

Module III - Table of Contents – In Detail

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A blue and white calculator is positioned at the top of the frame. Below it, a stethoscope is visible on the left. In the center, a 'HEALTH INSURANCE' claimant information form is spread out. The form includes sections for 'CLAIMANT INFORMATION' and 'PATIENT INFORMATION'. The number '12' is displayed in a blue rounded square on the left side of the form.

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Healthcare Industry: Historical Overview

A Historical Overview of the Healthcare Industry Landscape

Module I introduces important health care industry regulations as they pertain to permissible- and non-permissible scribe functions. In *this* Module, we focus on the health care industry regulations as they pertain to the coding-, billing-, and reimbursement aspects of medical documentation. The first half of this Module provides a conceptual overview of the important coding-, billing-, and reimbursement aspects of medical documentation. The second half of this module provides greater details and subject information.

The health care landscape is one of continual evolution and change. Below, we provide a chronological walk-through of this landscape and outline the historical landmarks that hold relevance to the Clinical Scribe role.

Chronological Overview of the Health Care Industry Landscape

In 1891, the International Statistical Institute (ISI) charged a committee to prepare a classification of causes of death^{28,29}. In 1900, ISI held the first international conference to revise the *International Classification of Causes of Death (ICD-1)* prepared by the committee^{28,29}. ICD-1 was formally adopted in the U.S. as the national standard diagnostic tool for clinical purposes. ICD-1 has since evolved into the **International Classification of Diseases and Related Health Problems (ICD)**, which remains the national standard diagnostic tool for epidemiology, health management and clinical purpose today^{28,29,32}. ICD Coding is further addressed in chapter 14.

In **1935**, the **Social Security Act** governed Medicare reimbursement for all services, including Evaluation and Management of medical services, to Americans over the age of 65 years old, and to young Americans with disabilities^{10,34}. The act also prohibited payment for a claim that was missing necessary information^{10,34}, thus setting the standard for documenting **Medical Necessity**, which remains a pillar of medical documentation today.

In 1939, the United States Federal Security Act (FSA) was established to bring together in one agency all federal programs in the fields of health, education, and social security³⁷. In 1953, the FSA was dissolved and its health, education, and social security programs were transferred to the Department of Health, Education, and Welfare (HEW) which was renamed the **Department of Health and Human Services (DHHS)** in 1979³⁷.

In 1965, **Medicare** and **Medicaid** were established under the Department of Health, Education, and Welfare (HEW), and used federal funding to provide health insurance to 19 million elderly-, disabled-, and low-income/resource Americans³⁸⁻⁴⁰. The “Original Medicare” program included Part A (Hospital insurance) and Part B (Medical Insurance), which are still used today³⁹.

- **Medicare** is a federally funded program that provides health insurance to Americans over the age of 65 years old, and to younger Americans with disabilities or with End-Stage Renal Disease (ESRD, permanent kidney failure requiring dialysis or a transplant)^{41,42}.
- **Medicaid** is a program funded by both the federal and state governments for families and individuals with low income or resources^{43,44}. Currently, Medicaid is one of the largest payers for health care in the United States⁴⁴.

In 1966, the American Medical Association (AMA) published the first edition of the **Current Procedural Terminology code set (CPT)**, which provided standardized terminology and reporting guidelines for medical procedures^{45,46}. CPT subsequently expanded in scope and in 1983, CPT was federally adopted for reporting and billing outpatient and office procedures^{45,46}.

In 1968, the first known **electronic health record systems (EHRs)** were implemented⁴⁷⁻⁴⁹. Early EHRs provided incomplete hybrids of computerized and paper data centered around either⁴⁹:

- Hospital billing and scheduling systems (to improve administrative objectives)
- Clinical systems (to improve medical care)

In 1977, the Health Care Financing Administration (**HCFA**) was established under the HEW and became responsible for coordinating Medicare and Medicaid services⁴⁰. In 2001, the HCFA formally became what is now known as the **Center for Medicare & Medicaid Services (CMS)**⁵⁰.

In 1978, the HCFA (now CMS) established the **HCFA Common Procedure Coding System (HCPCS)**, also informally called “**HICKS PICKS**”) to provide a standardized terminology and coding system for describing specific items and services provided in healthcare delivery^{13,14,18}.

- The HCPCS provided healthcare practitioners and organizations with standardized guidelines for terminology and coding that could be used to report and bill for medical care, including: services, procedures, medications, and devices^{4,18,51}.
- The HCPCS also enabled federal and private health insurance programs (including Medicare and Medicaid) to ensure payment claims were processed in an orderly and consistent manner^{13,14,18}.

The HCPCS consists of two levels of numeric and alpha-numeric code sets:

- **Level I** consists of the numeric (5-character) **Current Procedural Terminology (CPT)** code set, which is updated annually by the American Medical Association (AMA) and is used for documenting, coding, and billing services and procedures^{13,14}.
- **Level II** consists of a 5-character alpha-numeric code set that is maintained by CMS and used to identify products, supplies, and non-physician services, such as ambulance services and prosthetic devices^{13,14}.

