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Big Changes on the Horizon: Documenting Office and Outpatient E&M Visits

But Will These Changes Really Reduce Provider Burden?

In October 2017, the Centers for Medicare & Medicaid Services (CMS) launched the "Patients over Paperwork" initiative, meant to reduce unnecessary administrative burden, increase efficiencies, and improve the beneficiary's experience when seeking health care services.[1] The goal of CMS's efforts to identify and eliminate overly burdensome administrative tasks is to minimize distractions and allow practitioners to focus their time and attention on actual patient care.

As part of these efforts to reduce provider burden, CMS made an ambitious proposal this summer to reform evaluation and management (E&M) coding and documentation requirements under the Medicare Part B Physician Fee Schedule (PFS).[2] This proposal, according to CMS, stems from concerns voiced by health care practitioners that the existing E&M coding guidelines are outdated, complex, ambiguous, and fail to distinguish meaningful differences among the five levels of E&M office visit codes. CMS's proposal aims to make use of electronic health records more efficient and effective and to improve documentation workflows to support patient-centered care instead of being focused on meeting billing documentation requirements.

Specifically, CMS proposed to eliminate the existing documentation requirements that differ for each of the five levels of E&M codes for office and outpatient visits. Instead, CMS proposed to adopt a minimum documentation standard, whereby practitioners would have a choice to code based on medical decision making (MDM) or time, or to continue using the current framework based on either the 1995 or 1997 E&M documentation guidelines. In conjunction with the documentation reform proposal, CMS also proposed to apply single-blended payment rates for new and established patients for office and outpatient E&M visit levels two through five.

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While practitioners generally supported CMS's efforts to reduce documentation requirements, CMS received significant pushback on the proposal to "collapse" the E&M visit codes and reduce payments for visits associated with the most complex patients. In response to this feedback, CMS finalized several policies to provide immediate regulatory relief with respect to E&M documentation requirements for calendar year (CY) 2019 but postponed the more significant coding and documentation changes until CY 2021.[3] This delay will give CMS more time to consider how best to implement broad changes to its E&M coding and documentation policies and allow practitioners more time to prepare for such changes.

Current E&M Coding Guidelines

Practitioners paid under the Medicare Part B PFS bill for E&M visits using a set of Current Procedural Terminology (CPT)® codes that distinguish visits based on level of complexity (*e.g.*, levels one through five), site of service (*e.g.*, office, outpatient, inpatient, emergency department, nursing facility), and whether the patient is new or established. Further, there are three key components of a patient encounter that practitioners must document in order to select and bill the appropriate E&M visit code. These three components include history of present illness (including a description of the chief complaint and, if applicable, a review of systems directly related to the problem(s) identified and past, family, or social history), physical examination (including a review of the affected body area or organ system), and MDM (as measured by the number of diagnoses/treatment options, the amount and/or complexity of data to be reviewed, and the risk of complications and/or morbidity or mortality).

Practitioners may use either the 1995 or the 1997 E&M documentation guidelines to determine how to document these three key components of a patient encounter.[4] Alternatively, for visits that consist predominantly of counseling and/or coordination of care, time (in conjunction with MDM) can be used as the key or controlling factor used to determine visit level.

E&M Documentation Changes for CY 2019 and Beyond

For CY 2019 and beyond, CMS finalized several policies to address areas of redundancy and "note bloat" within patient medical records, but CMS did not make any changes to the current documentation guidelines for office and outpatient E&M visit codes or the payment rates associated with these codes.

First, CMS eliminated the requirement, currently included in the Medicare Claims Processing Manual, that the medical record must document the medical necessity of furnishing an E&M visit in the patient's home rather than in the practitioner's office. Therefore, the practitioner who sees a patient in his or her home no longer needs to specifically state the reason why the patient could not be seen in the practitioner's office in the patient's medical record.

Second, CMS simplified the required documentation of history and exam for established patient office and outpatient visits. Specifically, for established patient office and outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed. Practitioners do not need to re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Under these new standards, practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.

Third, CMS clarified that for new and established patient E&M office and outpatient visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that

has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

Finally, CMS removed requirements to maintain potentially duplicative notations in patient medical records that may have previously been included in the medical records by residents or other members of the medical team when E&M visits are furnished by teaching physicians. The teaching physician continues to be responsible for reviewing and verifying the accuracy of notations previously included by residents and members of the medical team, along with further documenting in the medical record if the notations previously provided did not accurately demonstrate the teaching physician's involvement in the E&M visit.

