

Outpatient Chart Documentation Tips and Introduction to Outpatient Billing

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*Literature review current through June 2023
Last updated June 2023*

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Educational Objectives:

1. Review strategies for streamlined and efficient chart documentation within the electronic medical record
2. Demonstrate effective strategies for comprehensive but succinct office notes.
3. Discuss the necessary components for appropriate billing using time-based or medical decision-making (MDM) codes.

Please note that there will be variation in each institution's documentation and billing practices based on the use of different electronic medical records and documentation systems. This handout was originally structured based on the EPIC electronic medical record. Each institution should incorporate its strategies based on site experience and practice culture

Scenario:

You are the attending, preparing for a busy day at the ambulatory clinic. You have patients scheduled every 30 minutes and are trying to strategize ways to improve your efficiency as you always fall significantly behind schedule. You've decided to take some time to familiarize yourself with the electronic medical record and develop general strategies to streamline your documentation and make your visits flow easier. What are some strategies you might incorporate into your chart documentation practice?

Finding ways to streamline documentation can be a challenge. Striking a balance between being comprehensive and succinct is often a challenge. When a clinic note is too long, full of old imaging studies from 6 years ago, and a running log of every visit your patient has ever had in your office, it is difficult for you and other consultants to sort out the important information from the superfluous.

Some strategies for efficient and effective chart documentation are listed below:

- **Review your patient panel briefly before your scheduled clinic.** This will allow you to review consultant notes, patient imaging, and laboratory data to help you prepare for the visit. Consider discussing what methods of "pre-charting" your group has found helpful. You might make written notes on a printed schedule, or use the "sticky note" feature of your EMR in each chart. As discussed in the billing section, any attending time spent on the day of the clinic pre-charting can be added to the total time spent on the patient encounter.

- **Create a pre-populated template for your clinic notes.** Continue to refine this over time. We suggest having a template for both a new patient and a return patient visit. Discuss whether your group’s members have concise templates they are using. You might adopt or edit an existing template to get new ideas. You may even consider separate templates for certain common visits such as asthma, COPD, interstitial lung disease, etc. Examples of new patient and return visit templates are provided in Appendix 1 and 2.
- **DON’T note-bloat with full reports of diagnostic studies, medication lists, labs, etc.** Avoid direct copy and paste whenever possible. Instead, try to paraphrase/summarize the most important and key information. In general, aim for a one-sentence summary (or edited version).
 - For example, A CXR read of “PA and lateral views of the chest are compared to a study from June 26, 2014. Again seen is elevation left hemidiaphragm. The heart is normal size and the lungs clear. No active disease is seen” can be more succinctly summarized as “Personally reviewed CXR image: Unchanged elevated L hemidiaphragm” in your note.
- Use the “Visit Diagnosis” area to indicate the problems you are addressing during the visit, and then associate any orders with the relevant diagnosis. This will allow you to quickly document a diagnosis-based problem list and plan using smart-phrases.
- **Make Smart-Phrases** (or copy those of other fellows or attendings in your practice). Suggestions of helpful phrases to have prepopulated for a general pulmonary visit include:
 - A table for populating PFT and/or 6MWD data over time (if your EMR doesn’t have smart phrases for these)
 - Procedure consent and documentation
 - Patient instructions for procedures or new medications.
 - Discuss other commonly used data or scoring systems that your group might find helpful to have as smart-phrases.

Pulmonary Function Test Results

Date	FVC	FVC %	FEV1	FEV1%	FEV1/FVC	TLC%	DLCO	DLCO%	Comments

Six-Minute Walk Test Results

Date	6MWD	Nadir O2 % Sat	Last insp O2 l/min

Example of a pre-drawn table for PFT and 6MWT data.

- **Utilize any existing smart sets/order sets** organized by disease conditions. These include common diagnostic testing and therapies grouped by disease state for easy ordering. For example, a COPD smart set might consist of commonly prescribed inhalers, and frequently ordered tests (CT chest, PFTs, 6MWT, echocardiogram) with associated diagnosis codes.

The screenshot displays a section titled "PACC DYSPNEA" with a dropdown arrow. It is divided into four main categories:

- Diagnoses:** Includes a "Collapse" link and a "Click for more" link.
- Procedures:** Includes a "Collapse" link and a list of five items, each with a checkbox and "Qty-1":
 - Spirometry
 - Spirometry With Bronchodilators
 - Pulmonary Diagnostic Testing (Methacholine Challenge)
 - Pulmonary Exercise Testing
 - Pulmonary Function Testing (Lung Volumes, DLCO)
- Labs:** Includes a "Collapse" link and a "Click for more" link.
- Imaging:** Includes a "Collapse" link and a list of three items, each with a checkbox:
 - XR CHEST PA AND LATERAL (71020)
 - CT CHEST W IV CONTRAST (71260)
 - CT CHEST WO IV CONTRAST (71250)

Example of part of the Penn pulmonary division's dyspnea order set from the EPIC EMR.