In 1996, HIPAA mandated HCPCS use for all transactions involving health care information^{13,14,18,19}. In 2001 when the HCFA formally became CMS, the HCPCS formally became the **Healthcare Common Procedure Coding System**, which is still at the core of Evaluation and Management Coding today^{13,14,18}.

In 1979, the Department of Health, Education, and Welfare (HEW) was renamed the **Department of Health and Human Services (DHHS)** and became the executive branch charged with U.S. national healthcare³⁷.

In 1983, the **HCFA (now CMS) adopted the CPT code set** for reporting and billing outpatient- and office procedures^{45,46}. This adoption represents a major advancement towards standardizing medical coding-, billing-, and reimbursement procedures and regulations.

In 1990, EHR hardware become more affordable, useable, and accessible⁴⁹. The dawn of the **internet** gave birth to web-based EHRs that enabled health information to be documented, accessed, and shared electronically in a more accessible fashion^{49,52}. A new era of **Health Information Technology (HIT)** and electronic health information exchange was born^{49,52}.

In 1995, congress established a set of standards and guidelines for medical coding that could be used to support billing and reimbursement for medical care, termed **Evaluation and Management Coding (E/M Coding, E&M Coding)**^{4,53}. E/M Coding uses both the International Classification of Disease (ICD) codes for diagnoses and the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes for services and procedures⁴. E/M Coding has now been adopted by CMS and private health insurance companies as “the standard guidelines for determining type and severity of patient conditions⁵⁴.” This standardized coding system enables medical providers to document and bill for reimbursement of their services, and is addressed in Chapters 14 – 15.

Also in 1995, the earliest documented **medical scribe programs** emerged to help relieve physicians of the clerical burden and “technostress⁵⁵” associated with medical documentation, coding, billing, and HIT use^{56,57}.

In 1996, the **Health Insurance Portability and Accountability Act (HIPAA)**^{19,58,59} was enacted to increase American health insurance coverage and health care provisions^{19,52,58,59}. A large portion of HIPAA focused on protecting patient rights in an effort to combat insurance fraud⁵². This aim lead to the **HIPAA Privacy-, Security-, and Enforcement rules** outlined in Chapter 5 of Module I and Chapter 18 of Module IV. HIPAA also mandated use of the HCFA's Common Procedural Coding Set (**HCPCS**) for all transactions involving health care information, as outlined above and in Chapter 14^{13,14,18,19}.

In 1997, the **National Academy of Medicine (NAM)** (a non-partisan organization that provides evidence-based scientific advice to policy developers)⁵² formally advocated a **shift from paper-based- to electronic medical records (EMRs)**⁶⁰.

Also in 1997, the Health Care Financing Administration (HCFA) began using a **Sustainable Growth Rate Formula (SGRF)**^{61,62} for **Physician Fee Scheduling (PFS)**⁶³⁻⁶⁹. The SGRF calculated payment reductions for Medicare providers and incentivized providers to administer quality care to Medicare patients. SGRF's PFS system was later replaced by the Quality Payment Program (QPP) in 2017.

In 2001, the Health Care Financing Administration (HCFA) formally became what is now known as the **Center for Medicare & Medicaid Services (CMS)**⁵⁰.

- Today, the **Centers for Medicare & Medicaid Services (CMS)** is an agency within the U.S. Department of Health & Human Services responsible for administering several important health care programs and initiatives³⁸. The healthcare industry receives a large portion of its funding from CMS through these programs. Common CMS programs include: Medicare; Medicaid; CHIP; MACRA, QPP; MIPS; and APPs (addressed in Chapter 13).

In 2003, **NAM identified “core functions” for meaningful use of Health Information Technology (HIT) and Electronic Health Record (EHR) systems**⁷⁰. NAM's “EHR core functionalities” centered around user interoperability, meaningful use, and transparency, and included:

- Ability to function in multiple settings (ex: inpatient hospitals, ambulatory care settings, and community-based facilities)
- Ability to enhance health care delivery and billing, coding, and reimbursement processes
- Ability to interact with patients and provide patient access to medical records
- Ability to provide a platform for research and policy development

In 2004, the Department of Health and Human Services (DHHS) established the **Office of the National Coordinator for Health Information Technology (ONCHIT)** to improve national health care by “supporting health information technology adoption and promoting nationwide health information exchange^{52,71}.” One important responsibility of the ONC is EHR certification.

In 2004, CMS initiated **Hierarchical condition category (HCC) coding**, a risk-adjustment model designed to estimate future health care costs for patients. HCC relies on ICD-10 coding to assign risk scores to patients, with each HCC mapped to an ICD-10 code. CMS and other insurance companies use HCC coding to assign patients a **Risk Adjustment Factor (RAF)** score used to predict and determine patient insurance costs⁷².

