

# STATE OF THE NOTE SUMMIT 2021

## **JAN – APR 2021 E/M DOCUMENTATION GUIDANCE INTERPRETATIONS AND REMAINING QUESTIONS**

The following document is offered as background for the conclusions that were arrived at from the E/M Summit that occurred on April 9<sup>th</sup> 2021. In the preceding weeks various vendors and clinician groups provided their interpretations of the AMA's guidelines up to that moment. This document is an aggregation and summary of feedback from representatives of:

AAFP

ACP

AAP

ACC

Cerner

Endocrine Society

Epic

NextGen

Office Practicum

Sparrow Health System

It should serve as a useful 'slice of life' that provides context on the broader conversation that occurred at the beginning of 2021 and leading into our summit.

The AMA was able to provide clarification of a number of points before the summit, and continues to be engaged with the broader healthcare community on educating and discussing the practicalities of the E/M coding changes.

## **History and/or Examination will not impact code level**

### **WHAT WE AGREE ABOUT**

- Even though History is not defined in the updated CPT guidance, [per AMA clarification](#), the intent was that the concept of History, as previously defined, has not changed (i.e., Chief Complaint, History of Present Illness, Past Family Social History, and Review of Systems). History is simply not mandatory anymore and should only be provided as determined appropriate by the physician/qualified healthcare professional (QHP).
- Physical Exam needs to be medically pertinent for communication and legal reasons but having no relevance for coding level has significant impact for Telehealth visits and “Well plus Sick” visits in pediatrics.
- The care team may collect information and the patient or caregiver may supply information directly – this should be implemented consistently across states and applies to all aspects of History (i.e., Chief Complaint, History of Present Illness, Past Family Social History, and Review of Systems).

### **WHAT WE HAVE QUESTIONS ABOUT**

- For practices trying to use “patient-entered information” for subjective parts of notes, how should this information be included and displayed?
- How can the detailed History, Review of Systems, Physical Exam templates embedded in EHRs be updated to address this change?

## **Time-based Documentation**

### **WHAT WE AGREE ABOUT**

#### **PROLONGED SERVICE CODE 99417**

This has been confusing, mainly because Medicare has released conflicting information compared to the AMA. [Per AMA clarification](#), for the 99417, the 15 minutes should be added beyond the minimum required time of the primary procedure (99205, 99215). The CPT code set has clear tables provided. (See below.)

<b>Total Duration of New Patient Office or Other Outpatient Services (use with 99205)</b>	<b>Code(s)</b>
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 X 1
90-104 minutes	99205 X 1 and 99417 X 2
105 or more	99205 X 1 and 99417 X 3 or more for each additional 15 minutes.
<b>Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)</b>	<b>Code(s)</b>
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 X 1
70-84 minutes	99215 X 1 and 99417 X 2
85 or more	99215 X 1 and 99417 X 3 or more for each additional 15 minutes.

## WHAT WE HAVE QUESTIONS ABOUT

- Does time attestation on day of service need to be in the body of the note or a separate document? Do professional activities need to be tabulated within the chart when billing time? How much detail is needed?
- Preparing for a patient visit in advance of the day of service does not count towards total time – complex patients often require, or at least benefit, from careful review and pre-charting before the visit and there simply isn't time to do this on the day of the visit for all patients who would benefit.
  - Professional time includes “preparing to see the patient” – what types of “preparing” would count within this attestation?
  - How do you update office scheduling policies to account for time-based billing?
- Time attestation includes time in activities that require physician/QHP and does not include time in activities normally performed by clinical staff – is there a standard list of activities normally performed by clinical staff?
- Discuss establishing national and local standards as to what is needed to document when billing based on time. Only total time should be required without need to specify which activities were performed. Different MACs have interpreted and required different standards.
- What is the definition and scope of “separately obtained history” for purposes of accounting for time? If the History from yesterday’s urgent care visit is reviewed and incorporated, does this time count? Or does it only count if received from another person who is part of the visit?
- Do only medications requiring a PRESCRIPTION count? If you order a RENEWAL of medications, which a pharmacy considers a new order, does this count towards the time attestation? What about medications that can be both prescribed or OTC? Shouldn't OTC meds count independently (cheaper but no less thought or documentation required for many).
- **TELEHEALTH:** Does time spent on performing a medically appropriate evaluation count for telehealth/video visits?
- **SHARED/SPLIT VISIT:** Is there still a distinction between Hospital vs. Clinic location and the ability to do shared/split visits? Previously this required hospital only – if this distinction no longer exists should be explicit about this.

