

Documentation Guidance in the Era of the 2021 E&M 2021 Coding Rules

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2021, as we all know, ushered in the first significant changes to the Evaluation and Management (E&M) Codes set used in an office setting since 1997. The changes eliminated much of the practice I term “coding by the numbers” where a specific number and type of elements for history and examination were required for each level of coding and the medical decision-making component was fuzzy at best. What did not change, however, was the need to continue to appropriately document both the patient history and the examination as medically appropriate to care for a particular patient. I have heard some providers state that the rules changes mean “I do not have to worry about history or examination documentation” which, at best, is incorrect. The question becomes: What is an “appropriate history” and “appropriate examination”?

The 2021 E&M Office-based codes (and all of the other E&M codes beginning in 2023) did not eliminate the necessity for history or examination documentation. We cannot go fully “retro” to the time when physicians maintained patient records on index cards in a small file box. The changes were intended to reduce the burden of repeating documentation that is not necessary when it can be reviewed from elsewhere in the medical record. Most providers are using electronic health records (EHRs) in practice which makes pulling complete patient histories forward from one examination to the next examination as easy as pushing a button. However, even with the ease of pulling information forward, providers still need to update and review histories for every visit.

The best advice I can provide for histories is as follows:

1. New patient to practice: complete a thorough patient history of any system or disease that could impact their ocular health and overall health. To me this means asking about and gathering information on most body systems from cardiovascular disease to venereal disease to skin diseases since all of these can impact any symptom or ocular issue a patient might endure. However, I do not necessarily need to know about an ankle fracture repair at age 16. Gathering an appropriate history means obtaining complete patient, family and social history information to be able to properly consider and assess all possible causes for any specific visit.
2. Established patient visit: A quick review of the history to determine if there are any specific changes that you should know in order to properly treat that patient for that particular visit. For example: has that 45-year-old patient with a complaint of dry eye syndrome recently been diagnosis and started treatment for hypothyroidism since the last visit. This history might be an important key to their current ocular symptoms. If you or your technician did not update the patient history, this fact might be missed.
3. All patient encounters: Inquire about, update or list all current medications (prescription, over-the-counter and herbal) the patient is taking. This is a requirement for most of us who are participating in the MIPS program but is also important in the understanding of your patient.
4. Ensure chief complaint(s) are properly and completely documented - patient problems, symptoms, known disease processes, illness, etc. to support the medical decision making or time for each encounter. If an issue is simply listed but not addressed during an encounter, it cannot be counted toward either medical decision making.

Using a patient with dry eye syndrome, allergies, cataracts and glaucoma as an example for an appropriate history:

Example of good history documentation:

Follow up for glaucoma – using drops no new symptoms – exam documented

Follow up for dry eye syndrome – using drops, eyes very dry during sleep time and in mornings – exam documented

Follow up for cataract – some glare little change in vision – exam documented

Follow up for allergies – no current symptoms to report – exam documented

New Symptoms- some swelling under lids in evening, slight itching – exam documented

Other history, allergies, medications reviewed and updated

When I address all 5 disease processes in the history and then document the examination for these diseases, all diagnoses can be counted toward MDM or time.

Example of lesser documentation:

Follow up for glaucoma – using drops, no new symptoms

Other history, allergies, medications reviewed and updated

If I only address the glaucoma in the history and examination and did not document any of the other ocular or systemic issues by history and examination, only the glaucoma would count as one controlled problem for the MDM or time. I may miss the fact the patient is having the issue with lid swelling or the dry eye symptoms. And, even if I did discuss these with the patient, my documentation does not reflect that fact, thus I cannot use any undocumented issues toward the E&M Coding choice.

Documentation for the examination component should include all that you do and anything you consider doing but opted to not do and why that decision was made. While there is no longer a check list of examination elements that need to be completed, you should always be mindful of medico-legal considerations, standard of care requirements and quality measure requirements. Perform the examination that is the standard of care for the patient on that particular visit to address the reason(s) for that visit.

The ultimate goal of documentation is to have an appropriate and adequate record of that patient encounter that can be used at a future time to aid in treating that patient. As well, appropriate and adequate documentation can be achieved within the 2021 E&M guidance without as much angst of whether you remembered every single element in the “coding by the numbers”. As always:” If you didn’t write it down, it was not done!” The record of the stellar job you did for each patient encounter will be obvious. If you use time rather than MDM in choosing your E&M code level, you can count the time you need to properly complete the documentation toward the total time of an encounter.

You can find all the background you need on applying the new 2021 E&M codes on the AOA EyeLearn #AskAOA page [here](#). Happy Coding.....

Introduction to KOA New Benefit:

My name is Rebecca Wartman, OD. You may be familiar with the work I have done for AOA in Coding and Reimbursement Committee and Third-Party Center. I have lectured often on coding and billing topics, including for MOA. I am now contracted by MOA to write a monthly column and be available to aid in answering any Coding and third-party questions you may have. If you have any topics you would like to see addressed in this monthly column, please let me know. All suggestions and all comments are welcome.

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