In 2006, the Centers for Medicare & Medicaid initiated the **Physician Quality Reporting System (PQRS)**, a “**pay for performance**”(P4P) program that financially rewarded providers for reporting specific healthcare quality data to CMS⁷³. CMS provided a list of quality measures that providers could choose to submit data on (addressed further in Chapter 13). PQRS measures were based on the U.S. National Quality Standard (NQS) health care quality domains⁷³:

- Communication and Care Coordination
- Community/Population Health
- Effective Clinical Care
- Efficiency and Cost Reduction
- Patient Safety
- Person and Caregiver-Centered Experiences and Outcomes

In 2008, the U.S. Department of Health and Human Services proposed that the Clinical Modification of the **International Classification of Diseases and Related Health Problems, 10th Edition (ICD-10-CM)** formally replace the previously used ICD-9-CM diagnostic code sets for formal use in reporting diagnoses and procedures on health care transactions^{7,29}. This proposal was implemented by U.S. Congress in 2015^{7,29}.

From 2007 – 2009, the collapse in the U.S. real-estate market caused Financial Crisis and a Great Recession nationally and globally^{74,75}.

In 2009, congress approved the **American Recovery and Reinvestment Act (ARRA)**, a \$787 billion economic stimulus package developed in response to the Great Recession with the aim to save existing jobs and rapidly create new ones⁷⁶⁻⁷⁸. Part of the ARRA directed \$155 billion in new funding to the health care sector^{49,77}. This new funding was designed and implemented to rapidly incentivize **health information technology (HIT) adoption and meaningful use** and **electronic medical record (EMR) privacy- and security measures**⁴⁹.

2009: Implementing the American Recovery and Reinvestment Act (ARRA)

Starting in 2009, ARRA's goals were accomplished in the following way:

- **Financial provisions** were directed as follows⁷⁶⁻⁷⁸:
 - ▶ \$87 billion for Medicaid⁷⁶
 - ▶ \$35.8 billion for health information technology (HIT) investments and incentive payments (as discussed below)⁷⁶
 - ▶ \$25 billion for the Consolidated Omnibus Budget Reconciliation Act (COBRA) to subsidize 65% of health care insurance premiums for unemployed individuals⁷⁶
 - ▶ \$1 billion to support prevention and wellness activities targeting chronic disease risk factors (such as obesity and smoking)⁷⁶
- **Federal Health Information Technology (HIT) Advisory Committees** were developed to report to the ONCHIT on Health information technology (HIT) ***Policy*** and ***Standards***^{49,52}. The overall purpose of the HIT Advisory Committees was to oversee development of a nationwide health information network, including:
 - ▶ Design of “‘interoperable’ electronic health records that permit the seamless exchange of data among physicians, pharmacies, and other health care organizations⁴⁹”
 - ▶ Methods for ensuring the privacy and security of patient data⁴⁹
- The **Health Information Technology Economic and Clinical Health Act (HITECH)**^{30,52,79-82} was passed to promote meaningful Health Information Technology adoption and use.
 - ▶ HITECH statutorily authorized the Office of the National Coordinator for Health Information Technology (ONCHIT) to develop a **Health Information Technology certification program** that set specifications and standards for HIT functionality and implementation^{79,83}.
 - ONC standards are based on the National Academy of Medicine (NAM)'s 2003 guidelines for HIT and EHR “core functions” for meaningful use⁷⁰⁻⁷¹.
 - HIT that meet these standards are called **Certified HIT (CHIT, CEHRT)**^{83,84}.
 - ▶ HITECH provided “substantial resources” to offset the costs of adopting and using EHRs, including information and funding for eligible hospitals and providers

- ▶ HITECH supported CMS' efforts to incentivize "Meaningful Use" of certified electronic health record technology (CEHRT) by funding the **Medicare and Medicaid EHR Incentive Programs** which funds and rewards meaningful use of ONC-certified health information technology (CHIT)⁸⁵.

In 2010, the **Patient Protection and Affordable Care Act (PPACA, ACA)**, commonly called the "Affordable Care Act" or "Obamacare," was enacted with the overall goal of increasing health care access⁸⁶⁻⁸⁸. ACA was implemented by the Centers for Medicare & Medicaid Services (CMS) in conjunction with other governmental agencies and focused on removing barriers to high quality care delivery. These barriers included: unnecessary administrative complexity; inaccessible clinical data; and insufficient access to primary care. This was achieved by four central aims to⁸⁹:

- Guarantee health care access to all Americans
- **Provide physicians with incentive and information to change healthcare delivery**
- **Provide incentives to increase quality and reliability of care.**

2011: Center for Medicare & Medicaid Services' EHR Incentive Programs

In 2011, CMS established the **Medicare and Medicaid EHR Incentive Programs** to "encourage clinicians and eligible hospitals to adopt, implement, upgrade, and demonstrate **meaningful use** of certified electronic health record technology (CEHRT)⁸⁵." Under ARRA's direction and funding, these programs provided \$40 – 65,000 to eligible physicians and up to \$11 million per hospital for adopting and demonstrating "meaningful use" of certified health information technology (CHIT). Initially, these programs incentivized and rewarded CHIT Adoption, Implementation, and Upgrade (AIM)⁹⁰, and centered around 4 principles (meaningful use, quality of care, and date reporting)⁵², as outlined below.