- For Return Patient (Follow Up) Visits:
 - **Copy/paste or pull forward the prior note** as a start, not an end! This can serve as a reminder of your prior discussion and plan but needs to be edited and changed as appropriate for the current visit. When you perform this copy-forward, add a stop-text (in Epic, three asterisks "***") that prevents you from signing the note until the text is addressed.

Scenario continued:

You have finished the clinic visit and are ready to close your chart. You have done all your documentation, including medication reconciliation, updating the problem list and history, and sent a copy of your office visit or a consult letter to the appropriate physicians involved in your patient's care. You now must assign a level of service to the office visit. How do you decide what to click?

As of January 2023, CMS has again updated billing requirements. These requirements are also usually adopted by private insurers and are important for physicians to be familiar with. These codes have similarities – they all end in 2 through 5, representing increasing work as the number increases. There are separate codes for new patient visits, return patient visits, and consultation visits (Medicare doesn't recognize consultation visits, but some private insurers are typically paid slightly higher amounts than new patient visit codes).

Outpatient work can be billed by two different methods: Either time spent on the day of service or medical decision-making complexity.

- A. Time spent billing does not consider decision-making or complexity of care. The time counted includes only the attending physician's time spent **during the same calendar day** as the appointment (the "encounter" in billing parlance). A smart phrase can be created to help document time, such as "I have personally spent XX minutes involved in face-to-face and non-face-to-face activities for this patient on the day of the visit." Or "I spent XX minutes today providing this care." A similar phrase might already be part of your hospital's EMR.
- B. What time can be counted? Only attending physician time counts – fellow time does not – so you may rarely use time-based codes during the fellowship. From the Medicare guidelines:
 - a. **A physician or other qualified health care professional time includes the following activities when performed:**
 - i. preparing to see the patient (e.g., review of tests)
 - ii. obtaining and/or reviewing separately obtained history
 - iii. performing a medically appropriate examination and/or evaluation
 - iv. counseling and educating the patient/family/caregiver
 - v. ordering medications, tests, or procedures
 - vi. referring and communicating with other health care professionals (when not separately reported)
 - vii. documenting clinical information in the electronic or another health record
 - viii. independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
 - ix. care coordination (not separately reported)
 - b. **Do not count time spent on the following:**
 - i. the performance of other services that are reported separately
 - ii. travel
 - iii. teaching that is general and not limited to the discussion that is required for the management of a specific patient

Below are the codes for billing using time:

Outpatient consultation	
20 minutes	99242
30 minutes	99243
40 minutes	99244
55 minutes	99245

New Patient	
15 minutes	99202
30 minutes	99203
45 minutes	99204
60 minutes	99205

Established Patient	
10 minutes	99212
20 minutes	99213
30 minutes	99214
40 minutes	99215

What happens if you spend greater time on a new or established patient either during the visit or afterwards on the same day (ie 90 minutes)?

- Code 99417 is used for prolonged total time (direct and indirect patient contact). It starts 15 minutes after "suggested time" is surpassed (ie. For a new patient you can use prolonged billing code starting at 75 minutes). Each 99417 covers 15 additional minutes of total time spent. Multiple units can be recorded. An example may be helpful.
 - Medicare requires use of code G2212 for prolonged total time, starting 15 minutes beyond the maximum duration of the high complexity visits (74 minutes for 99205 and 54 minutes for 99215). You can begin to report G2212 at the 89th and 69th minute, respectively, for 99205 and 99215. As with 99417, multiple units can be recorded each time another 15 minute threshold.
 - You see a new complex patient referred for a third opinion. Prior to seeing the patient it takes you 45 minutes to review the records. You spent an additional 45 minutes in direct contact with the patient. Documentation and correspondence take an additional 45 minutes. Total time 135 minutes. Billing would include 99205 (60-75 minutes) and 5 separate 99417 codes (Minutes 76-135) for a payer recognizing 99417; for Medicare, only 4 separate G2212 codes would be reported.

- C. What makes a patient visit a "New" patient? From the AMA guidelines 2022:
- a. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.
- D. Billing by medical decision making complexity (MDM) is complicated. Historically, since MDM often leads to greater codes than time-based billing, **most visits are billed based on MDM**. With the new guidelines that record total time spent on the same calendar as the patient visit, the less cumbersome time-based billing may be more beneficial for some patient encounters. Your EMR may have a tool built in to suggest an appropriate billing code, although this will require entering data in a specific form or in a specific way. When MDM is used for billing, time should not be mentioned. A much appreciated upgrade to the new billing guidelines is that E/M services include a "medically appropriate" history and physical exam that does not factor into level of complexity coding. In the past, the requirement that the History and physical examination match the MDM complexity led to excessive documentation that should be curtailed moving forward. To further stack the deck for the clinician,

1. Kuhn T, Basch P, Michael M, Yackel T, for the Medical Informatics Committee of the ACP. Clinical documentation in the 21st century: Clinical documentation to improve patient care. *Ann Intern Med*, 2015;162(4):301-303. DOI: 10.7326/M14-2128
2. Weis JM, Levy PC. Copy, paste, and cloned notes in electronic health records. Importing content into electronic health records: prevalence, benefits, risks, and best practice recommendations. *Chest* 2014; 145(3): 632-638
3. CPT® Evaluation and Management (E/M) Code and Guideline Changes. Available at: <https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf>

Appendix A: An example of a new patient visit note template

***Pulmonary Medicine Outpatient Clinic
New Patient Consultation***

Primary Care Physician: @PCP@
Referring Provider: @REFPROV@

Thank you for the consultation request regarding @M@@LNAME@. Below is the documentation for today's visit.