## **Documenting for Time vs MDM**

### **WHAT WE HAVE QUESTIONS ABOUT**

- Since the payer only received the CPT code, does the note have to clearly state which documentation method was used to determine code for auditing purposes?
- Can EHRs support both time- and MDM-based billing simultaneously? Should the user have to choose or should that be automated?

## **Data Review: Lab Results, External Data, Documenting Review**

### **TESTS/RESULTS ANALYZED AS PART OF MDM**

#### **WHAT WE AGREE ABOUT**

Per AMA clarification, one test with six different dates of service still counts as one test reviewed. The general principle is that you get credit for one "point" towards data when a test is ordered/reviewed.

### **WHAT WE HAVE QUESTIONS ABOUT**

- Is additional documentation in the note required for each separate order and interpretation of diagnostic tests?
- What is the threshold qualification and content for "independently interpreting results"? Could a physician/QHP document something like "image reviewed and spiculated lung nodule confirmed" or are there other requirements?
  - For example, if Vitamin B-12 is low normal but methylmalonic acid is high, I might say by my interpretation, B12 deficiency exists despite the normal B-12 level. Would that be "independent interpretation" and if so, how much documentation is required?
- Physicians/QHPs frequently find patients have not gotten the lab draws for tests they ordered before the visit, whether or not as part of a previous billable service. Since they were already ordered prior to the current encounter, they apparently cannot be counted as "labs ordered" unless the previous ones are canceled and new ones re-ordered, or if the physician/QHP waits and counts them in a future visit. Suggested recommendation would be to allow physician/QHP to count "review of ordered but not yet completed tests due to patient follow-thru", since that involved MDM (test still needed, patient counseling to increase compliance, etc.)
- CPT guidance implies taking the action rather than documenting it in the note is sufficient. Does this suggest that code selection could rely on the EHR system record of placing the order instead of explicitly documenting in the note the order was placed? (e.g., populating that information within the visit summary)
- If ordering a test may include those considered, but not selected after shared decision making and these considerations must be documented. Relates to 3 categories of reasons for not ordering a test (necessity, risk, benefit). This guidance is likely unknown by many physicians/QHPs.
  - Tools for documenting this in A&P templates, and clarity in EHR coding calculators would be helpful.
- Should all clinical lists, results, and lab reports, imaging studies, reports be included in the body of every note?

## **EXTERNAL REVIEW**

### **WHAT WE AGREE ABOUT**

If you practice in a multi-specialty group under one Tax ID, then is data from other specialties under that Tax ID is not “external”? Same is true for practices that are hospital-owned and an ambulatory physician reviews a discharge note from the hospital, technically that is not external.

[Per AMA clarification](#), the distinction the CPT code set has tried to make is not necessarily Tax ID, but around specialties. If there are two PCPs in the same large practice, data could only be counted once among them between a test ordered and reviewed by two separate PCPs. However, if a Pulmonologist orders a test performed by a Cardiologist they could both get a point for order/review in the data column. The concept is that a physician from another specialty would need to still perform his/her own review of the data in their continued assessment of the patient.

## **DATA REVIEWED**

### **WHAT WE AGREE ABOUT**

Guidance states physicians cannot count the review of surveys/screening tools for which they bill a separate CPT code – even if those codes have no physician wRVUs. This is significant for clinicians who use validated screening tools on a regular basis – physicians should be able to count those as part of the data reviewed to guide their MDM.

[Per AMA clarification](#), this is no longer the case. Now, simple tests, such as CBC, rapid strep or UA can be counted as an “order” in the data column of MDM. What still cannot be counted as part of MDM are those tests, which the professional component (26) are separately billed through a CPT code.

### **WHAT WE HAVE QUESTIONS ABOUT**

- How much detail of what was reviewed is necessary for auditing without adding additional documentation burden and note bloat? – E.g., do you have to write “reviewed ER records, CT scan and CBC panel” in the note to get credit or will an EHR audit trail suffice?
- For purposes of data reviewed and analyzed, tests are imaging, laboratory, psychometric, or physiologic data – pulse oximetry is not a test.
  - If oximetry, which provides physiologic data, is not a test, then which physiologic data constitute tests? Do we have to know or be able to access the CPT code set that defines this? Do we need our EHRs to be able to scrub the structured data we enter into our note (e.g., heart rate), compare them with the CPT code set, and count them for us?
- Need to be clear if any combination of 2 are specifically 2 of the 3 bullets or 2 within that list. So can 2 unique test count as those 2 IE CBC and CMP are 2 unique tests?