- **Adoption, Implementation, and Upgrade (AIM)**⁹⁰
 - ▶ **Adoption:** Acquiring and installing HIT (and providing evidence of installation)
 - ▶ **Implementation:** Commencing to use HIT by providing staff training and entering patient data into the EHR
 - ▶ **Upgrade:** to *ONC-certified* EHR technology

- **Meaningful Use** of ONC-certified Health Information Technology (CHIT) (**MU-CHIT**), as outlined by NAM and ONCHIT⁵²
 - ▶ The Meaningful Use program was implemented in 3 stages, as addressed below
- Electronic exchange of information to improve healthcare (currently termed **Promoter Interoperability, PI**)^{3,30,126}
 - ▶ PI Principles are addressed in Chapter 13
- **Data Reporting:** CHIT use to submit clinical data on quality measures (ex: Physician Quality Reporting System (PQRS) measures and Clinical Quality Measures (CQM))^{3,110,112}
 - ▶ CQM- and PQRS Principles are addressed in Chapters 13



SuperScribe Tip: Defining “Meaningful Use”

Because CMS’ EHR “Meaningful Use” Programs were rolled out in stages, the detailed definition of “meaningful use” varies according to the particular stage and year. For example, the detailed definition for Stage I meaningful use differs from that for Stage II meaningful Use. Moreover, because the criteria for the different stages were updated over time, the detailed definition of meaningful use within a particular stage also depends on the year. For example, in 2014 clinical quality measure (CQM) reporting became a mandatory component of “meaningful use demonstration for all stages of meaningful use²¹.”

Although by CMS standards there is no one-size-fits-all definition for “Meaningful EHR Use,” a general working definition involves *“the use of certified EHR technology in a meaningful manner – ensuring that the cEHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care [**promoter interoperability**]; and that in using cEHR technology the provider must submit to the Secretary of Health and Human Services information on **quality of care** and other measures³⁰.”*

In general, the concept of meaningful use rests on “5 pillars” of health outcomes policy priorities³⁰:

- Improving quality, safety, efficiency, and reducing health disparities
- Engaging patients and families in their health
- Improving care coordination
- Improving population and public health
- Ensure adequate privacy and security protection for personal health information.

2011 – 2012: Stage 1 of CMS' EHR Meaningful Use Incentive Program

From 2011 – 2012, **Stage 1 of CMS' EHR Meaningful Use Incentive Program** focused on capturing and dispersing data using HIT⁵². This was achieved by establishing a “core and menu” structure of objectives that providers had to achieve to demonstrate meaningful use²¹. Core objectives referred to objectives that all providers must meet; menu objectives referred to a predetermined number of menu objectives that providers were required to select from a list and meet in order to demonstrate meaningful use²¹.

The “Final Rule” of Stage I required that all participants use HIT to meet the following criteria to receive monetary incentives^{90,91}:

- **Core Objectives:** Meet a “core set” of reporting standards (initially, providers could select 4 – 6 of the core measures; as of 2014 providers were required to meet all 15 core measures, unless eligible for exclusion). The 2014 Core Objectives set included⁹¹:
 - ▶ Computerized Provider Order Entry (CPOE)
 - ▶ Drug-drug and drug-allergy interaction checks
 - ▶ Maintaining up-to-date active:
 - Problem List of current and active diagnoses
 - Medication List
 - Medication Allergy List
 - ▶ Generate and transmit prescriptions electronically (eRx)
 - ▶ Record demographic information (language, gender, race, ethnicity, DOB)
 - ▶ Record and chart pt vital signs (height, weight, BP, BMI, growth plot)
 - ▶ Record smoking status
 - ▶ Report ambulatory clinical quality measures (CQMs) to CMS
 - ▶ Implement clinical decision support tools and track compliance
 - ▶ Pt ability to view online, download, and transmit health information in 4 business days of the information being available to the provider
 - ▶ Clinical summaries for patients after each visit
 - ▶ Capability to exchange key clinical information among providers

- ▶ Protect electronic health information on CEHRT

Note: in 2014, eligible providers and hospitals were required to meet all core objectives, unless eligible for an exclusion⁹¹.