History of Present Illness:

@AGE@ yo @SEX@ presents to Pulmonary Clinic for Consultation regarding

@TOBHXP@

A medically appropriate review of systems was completed, with pertinent details Included In the history of present illness.

Past History:

@PMH@

@FAMHX@

@SOC@

Medications:

@MEDSTABLE@

Physical Exam:

@VITALSM@

General appearance: {general exam:16600}

Head: {head exam:30909}

Throat: {throat exam:17160} Mallampati score is {Roman # I-V:19040::"III"}.

Neck: {neck exam:17463}

Lungs:{EXAM; LUNG:28829}.

Heart: {heart exam:5510}

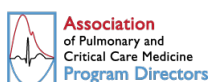
Abdomen: soft, nontender

Extremities: {extremity exam:5109}

Pulses: {pulse exam:10866}

Skin: {skin exam:31329}

Lymph nodes: {lymph node exam:14039}



Neurologic: {neuro exam:17854}

Diagnostic Review:

I personally reviewed the following:

Pre-Bronchodilator Spirometry:

@REVFS(664:::1)@

Post-Bronchodilator Spirometry:

@REVFS(676:::1)@

Total Lung Capacity and Diffusing Capacity:

@REVFS(677:::1)@

Imaging Studies:

- {DIAGNOSTICS:10410}

Other Important Studies:

- ***

@OBJECTIVEEND@ @PLANBEGIN@

Assessment/Plan:

@CAPHE@ is a(n) @AGE@ @SEX@ who@PMHPNN@

The following diagnoses were reviewed and addressed today:

@DIAGX@

@DIAGMEDREF@

Keep up to date on adult immunizations, especially influenza and pneumonia.

@FOLLOWUP@

Thank you for the opportunity to provide care for your patient. If I can be of further assistance please do not hesitate to contact my office.

Electronically signed by: @MEMD@ @TD@ @NOW@

Note that you can consider using Notewriter in EPIC and a variety of macros rather than a SmartPhrase for the exam.

Appendix B: An example of a return patient visit template

Pulmonary Medicine Return Visit

Primary Care Physician: @PCP@
Provider requesting consultation: @REFPROV@

Dear Dr. @REFPROVLNAME@,

Thank you for the consultation request for the patient's problem of ***. Below is the documentation for today's visit.

Subjective:

History of Present Illness: @M@@LNAME@ is a @AGE@ year-old patient. Patient is seen in the pulmonary clinic for ***

@TOBHXP@

Interval History: Since the last visit ***

Current Symptoms:

Cough:
Sputum:
Wheezing:
Fever:
Dyspnea:

Oxygen Supply:

Inhaler Regimen:

Previous Report Reviewed: {OUTSIDE REVIEW:15817}

{Common ambulatory SmartLinks:19316}

@SUBJECTIVEEND@

Medications:

@MEDSTABLE@

Physical Exam:

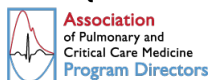
@VITALSM@

General appearance: {general exam:16600}

Head: {head exam:30909}

Throat: {throat exam:17160} Mallampati score is {Roman # I-V:19040::"III"}.

Neck: {neck exam:17463}



Lungs:{EXAM; LUNG:28829}. Palpation of chest wall reveals {Exam; lung palpation:30182::"normal fremitus"} of the thorax.

Heart: {heart exam:5510}

Abdomen: {abdominal exam:16834}

Extremities: {extremity exam:5109}

Pulses: {pulse exam:10866}

Skin: {skin exam:31329}

Lymph nodes: {lymph node exam:14039}

Neurologic: {neuro exam:17854}

Diagnostic Review:

I personally reviewed the following:

{DIAGNOSTICS:10410}

Pre-Bronchodilator Spirometry:

@REVFS(664:::1)@

Post-Bronchodilator Spirometry:

@REVFS(676:::1)@

Total Lung Capacity and Diffusing Capacity:

@REVFS(677:::1)@

Imaging Studies:

- {DIAGNOSTICS:10410}

Other Important Studies:

- ***

@OBJECTIVEEND@ @PLANBEGIN

Assessment:

@DIAGX@

Plan:

@DIAGMEDREF@

Keep up to date on adult immunizations, especially influenza and pneumonia.

@FOLLOWUP@

Thank you for the opportunity to provide care for your patient. If I can be of further assistance please do not hesitate to contact my office.

Electronically signed by: @MEMD@ @TD@ @NOW@