These policy changes are optional for practitioners to adopt. The goal of these changes, if practitioners do adopt them, however, is to allow practitioners to streamline the amount of potentially duplicative information maintained in a patient's medical record, without raising significant program integrity questions or concerns about the appropriate selection of E&M codes.

Additional E&M Documentation Changes for CY 2021 and Beyond

CMS decided to delay the implementation of broader changes to the E&M documentation requirements until CY 2021. Starting in CY 2021, however, practitioners will have choices for how they record information about office and outpatient E&M visits in the patient's medical record. Specifically, for office and outpatient E&M visit levels two through five, practitioners will have the choice to document the E&M visit using the current 1995 or 1997 E&M documentation guidelines, MDM, or time.

When practitioners decide to use the current framework or MDM to document office and outpatient E&M visit levels two through four, CMS will only require the supporting documentation currently associated with level two visits. Essentially, that would mean that a practitioner will only need to document the following for visit levels two through four when choosing to continue to use the current guidelines: (1) a problem-focused history that does not include a review of systems or a past, family, or social history; (2) a limited examination of the affected body area or organ system; and (3) straightforward MDM measured by minimal problems, data review, and risk (two of these three). If the practitioner chooses to document based on MDM alone, CMS will only require documentation supporting straightforward MDM measured by two of the following: minimal problems, data review, and risk.

When time is used to document office and outpatient E&M visit levels two through five, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary (*e.g.*, the typical amount of time for the CPT® code reported, plus any extended or prolonged amount of time spent with the patient).

In addition, CMS will implement payment changes starting in CY 2021 by establishing a single payment rate for office and outpatient E&M visit levels two through four, for both new and established patients. CMS will maintain separate payment rates for level one visits (*i.e.*, the least complex visits, often provided by clinical support staff) and level five visits (*i.e.*, visits for the most complex patients). CMS will adopt add-on codes for the level two through four codes, which will be used to describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care. CMS also will adopt an "extended visit" add-on code for level two through four codes to account for the additional resources required when

practitioners need to spend additional time with patients.

Considerations for Future Changes

The current Administration's goal is to allow practitioners to document what truly matters, in a way that conforms to modern medical practice, and eliminate excessive or duplicative documentation that is not necessary for the care of the patient. Practitioners are generally supportive of this goal. Practitioners, however, will have work to do now and in the lead-up to CY 2021 to change their mindset toward E&M documentation and to be prepared to implement the documentation changes that CMS has adopted.

For example, practitioners will have to take stock of their current documentation practices—*i.e.*, what information is the most clinically meaningful to document and what information is only collected currently for purposes of billing a certain level E&M visit code. Practitioners will have to determine what will be the best way to document the care that they are providing based on the options they will have—*i.e.*, by using the existing guidelines, or switching to a time-based or MDM-based process for documenting the practitioner's interactions with and time caring for the patient.

Practitioners will have to learn how to use the new add-on codes appropriately and determine what documentation will be necessary to justify the use of any add-on code (taking into account CMS's statement that use of these add-on codes would generally not impose new documentation requirements). And practitioners will have to determine how to appropriately keep track of the guidelines they are using for billing the E&M visit codes and add-on codes, in order to make sure that the documentation that is maintained is sufficient and to be able to efficiently and effectively respond to audits when they arise under this new construct for E&M billing. Practitioners also will have to keep straight which documentation guidelines apply to which level of E&M visit code and which payer the code will be billed to (assuming that not all payers will adopt the same changes to E&M documentation standards that CMS plans to adopt).

Finally, CMS has acknowledged that the Center for Program Integrity may need to issue more specific instructions and Medicare administrative contractors (MACs) may need to update some of their coding policies and guidelines to reflect both the changes adopted for 2019 and future changes to be implemented in 2021. Further, CMS noted that many details related to audits for program integrity will have to be developed. This means that practitioners will have to watch for new guidance from CMS and their MAC and be prepared to be able to respond to evolving audit standards over time under the new rules. Practitioners should continue to weigh in with CMS about the implementation of these changes to ensure that they do, in fact, make documentation requirements simpler and less burdensome.

Endnotes

1. *See* www.cms.gov/About-CMS/story-page/patients-over-paperwork.html.
2. 83 Fed. Reg. 35,704 (July 27, 2018).
3. 83 Fed. Reg. 59,452 (November 23, 2018).
4. *See* www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf.

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