- **Menu Objectives:** Report 5 – 25 additional **Clinical Quality Measures (CQMs)** (depending on the year and differing for eligible providers vs. hospitals)
 - ▶ In 2014, eligible providers were required to report 5 Menu Objectives, including at least one public health measure. The 2014 Menu Objective options included⁹¹:
 - Public Health Measure: Submit electronic data to immunization registries
 - Public Health measure: Submit electronic syndrome surveillance data to public health agencies
 - Conduct drug formulary checks electronically
 - Enter laboratory results into the EHR as structured data
 - Generate lists of patients by specific conditions
 - Provide patient reminders for preventative and follow-up measures
- **Clinical Quality Measure (CQM) Reporting:**
 - ▶ **Clinical Quality Measures (CQMs)** track the quality of health care services provided by eligible professionals and hospitals⁹². CQMs have been used for decades by a variety of different stakeholders to inform **Pay for Performance (P4P)** and **“value-based purchasing”** payment models that offer financial incentives to healthcare providers for meeting performance standards^{93,94}.
 - ▶ In 2014, all providers *regardless of their stage of meaningful use* were also required to report on CQMs to demonstrate meaningful use²¹.
 - ▶ Eligible providers (EPs) were required to report on 9 out of 64 CQMs^{21,91}
 - ▶ Eligible hospitals were required to report on 16 out of 29 total CQMs^{21,91}
 - ▶ All providers were required to select at least 3 out of 6 health care policy CQMs that had been recommended by the Department of Health and Human Services:
 1. Patient and Family Engagement
 2. Patient Safety
 3. Care Coordination

4. Population and Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Processes/Effectiveness
 - Additional CQM reporting categories included measures related to:
 - ◆ Preventative Care and Screening
 - ◆ Management of Specific Diseases and Medications (such as Diabetes- or Antidepressant Medication Management)
 - ▶ The core Clinical Quality Measures recommended for adults in 2014 included⁹⁵:
 - Patient Safety: Use of high-risk medications in the elderly
 - Efficient Use of Healthcare Resources: Use of imaging studies for low back pain
 - Care Coordination: Closing the referral loop by receiving a specialist report
 - Preventative Care and Screening for:
 - ◆ Tobacco use, including screening and cessation intervention
 - ◆ Clinical depression, including a follow-up plan
 - ◆ Body Mass Index (BMI), including follow-up
 - Controlling High Blood Pressure
 - Documentation of current medications in the medical record
 - Functional status assessment for complex chronic conditions
 - ▶ Additional Core Measures Include:
 - Population/Public Health: weight assessment and child counseling on nutrition and physical activity
 - Clinical Process/Effectiveness: Initiate and engage alcohol and drug dependence treatment
 - Preventative Care, Screening, and Follow-Up for:
 - ◆ Blood pressure
 - ◆ Diabetes
 - ◆ Antidepressant Medication Management

- Patient/Family Engagement: Oncology/Radiology Pain Intensity Rating
- Providers were required to meet these standards for a continual 90-day reporting period for the first year, and for one full year subsequently.

In 2014, the World Health Organization's **International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)** was formerly adopted in its entirety in the U.S. as the national standard diagnostic tool for clinical purposes^{28,29}. ICD-10 contains one volume for procedure codes (ICD-10-PC) and two volumes for diagnosis codes (ICD-10-CM)^{7,29,32}.

2014 – 2015: Stage 2 of CMS' EHR Meaningful Use Incentive Program

In 2014, **Stage 2 of CMS' EHR Meaningful Use Incentive Program** became available to eligible providers who had completed Stage 1^{21,52,96,97}. Stage 2 retained Stage 1's Core- and Menu structure for objectives that providers must meet and focused on enhancing clinical practice through Meaningful Use of CHIT and electronic exchange of health information²¹. Additionally, Clinical Quality Measure (CQM) Reporting became mandatory for all eligible providers and hospitals, as specified above in the information on Stage 1 "Meaningful Use" criteria²¹.

- **Core Objectives:**^{21,52,96,97}
 - ▶ Many Stage 1 Menu objectives became Core Objectives in Stage 2, including²¹:
 - Generating lists of patients by specific conditions
 - Facilitating patient reminders for preventative/follow-up care
 - Using CEHRT to identify patient-specific education resources
 - Performing medication reconciliation
 - Submitting electronic data to immunization registries
 - ▶ Provider- and hospital thresholds for reporting requirements were raised (EPs were required to meet 17 core- and 3 menu objectives or 20 core objectives).
 - ▶ A new core objective required use of secure electronic messaging to communicate with patients on relevant health information²¹
- **Menu Objectives:**^{21,52,96,97}
 - ▶ New Menu objectives were introduced, including²¹:

- Recording electronic notes in patient records
- Making imaging results accessible through CEHRT
- Recording patient family health history
- Identifying and reporting cancer (CA) cases to a state cancer registry
- Identifying and reporting certain non-CA cases to specialized registries
- Generating and transmitting discharge prescriptions electronically (eRx)
- Providing structured electronic lab results to ambulatory providers
- Allowing patients to access their health information online
- **Clinical Quality Measure (CQMs) Reporting** became mandatory for all eligible providers and hospitals in 2014 *regardless of their Meaningful Use Stage*, as specified in Stage 1²¹.
- **Physician Quality Reporting System (PQRS)** measures were accepted as a way for providers and hospitals to electronically report CQMs. PQRS is addressed in Chapter 13.

2015: MACRA & QPPs

In 2015, bipartisan legislation signed the **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** into law as part of the Patient Protection and Affordable Care Act (ACA)'s health care reform initiative^{67,88,98}.

