LETTER FROM THE EDITOR-IN-CHIEF

A Rational System for Charting Has Finally Arrived

Remember the fall of last year—when the nation and world pined for an expedient end to 2020, as if such an arbitrary change as turning a page on the calendar could somehow reverse our collective fortune? Unsurprisingly when January 2021 arrived, all our woes were not magically and immediately remedied. In fact, the start of this year was among the most grim in U.S. history: nearly a quarter of a million new cases were being diagnosed and several thousand people were dying every day from COVID-19 in the U.S. alone, vaccination rollouts were off to a rocky start, and an unruly mob broke into the Capitol building, threatening the security of our democracy.

And this was only the first week of the year—a less auspicious start than we'd hoped for.

It was against this backdrop that, on January 1, a major overhaul to outpatient (including urgent care) billing and coding came into effect in the U.S. The changes made were dramatic, yet the news of their arrival was largely drowned out. In fact, amidst the tumult of the pandemic this extensive revision in CPT coding, which in any other year would have certainly caused a commotion, took effect without much chatter in the UC clinician community at all.

I'll bet many of you can recall little more than a few mutterings on the topic buried amongst the onslaught of daily emails sent from your administration discussing changes in various COVID-related policies. Or perhaps you simply noticed the templates in your EMR had been annoyingly rearranged. Regardless, this year the American Medical Association released its first major update in the evaluation and management CPT coding structure since 1997.

You may be asking: why now?

It's true, coping with a significant change can feel overwhelming. Most of us are frankly already exhausted from change at present. Unsurprisingly, this has fostered a situation of relatively slow acceptance for the new E/M coding guidelines in the UC world. The providers I supervise mostly continue to chart as they always have, making only slight modifications in the medical decision-making (MDM) sections of their templates (I suspect to avoid being nagged more than all else).

In a way, it's tragic that this revision came when it did. We've been asking for a rational system for coding our documentation for years. When it finally arrived, however, many of us were too distracted to notice, much less appreciate it. Sure, the old system was familiar. We'd memorized how many areas of the body we needed to examine, how many systems we needed to chart as "reviewed," and when we needed to include some rarely useful piece of family history to get a level 4 or 5 chart.

The *Catch-22*-esque absurdity of the system was laughable, if you stop and think about it. But, for most of us it's the only way we'd ever known, and we'd resigned ourselves to its eternal dominion over our charts.

Based on the nature of this situation, it's no wonder that documentation demands have routinely topped the list of reasons cited for provider burnout. None of us went into medicine for the love of charting, yet studies on provider behavior have shown we spend much more time interacting with our EMR than we do with our patients.

This has been largely driven by a nonsensical demand for excessive and irrelevant data in our history and physicals, which has taken our time and energy away from patient care and led to what has come to be referred to as "note bloat." We've all experienced note bloat—the challenge of finding relevant information when reviewing a patient's previous visits because it's buried in a novella of immaterial macros.

Ironically, this distracting data, which we frustratingly have had to sift through on our quest to find the useful information required to take good care of patients, was inserted for the specific purpose of telling payers how hard we're working taking care of patients. (I wonder why we've faulted our patients for complexity for years, but rarely blamed the payers who've demanded this sort of soulless form of charting.)

Thankfully, the AMA's new system for coding puts an end to the madness. Clinicians are now able to collect and document as much or as little data as we feel is indicated in our H&Ps without worrying about billing. Instead, billing will be based on the documentation of our thought processes and risk assessment in the MDM.

The advantage of this new system for the busy UC provider is twofold.

First, focusing efforts on showing our work in the MDM

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forces us to reconsider the relevant aspects of each case and offers us a chance to review our assessment as we put it into writing. This can be done quickly and in real time, subverting cognitive errors in the moment of care that could lead to poor outcomes for patients.

Secondly, this alleviates the onus for templates, macros, and dot phrases and consolidates the salient aspects of the note into a reliable location (ie, the MDM section). This promises to significantly streamline our process of reviewing data when scanning through prior documentation.

Admittedly, charting in this way will require breaking old habits and forming new ones. Because documentation is such a painful topic of discussion and a common source of burnout, I fear that many providers will not embrace this change and the opportunity to make our clinical lives more enjoyable that it offers. Indeed, rethinking and retraining how we chart is considered by few to be a fun process. It's like spending time practicing on the putting green. Most who play golf would much prefer to spend their time at the driving range; however, any experienced golfer will tell you that it's your skill in the short game that most influences how few strokes it takes to play the course.

Similarly, documentation is the short game for UC practice. By engaging with this new and much more rational paradigm for charting, you'll exponentially improve your efficiency in documentation, which again is what we spend most of our time doing. Charting better and more efficiently means more time with patients and less burnout.

So, as painful as it may sound, work on the "short game" of your UC practice and take an afternoon to learn the new E/M documentation rules and revamp your templates. The work of dialing in your charting probably won't be fun, but it will allow you to enjoy the game a lot more the next time you find yourself on the course. ■