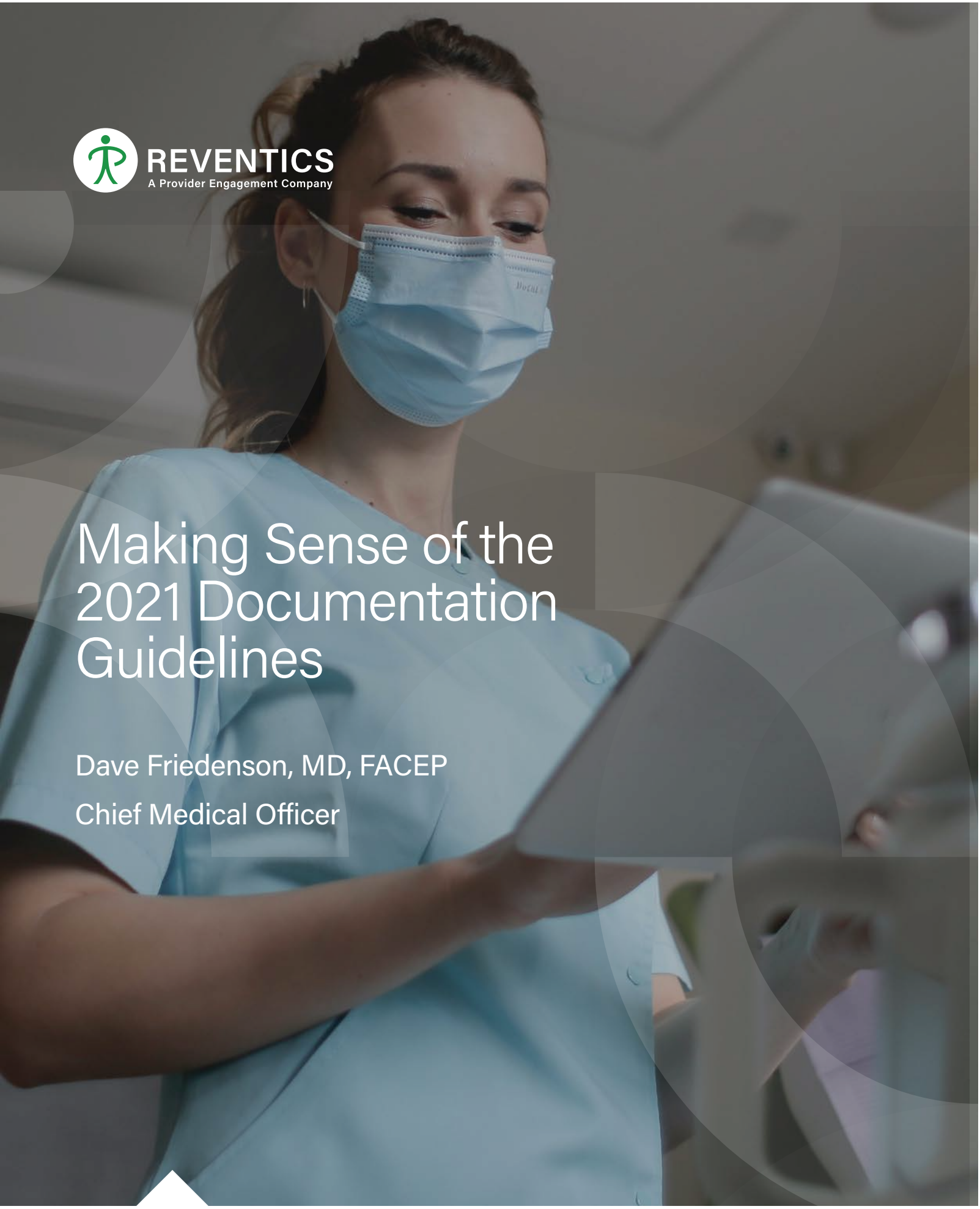

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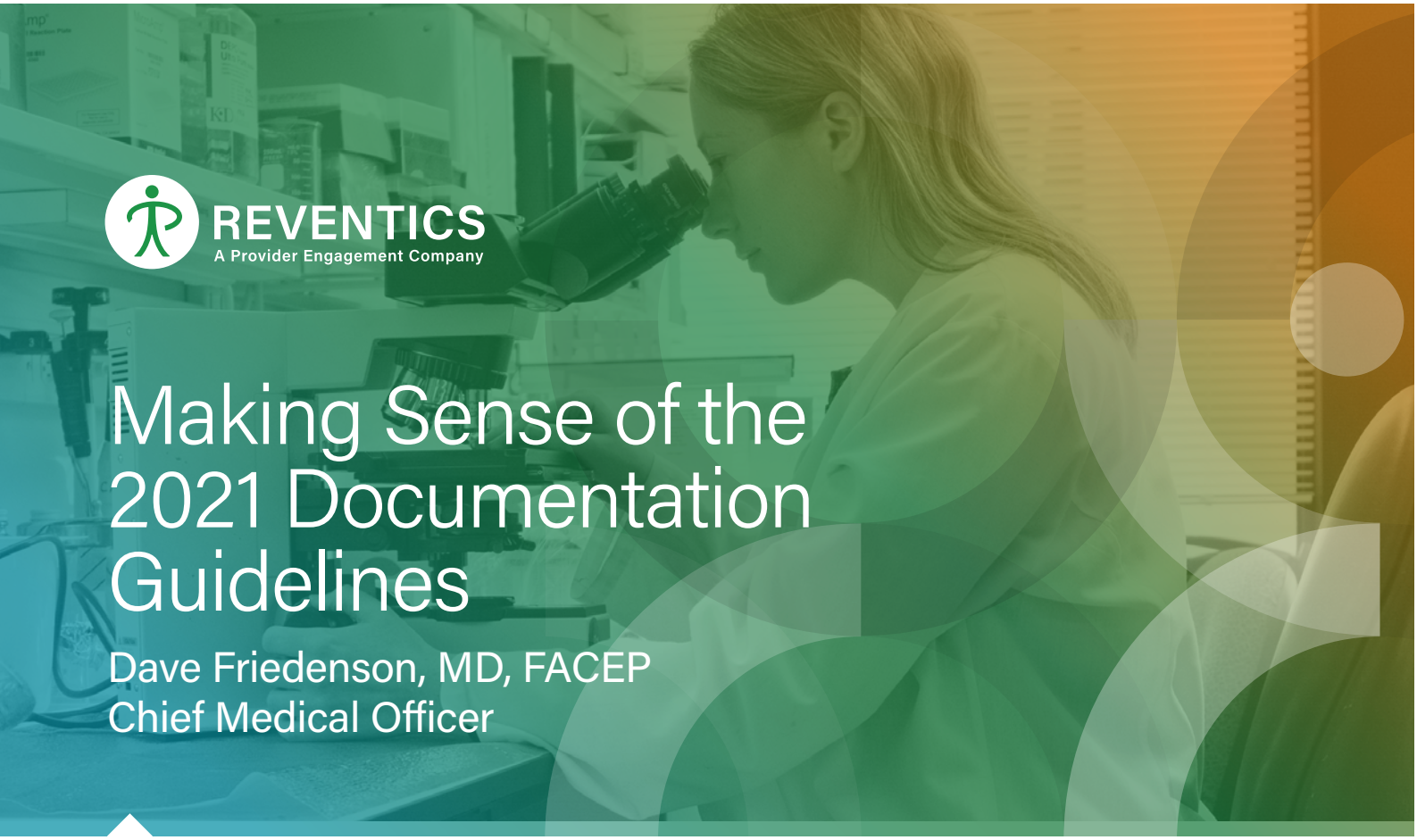
Making Sense of the 2021 Documentation Guidelines

Dave Friedenson, MD, FACEP
Chief Medical Officer

About Dave Friedenson, MD, FACEP

Dr. Friedenson is the Chief Medical Officer and Compliance Officer of Reventics. He is also a past President of Colorado ACEP, served on the Colorado Medical Society's task force on network adequacy and insurer issues, and a member of the national task force on Insurance and Medicaid provider issues. Dr. Friedenson served as board member and as Compliance Officer for a large multispecialty group practice from 2009 -2014. In his role as the CMO of Reventics, Dr. Friedenson plays a vital role with the clients by helping in improvement of diagnosis & documentation, undertaking compliance audit, and leading policy development initiatives. He is currently an active member of ACEP's Reimbursement Committee, Chair of ACEP's Coding and Nomenclature Committees, and Co-Chair of EDPMA's State Regulatory and Insurance Committee. where he has been integral in the development and revision of many of ACEP's FAQs on reimbursement. Dr. Friedenson has over 25 years of clinical experience at level 2, 3 and 4 trauma centers with oversight of Emergency Medicine, Hospitalist, Wound Care, Neurology, Urgent Care, Telemedicine and Free-Standing ED programs. Dr. Friedenson received his Undergraduate and medical degrees from The University of Massachusetts and completed his residency training at The Johns Hopkins Hospital.