In 2017, MACRA's **Quality Payment Program (QPP)** went into effect, and:

- Created a new system for the way that Medicare rewards clinicians for value over volume
- Streamlined multiple old quality programs (CMS' EHR "Meaningful Use" Incentive Programs and PQRS) into a new **Merit-Based Incentive Payment System (MIPS)**
- Awarded bonus payments for participation in eligible Alternative Payment Plans/Models (**APPs/APMs**)⁶⁷
- Repealed the former Sustainable Growth Rate (SGR) payment formula used to calculate Medicare Reimbursement

The old quality programs that are currently streamlined under MIPS include:

- **Clinical Quality Measures (CQMs)**⁹⁹
- **Physician Quality Reporting System (PQRS)**^{68,100,101}

- CMS' **Meaningful Use Electronic Health Record Incentive Programs (MU-CEHR)**^{65,85,101}
- The **Physician Value-Based Payment Modifier (VBM or VM)**¹⁰²⁻¹⁰⁵

These old programs were re-branded and rolled into MIPS' new "Four Pillars" terminology of:

- **Quality Care** (replacing PQRS)
- **Promoting Interoperability** (replacing EHR "Meaningful Use" Incentive Programs)
- **Improvement Activities** (replacing parts CQM, eCQM, and parts of PQRS and MU)
- **Cost** (replacing the VBM payment system)

As of 2018, approximately 95% of hospitals meet Meaningful Use criteria, and eligible providers can still receive up to \$44,000 toward implementing HIT⁵².

MACRA's QPP is the current existing payment program for providers, and is discussed in greater depth in the following chapters.

Also in 2018, the World Health Organization completed the final draft of the **International Classification of Diseases and Related Health Problems, 11th Revision (ICD-12)**, which will be submitted to the WHO's World Health Assembly (WHA) for official international endorsement in May, 2019^{8,29,106}.

Review & Assessment

The health care landscape is one of continual evolution and change. Below, we have outlined the historical landmarks that hold relevance to the Clinical Scribe role.

Review I: Evaluation and Management (E/M) Terms for the Clinical Scribe

Evaluation and Management Coding (E/M Coding, E&M Coding) provides an established set of standards and guidelines for medical coding that is used for documenting, coding, billing, and receiving reimbursement for medical care^{4,53}. Most private and federal health insurance companies and programs recognize E/M coding as “the standard for determining type and severity of patient conditions⁵⁴. E/M Coding utilizes two different code sets together within a given patient chart: The International Classification of Disease (ICD) codes associated with *diagnoses* and the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes associated with *services and procedures*.

- The **International Classification of Diseases and Related Health Problems (ICD)** is a medical classification system provided by the World Health Organization (WHO) that provides “a system of diagnostic codes for classifying diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease²⁹.” The ICD system provides “a diagnostic classification standard for all clinical and research purposes⁹.” The ICD-10 consists of 3 volumes; one for procedure codes (ICD-10-PC) and two for diagnosis codes (ICD-10-CM)^{7,29,32}. The 10th revision (ICD-10) was fully adopted in the U.S. in 2014, and its use is currently required by CMS and HIPAA^{28,29}.
- The **Healthcare Common Procedure Coding System (HCPCS, “HICKS PICKS”)** is a standardized terminology and coding system used for describing specific items and services provided in healthcare delivery^{13,14,18}. The HCPCS provides healthcare practitioners and organizations with standardized guidelines for terminology and coding that can be used to report and bill for medical care, including: services, procedures, medications, and devices^{4,18,51}. The HCPCS also enables federal and private health insurance programs (including Medicare and Medicaid) to ensure payment claims are processed in an orderly and consistent manner^{13,14,18}. The HCPCS consists of two levels of 5-character numeric and alpha-numeric code sets. **Level I** consists of the numeric Current Procedural Terminology (**CPT**) code set maintained by the American Medical Association (AMA) and is used for documenting, coding, and billing *services and procedures*^{13,14}. **Level II** consists of an

alphanumeric code set that is maintained by CMS and used to identify *products, supplies, and non-physician services*^{13,14}. In 1996, HIPAA mandated HCPCS use for all transactions involving health care information^{13,14,18,19}.

- The **Current Procedural Terminology (CPT)** code set is maintained by the American Medical Association and provides the national standard for “how medical professionals document and report medical, surgical, radiology, laboratory, anesthesiology, and evaluation and management services¹⁰⁷.” The five different CPT code sets provide a nationally standardized terminology and reporting system that providers and hospitals use to appropriately code and bill for services rendered^{45,107}.

Hierarchical condition category (HCC) coding is a risk-adjustment coding model designed by CMS to estimate future health care costs for patients. HCC relies on ICD-10 coding to assign risk scores to patients, with each HCC mapped to an ICD-10 code. CMS and other insurance companies use HCC coding to assign patients a **Risk Adjustment Factor (RAF)** score used to predict and determine patient insurance costs⁷².