## **Diagnoses, Symptoms, and Problems**

### **WHAT WE HAVE QUESTIONS ABOUT**

#### **PROBLEM STATUS**

- Will physicians need to document what they believe the problem status to be or will it be up to an auditor's interpretation?
- What about a problem that impacts either directly or indirectly the primary problem a provider is managing?

#### **ACUTE ILLNESS WITH SYSTEMIC SYMPTOMS**

- Does strep throat or otitis media with fever and sleep interruption count?
  - Systemic symptoms may not be general but may be single system: Systemic symptoms (fever) felt to be due to a minor illness do not qualify, while single system symptoms without systemic symptoms would seem to qualify (colitis)

#### **CHRONIC ILLNESS**

A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function...the risk of morbidity without treatment is significant. This is different than common wording - "One or more chronic illness w/ exacerbation, progression, or side effects of treatment".

- Does treatment goal need to be explicitly specified or can "Hypertension, not at goal" suffice? For the term "significant" as applied to risk, can that be defined by the physician/QHP and patient or is there an external definition physicians/QHPs need to follow?
- How does the following differ from Chronic, not stable: "Chronic illness with exacerbation, progression, or side effects of treatment."
- If a chronic condition not at goal is not considered stable, is it then in the same Problems Addressed MDM category as on that is acutely worsening, poorly controlled, or progressing with an intent to control progression?

#### **UNDIAGNOSED NEW PROBLEM WITH UNCERTAIN PROGNOSIS**

- Does the diagnosis in the differential that has a high risk of morbidity without treatment need to be documented explicitly in the note or can it be inferred (e.g., lump in breast)?

#### **SEVERE**

- How severe is severe? Definition is unclear and risk of morbidity appears in several of the "problems addressed" section, so it is not a distinguishing characteristic.
- "May require hospital level of care" is vague. Does this mean you are actively thinking about hospitalizing the patient even if you decide not to?

## **Therapies and Medications**

### **RISK LEVELS**

#### **WHAT WE AGREE ABOUT**

Does discussion around not taking a medication (e.g., antibiotic) or not getting an MRI count towards risk levels? Or does it only count if the prescription is written or order placed?

[Per AMA Clarification](#), this concept is accounted for in the data column (via the updated guidance on the AMA website) and should also be accounted for in risk. The new guidelines are intended to incentivize the code level selection based on the cognitive work of the physician/QHP. If a physician has gone through medical decision making and assessed the risk of the individual patient in terms of medication, etc, then he/she should get credit for that real work.

#### **WHAT WE HAVE QUESTIONS ABOUT**

- Should level of risk be documented in the body of the note? How much detail is needed for an audit vs what is medically useful/appropriate?
- Should notes be reorganized to appropriately aggregate problems and symptoms to account for the risk dimension?

#### **WHAT WE HAVE QUESTIONS ABOUT**

### **DEFINITION OF INTENSIVE**

For example, drug therapy requiring intensive monitoring for toxicity – what is the definition of “intensive”?

All examples in guidance reflect monitoring, but intensity is not clear. Do they mean monitoring that requires a lab test, a physiologic test or imaging for toxicity, regardless of frequency?

### **PRESCRIPTION DRUG MANAGEMENT**

Which of these count: PTA medication verification, adding or removing meds prescribed by others from list, ordering, renewing, modifying instructions (take in evening instead of morning)?

## **Other Scenarios**

#### **WHAT WE HAVE QUESTIONS ABOUT**

### **SOCIAL DRIVERS OF HEALTH**

How do you appropriately document social drivers of health components that could factor into MDM?

### **DISCUSSION OF MGMT OR TEST INTERPRETATION WITH EXTERNAL SOURCE**

How much of this must be documented and if you are playing phone tag, can you still count it as valid? (Akin to ordering the test, but not yet having the result). Should this be documented in the note? In a message? Both?

**INDEPENDENT HISTORIAN**

Concerns about having to document more because of audits.

- What are the auditing requirements? For example, will every infant need an independent historian or does it have to be documented who it was and what part of the information was provided by them? What about a 7 or 14 year old?
- Do the specifics of an independent history need to be detailed separately, or can they simply be included in the HPI with a reference to multiple sources?

**DECISION FOR SURGERY AND DETERMINATION OF ELECTIVE VS. EMERGENCY**

- Can the risk dimension only be used by the surgeon? Does a PCP or other physician referral for surgery count?
- Is additional documentation in the note required to indicate the timing of discussion relative to the patient's condition?