Looking Forward to 2021

MONTE SANDLER

2020 has been a rough year for all of us, and everybody is eagerly awaiting 2021. One thing for urgent care providers to look forward to is simplified documentation standards for evaluation and management guidelines. Current documentation guidelines are over 20 years old. A lot has changed in that time, most importantly the adoption of electronic medical records (EMR). Thus, outdated expectations have created "note bloat," unnecessary work, and contributed to provider burn out.

The first major change that should save providers the most time is that only a "medically appropriate" history and/or examination is required. These two formerly "key" elements have no impact on the level of care. While still necessary, the amount of documentation is up to the clinician.

That leaves codes to be selected by either medical decision-making (MDM) or time. These two elements look a lot different than they do today. The documentation requirements are also the same whether the patient is new or established.

Medical Decision-Making

The level will continue to be based on two out of three elements, though the requirements and concepts have changed. The three elements are:

- Number and complexity of problems addressed
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

The second element is where we see the biggest impact. Here doctors will get credit for the clinically important work they are already performing. Data is divided into three categories:

1. Tests, documents, orders, or independent historian(s)
2. Independent interpretation of tests
3. Discussion of management or test interpretation with external physician/other qualified health professional (QHP)/appropriate source

Each unique test, order, or document contributes to the combination for category 1. Each CPT is a unique test. Credit is giving separately for ordering of each unique test and reviewing the results.

Also counted is an assessment requiring an independent historian (eg, from a daughter whose mother has dementia). Providers should take care to document these conversations.

Independent interpretation and discussion of test interpretation would only be counted if the clinic is not also billing for the test (eg, a patient brings in their x-ray from another provider). This would be rare in the urgent care setting.

As for "appropriate source," these are individuals who are not healthcare professionals but who may be involved in the management of the patient (eg, a workers compensation case manager). Providers have not received credit for this in the past.

A new item for risk is when care is significantly limited by social determinants of health. This could be a patient who is homeless or somebody who cannot afford their medication, for example. The additional complexity for these patients is classified as moderate risk.

Time

Today, levels can be based on time when 50% of the face-to-face time is spent in counseling and coordination of care. That is not the case in 2021.

Time is defined as the total time spent by the "reporting" practitioner on the day of the visit (including face-to-face and non-face-to-face time). This is not limited to the time the patient is physically in the office. Examples of non-face-to-face time include reviewing of tests to prepare to see the patient; ordering medications, tests, and procedures; and documenting the service in the EMR.

Also, the guidelines state that when both a physician and a nonphysician provider see the patient, the total time for both providers should be combined to determine the correct code. Time spent by clinical staff (eg, nurses) and time spent on a procedure should be excluded from the total time calculation.

Monte Sandler is Executive Vice President, Revenue Cycle Management of Experity (formerly DocuTAP and Practice Velocity).

Background on Changes to CPT Evaluation and Management

[*Editor's note:* The American Medical Association posted a summary of the recent history of changes relating to evaluation and management on the CPT portion of its website. Below is an overview. To view the entire summary, and to access links to other resources, visit https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management.]

E/M Office Visit Revisions

The provision to the 2020 Medicare Physician Fee Schedule Final Rule posted on November 1, 2019 includes revisions to the Evaluation and Management (E/M) office visit CPT codes (99201-99215) code descriptors and documentation standards "that directly address the continuing problem of administrative burden for physicians in nearly every specialty, from across the country." The end result is that "documentation for E/M office visits will now be centered around how physician think and take care of patients and not on mandatory standards that encouraged copy/paste and checking boxes."

Main Objectives of the CPT Editorial Panel Revisions

The CPT Editorial Panel outlined four primary objectives:

1. Decrease administrative burden of documentation and coding.
2. Decrease the need for audit, through the addition and expansion of key definitions and guidelines.
3. Decrease unnecessary (ie, not needed for patient care) documentation in the medical record.
4. Ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

An add-on code will be added for each additional 15 minutes if the visit goes over the time stated in the CPT description for 99205 or 99215. It must be a *complete* 15 minutes to report this code—no rounding up.

Providers should consider documenting time for every visit. When total time gives you a higher level than MDM, that is what you should report, and vice versa.

As always, documentation should be sufficient for a subsequent provider to treat the patient and a proper legal defense. Make sure you are documenting these new items so you get credit for all the work you are doing. ■