Review II: Legislative Standards that affect the Clinical Scribe

The **Health Insurance Portability and Accountability Act (HIPAA)**^{19,58,59} was enacted in 1996 to increase American health insurance coverage and health care provisions^{19,52,58,59}. A large portion of HIPAA focuses on protecting patient rights in an effort to combat insurance fraud⁵². This aim lead to the HIPAA Privacy-, Security-, and Enforcement Rules outlined in Chapter 5 of Module I. HIPAA also mandated use of the HCFA’s Common Procedural Coding Set (**HCPCS**) for all transactions involving health care information, as outlined above and in Chapter 14^{13,14,18,19}.

The **Health Information Technology Economic and Clinical Health (HITECH)** Act was passed in 2009 under the American Recovery and Reinvestment Act (ARRA) to promote Health Information Technology (HIT) adoption and meaningful use^{30,52,79-82}. HITECH promoted standardized regulations for certified health information technology (CHIT) and provided “substantial resources” to offset the cost of adopting and using EHRs for eligible hospitals and providers.

Certified Health Information Technology (CHIT, CEHIT) refers to electronic health record technology that has been certified by the **Office of the National Coordinator for Health Information Technology (ONCHIT)** and meets “core functions” for meaningful use of HIT and EHR systems, according to the National Academy of Medicine (NAM) 2003 standards^{52,70,71}.

Review III: Centers for Medicare & Medicaid Services Programs that affect the Clinical Scribe

The **Centers for Medicare & Medicaid Services (CMS)** is an agency within the U.S. Department of Health & Human Services responsible for administering several important health care programs and initiatives³⁸. The healthcare industry receives a large portion of its funding from CMS through these programs. Common CMS programs and initiatives include:

- **Medicare:** A federally funded program that provides health insurance to Americans over the age of 65 years old, and to younger Americans with disabilities or with End-Stage Renal Disease (ESRD, permanent kidney failure requiring dialysis or a transplant)^{41,42}.
- **Medicaid:** A program funded by both the federal and state governments for families and individuals with low income or resources^{43,44}. Medicaid is one of the largest payers for health care in the United States⁴⁴.
- **Children's Health Insurance Program (CHIP):** A program designed to cover uninsured children in families with low incomes, but that are not low enough to qualify for Medicaid^{108,109}.

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a health care reform initiative that was signed into law in 2015 as part of the Patient Protection and Affordable Care Act (ACA)^{67,88,98}. MACRA created a new Quality Payment Program (QPP) that rewards quality health care provisions by emphasizing value over volume. Providers and hospitals who participate in QPP can enroll in the Merit-Based Incentive Payment System (MIPS) or in an Alternative Payment Plan/Model (APP/APM)⁶⁷.

- **Quality Payment Program (QPP):** a new medical payment system enacted by CMS in 2015 under MACRA that: changes the way Medicare rewards clinicians; streamlines multiple quality programs under the new Merit-Based Incentive Payment System (MIPS); and awards bonus payments for participation in eligible Alternative Payment Models (APMs)⁶⁷. Under the QPP, MIPS combines requirements previously included in 3 separate CMS programs: The Physician Quality Reporting System (PQRS); the Medicare EHR Incentive Program ("Meaningful Use"); and the Value-Based Payment Modifier (VBPM).
- **Merit-Based Incentive Payment System (MIPS):** One of two tracks outlined in the Quality Payment Program (QPP) that providers can participate in to receive MACRA provisions^{110,111}. MIPS streamlines multiple quality programs previously used before MACRA's implementation (the Physician Quality Reporting System (PQRS); the Medicare EHR Incentive Program ("Meaningful Use"); and the Value-Based Payment Modifier

(VBPM)). By rolling these old programs into a new “4 Pillar” concept, MIPS uses new criteria to provide performance-based payment adjustments to eligible providers who report data to CMS for certain clinical activities^{1,2,70,71,84,88-9}. MIPS maintains a continued focus on quality, cost, and certified EHR technology (CEHRT) use through its focus on 4 Pillars: Quality; Promoting Interoperability (PI)/Advancing Care Information (ACI); Improvement Activities; and Cost.

- The **Physician Quality Reporting System (PQRS)**: An old “pay for performance” program initiated by CMS in 2006 to financially reward providers for reporting specific healthcare quality data to CMS⁷³. CMS provided a list of quality measures that providers could choose to submit data on to receive monetary rewards for providing quality patient care. PQRS has now been rolled into MIPS’ Quality of Care Pillar/performance category^{68,100,101,112}.
- The **Medicare and Medicaid Electronic Health Record (EHR) “Meaningful Use” Incentive Programs**: Old programs developed by CMS to “encourage clinicians and eligible hospitals to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record technology (CEHRT)⁸⁵.” These programs provided large financial support, incentive, and rewards to physicians and hospitals who adopted and demonstrated “meaningful use” (MU) of ONC-certified health information technology (CHIT). These programs have now been rolled into MIPS’ “Promoting Interoperability (PI)/Advancing Care Information (ACI)” Pillar/performance category³.
- **Alternative Payment Models/Plans (APPs)**: One of two tracks outlined in the Quality Payment Program (QPP) that providers can participate in to receive MACRA provisions^{110,111}.