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The new 2021 AMA CPT documentation guidelines are a breakthrough in documentation requirements. Effective January 1st of this year, this first major overhaul in 25 years shifts focus from documentation volume to the medical decision-making process. Rather than requiring the clinician to document every history and physical detail, the new guidelines require clinicians to thoroughly document what's pertinent to their evaluation and management. There's also a choice between the newly revised medical decision-making table or total time spent working for the patient, both face-to-face and indirectly on the day of the visit.

> *"Rather than documenting every detail, clinicians must document what's pertinent to their evaluation and management."*

The levels of medical decision-making remain the same, but the new medical decision-making guidelines provide coding levels based on any two of these elements :

- **Number and complexity of problems,** with or without a diagnosis.
- **Amount and complexity of data,** including each unique test, external document, external conversation ordered, reviewed, or discussed.
- **Risk of complications or morbidity** from additional testing or treatment

What does this mean to clinicians and coders? There's less potential of being down-coded because you missed a documentation step. There's also potential time-savings, though these are unlikely to be realized by seasoned practitioners accustomed to documenting required history and exam elements.

What we found.

Guidelines, by definition, indicate or outline conduct. People tend to take them too literally, yet they're intentionally vague. This ambiguity leads to widespread under-interpretation of their meaning across practices and coding organizations. If you ask the AMA for clarification, they appear to lean towards under-coding. Remember, guidelines are an indicator of direction. Clinicians and coders should improvise based on these directional indicators and adapt them to their practice, specialty, and patients.

> *"While you can document **less,** you need to document **better.**"*

One type of practice impacted by gaps in the guidelines are urgent care facilities. Urgent care facilities often see patients for problems people thought would resolve on their own, but don't. The guidelines indicate these types of problems fit the progression, exacerbation, or side effects of chronic problems, except these problems aren't chronic, they're acute. While the guidelines don't exclude acute problems, they also don't specifically address these scenarios, leaving several questions:

- How do we classify a worsening acute illness, an illness that doesn't follow the standard course, or fails to respond to limited or OTC treatment?
- How do we define the complexity of an illness or injury?
- How do we differentiate between a moderate and life-threatening presentation?

Another gap in the guidelines stems from the happenstance of timing. When the new guidelines were being formulated, SARS-CoV-2, which would soon wreak global havoc, didn't exist. How was the AMA to know that a new cold virus could be everything from asymptomatic to fatal? How does a clinician classify that risk when a patient who seems fine today may be critically ill tomorrow? How does COVID-19 fit as an exception to the self-limited infection rule?

These guidelines impact essentially all types of practice across ambulatory and inpatient settings. We found that specialties such as OB-GYN, family practice, and procedural specialties are among the most susceptible to misinterpretation impacting accuracy, compliance, and reimbursement.

What we recommend.

Reventics spent the last 60 days re-interpreting and using these guidelines in real-time to provide clinicians feedback on their documentation to improve accuracy, compliance, and reimbursement. We've developed additional guidelines for coders and clinicians to address the gaps we've identified and better suggest service levels, including the key elements of medical decision-making they need to document for better accuracy, compliance, and reimbursement. We've also provided clarifications on the definitions and implications of terms.

We've specifically not included code 99211 because it assumes a minimal level of required services, therefore medical decision-making doesn't apply.

We've also added specific COVID-19 guidelines, since this will be the bulk of the practice for many physicians, particularly urgent care facilities, for the foreseeable future. These guidelines reflect our belief that COVID-19 should never be considered as a self-limiting illness, even if the patient is only concerned about exposure, due to the high potential for mortality shortly after exposure .

