Moving Beyond Bullets and Body Systems – AMA 2021 Changes to Reporting a Visit

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Three (3) HPI + Two (2) PFSH + Two (2) ROS + One (1) PE + One (1) new problem equals the exclusive coder's language attempting to translate clinical documentation into a reportable "level of service."

Physicians have monitored their place on a specialty or geographical bell curve and frequently expressed frustration with the administrative burden. The American Medical Association (AMA) will soon release a new language (guidelines) for reporting the most basic healthcare services. Will it result in better communication between the provider, the patient, and the payer? Where will chiropractors land in this version?

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The evolution of billing for a "visit" has been interesting to watch over the years. In the beginning, a clinical visit was translated using the vague options of "straightforward," "intermediate," and "comprehensive." Many years of healthy discussion produced the first major overhaul since the 1976 California Relative Value System (CRVS), which would be forever known as the 1995 evaluation and management (E/M). For specialties like chiropractic, this revamped system appeared to undervalue their initial visits and consultations by placing too much weight on a "full system" review or examination. Counting the bullets as prescribed would make it difficult to exceed the level two. The alternative method of documenting time spent with a patient also seemed to disregard the efficient providers. The specialty groups returned to the table, and two years later, the 1997 E/M guidelines were published. Two similar but not equal means of reporting the cognitive skill of the provider in evaluating and developing a treatment plan for their patients. Somewhere along the way, Medicare and other payers eliminated the consultative codes from their reimbursement models because of the complexity behind determining a consult versus a referral. Each variation on the system seemed to expose a new weakness, which provided an opportunity for the extreme minority of the population to game the system.

The electronic health record (EHR) provided a method to capture key data elements that would assist in supporting a specific level of service. It became almost expected that a final note wou[illegible]er

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and even a complete physical exam for a minor, focused problem. A past family, social, and medical history was "carried forward" with each visit and helped support that complete history—three of this, four of that, and two of those. Year after year, the expertise and judgment of the clinician was pushed further from the focus of the record and the reimbursement. The typical template seemed almost crafted to capture those key phrases for reimbursement without respect to capturing the patient's concurrent medical problems that affect the thought process of each visit.

Take the time to challenge this theory with just three recent initial consultation notes. Random selection will likely include patients who present with back pain, sciatica, or the inability to walk across the room due to osteoarthritis. Based on your practice's clinical demographics, there may be an auto accident with recurrent neck pain. Highlight areas of your documentation that address an individual patient's risk factors or the clinical significance of a patient's past medical history. Does the course of recommended therapy change for a patient with active metastatic bone cancer? Does the choice of pain relief change for a patient who is insulin dependent or has a long-term use of steroids, personal history of radiation therapy, or is non-compliant due to financial reasons? The neck/back/leg pain isn't the only focus of the visit; the skill is navigating the presenting condition with the rest of the patient's lifestyle and history to ensure the best outcome. This information doesn't always fit into a two-of-three model or even a prepopulated box on a traditional template.

Medicare has tried to level the playing field by bypassing the formal definition of "two of three" as a key component for an established patient with an additional requirement. Despite the volume of data in the chart, medical decision-making was the overarching criteria to determine the level of service assigned. A comprehensive history paired with a comprehensive physical exam for a single, straightforward problem would not support a level four. The severity of the patient's presenting condition would need to be one of those two key components for that individual evaluation, reevaluation, or even discharge note.

However, that was Medicare.

On January 1, 2021, the AMA and Medicare will be on the same page with more attention to the patient's total care. In short, the provider may choose to translate their documentation into the time spent—both face/face and non-face/face—or to apply the new medical decision-making criteria. The history and physical examination clearly contribute to both the time spent and the overall medical decision, but neither of the previous key components will be used to translate documentation into a level of service.

The emphasis on time and medical decision-making may significantly change reporting levels for a chiropractor since time spent outside of the face/face visit reviewing records and imaging studies is now "billable." Providing education to the patient, family, or even caregiver is now "billable." The new guidelines also include "documenting information within the medical record" as an example of time that may now be "billable."

It is important to ensure that any templates currently in use will adapt to gathering more than just a diagnosis code for reporting based on medical decision-making. The risk of complications and complexity of the problems addressed respecting that patient's medical history will need to be clearly documented, as well as the source of that information. A discussion with an external physician or an independent historian will affect the final level of service beginning January 1.

This is an opportunity to shift documentation away from data just collected for billing and be compensated for the time and cognitive skills used to improve your patient's mobility and quality of life. Take the time to carefully review the new guidelines and discuss any changes for your EHR templates soon. Will your existing template help you capture the non-face/face time efficiently? Does the existing workflow lean on a check-in/check-out process? If you choose to use the medical decision-making, does the assessment area of your template allow for more than just a diagnosis code? With the changes affecting all providers, every client of your EHR vendor will make a similar request, so don't be at the back of the line.

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