentation training services please contact us online or give our coding compliance experts a call at 303-801-0111. ■