> *"The new guidelines are complex. Risk of misinterpretation is high. We recommend aggressive MDM education for coders and clinicians to maximize compliant coding and reimbursement."*

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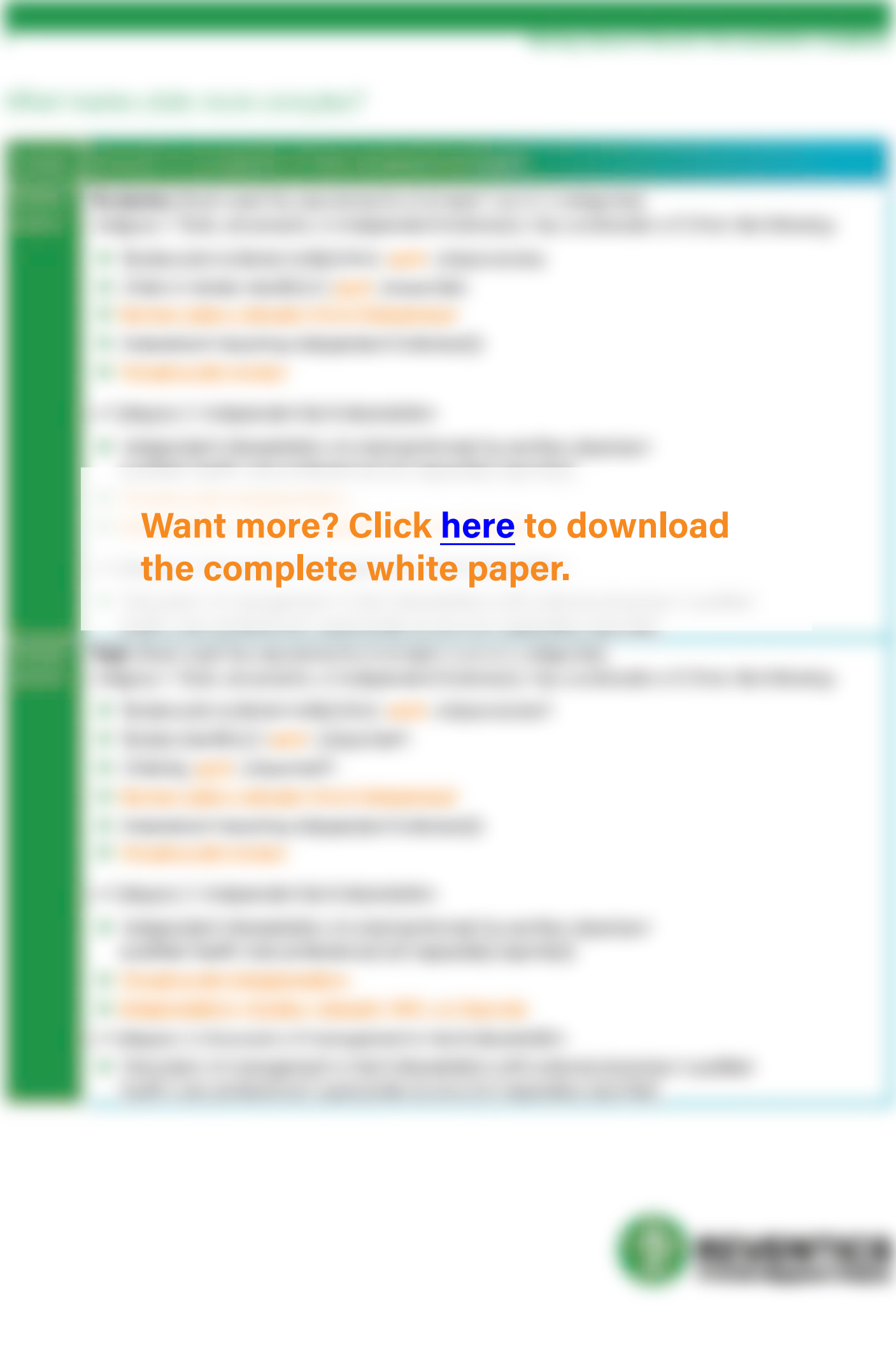
Want more? Click here to download the complete white paper.



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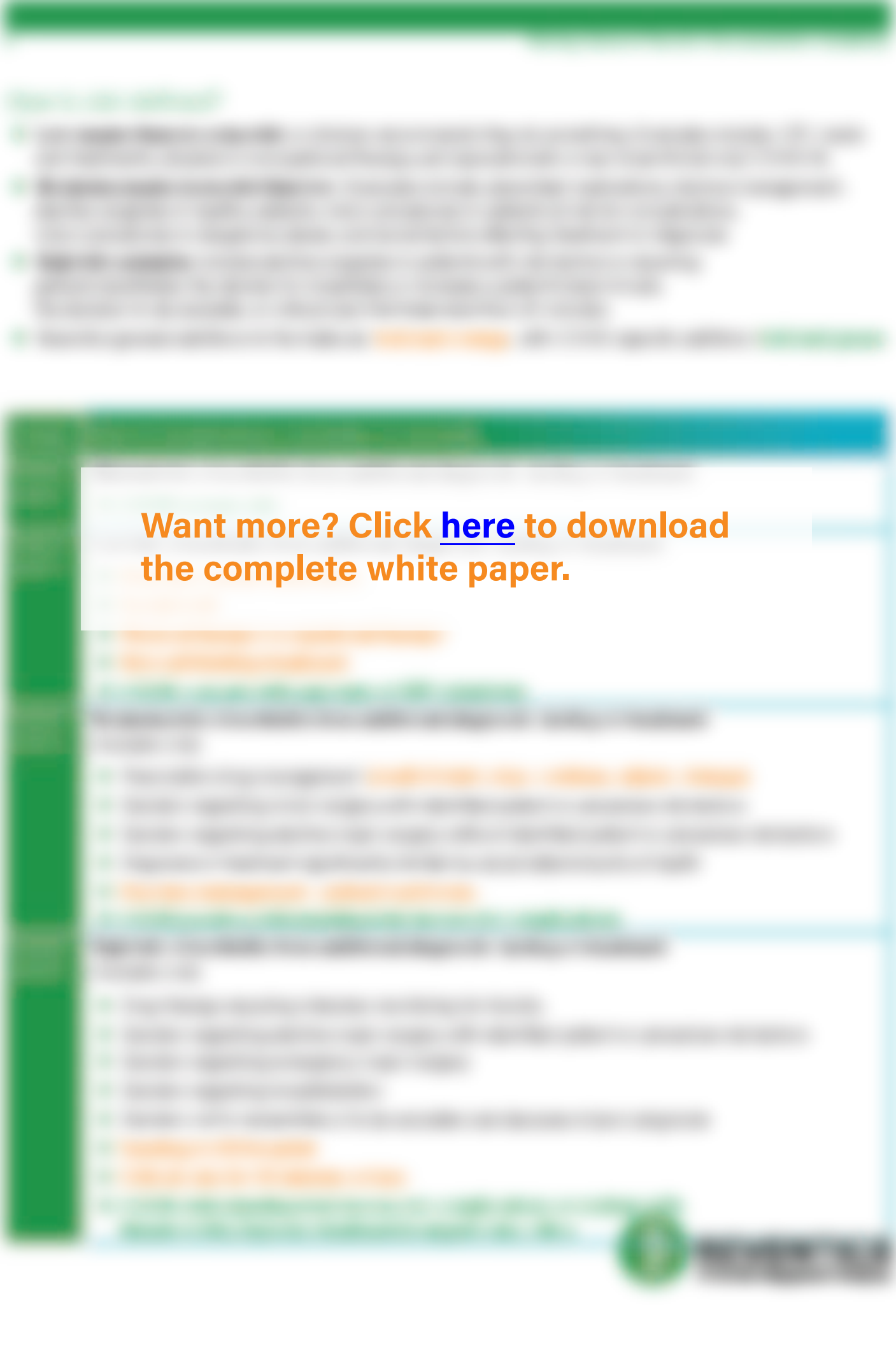
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What we concluded.

The new documentation guidelines offer significant and welcome change to the amount of documentation required. They're designed to save clinicians time and effort in documentation, and if implemented properly, should improve compliance and reimbursement.

The issue lies in determining proper implementation, both addressing the gaps caused by the timing of the COVID-19 pandemic relative to the release of the guidelines as well as properly interpreting the guidelines relative to your practice, specialty, and types of patients.

While interpretation and implementation risks impact all types of practice, we believe these risks are heightened in specialties such as OB-GYN, family practice, and procedural specialties, as well as in urgent care facilities.

> *"Remember that guidelines are directional. You need to interpret and implement those guidelines relative to your practice, specialty, and types of patients."*

About Reventics

Reventics delivers **Provider Engagement Solutions** that enhance physician reimbursement and compliance while improving clinical quality measures. Our technology streamlines coordination and communication between the coding/HIM teams and providers. Using advanced clinical machine learning, we offer near real-time, continuous feedback with clear, concise direction on improvements that empower providers and increase provider autonomy. We do this with fewer clicks, intuitive visualizations, and performance reporting that lower the technology demands that lead to physician burnout.

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For more information or a demo,

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