Clinical Quality Measures (CQMs) are “tools that help measure and track the quality of health care services that eligible professionals and hospitals provide⁹².”

- *In the private sector*, CQMs have been used by a variety of different stakeholders since the 1900s to inform **Pay for Performance (P4P)** and **“value-based purchasing”** payment models that offer financial incentives to physicians, hospitals, medical groups, and healthcare providers for meeting certain performance measures^{93,94}.
- *In the public/government sector*, Medicare’s **Physician Quality Reporting System (PQRS)** provides a federal set of CQMs. As of 2018, CMS’s Merit-based Incentive Payment System (MIPS) also requires all eligible providers and hospitals to use ONC-certified health information technology (CHIT) to report on CQMs *electronically* (eCQM)⁹².

Review IV: MACRA & QPPs

In 2015, bipartisan legislation signed the **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** into law as part of the Patient Protection and Affordable Care Act (ACA)'s health care reform initiative⁴¹⁻⁴³.

In 2017, MACRA's **Quality Payment Program (QPP)** went into effect, and:

- Created a new system for the way that Medicare rewards clinicians for value over volume
- Streamlined multiple old quality programs (CMS' EHR "Meaningful Use" Incentive Programs and PQRS) into a new **Merit-Based Incentive Payment System (MIPS)**
- Awarded bonus payments for participation in eligible Alternative Payment Plans/Models (**APPs/APMs**)⁴¹
- Repealed the former Sustainable Growth Rate (SGR) payment formula used to calculate Medicare Reimbursement

The old quality programs that are currently streamlined under MIPS include:

- **Clinical Quality Measures (CQMs)**⁵⁵
- **Physician Quality Reporting System (PQRS)**⁴⁸⁻⁵⁰
- CMS' **Meaningful Use Electronic Health Record Incentive Programs (MU-CEHR)**^{48,51,56}
- The **Physician Value-Based Payment Modifier (VBM or VM)**⁵⁷⁻⁶⁰

These old programs were re-branded and rolled into MIPS' new "Four Pillars" terminology of:

- **Quality Care** (replacing PQRS)
- **Promoting Interoperability** (replacing EHR "Meaningful Use" Incentive Programs)
- **Improvement Activities** (replacing parts CQM, eCQM, and parts of PQRS and MU)
- **Cost** (replacing the VBM payment system)

As of 2018, approximately 95% of hospitals meet Meaningful Use criteria, and eligible providers can still receive up to \$44,000 toward implementing HIT²⁶.

MACRA's QPP is the current existing payment program for providers, and is discussed in greater depth in the following chapters.

Also in 2018, the World Health Organization completed the final draft of the **International Classification of Diseases and Related Health Problems, 11th Revision (ICD-12)**, which will be submitted to the WHO's World Health Assembly (WHA) for official international endorsement in May, 2019^{5,17,61}.

Assessment

1. What is E/M Coding, and how might it be relevant to your role as a Clinical Scribe?
2. What are CPT and ICD-10? How do are similar to- and different from one another?
3. What information might you need to know about CPT and ICD-10 codes to excel in your role as a Clinical Scribe? How might you find this information?
4. What are Clinical Quality Measures (QCMs) and how are they similar to- or different from Physician Quality Reporting System (PQRS) measures?
5. How do MACRA, QPP, MIPS, and APP all relate to one another?
6. What are PQRS and Meaningful Use?
7. How do PQRS and Meaningful Use relate to MACRA's MIPS program?
8. How might PQRS and Meaningful Use relate to you as a Clinical Scribe?

A background image featuring a medical billing form, a blue stethoscope, and a blue calculator. The form has sections for 'PATIENT', 'REIMBURSE', and 'MEDICAL BILLING'. The stethoscope is positioned diagonally across the form, and the calculator is in the upper left corner.

13

MACRA & QPPs

The Medicare and CHIP Reauthorization Act of 2015 (MACRA) & the Quality Payment Program (QPP)

MACRA: The Medicare Access and CHIPS Reauthorization Act of 2015

On April 16, 2015, the Medicare Access and Children's Health Insurance Program (CHIPs) Reauthorization Act of 2015 (MACRA) was signed into law and many old payment and incentive programs were updated and consolidated into a new Quality Payment Program (QPP) that went into effect in January, 2017^{63,65-69,88,98,113-119}.

QPP: MACRA's Quality Payment Program

Like many old quality and payment programs, MACRA's Quality Payment Program (QPP) incentivizes and rewards providers who administer quality care to Medicare patients^{69,113-118}, and encourages Meaningful Use (MU)^{66,85,120} of Certified Health Information Technology (CHIT)⁶³⁻⁶⁹. However, MACRA's Quality Payment Program (QPP) provides a new payment system that focuses on rewarding *value- rather than volume*⁶⁷ of Medicaid patient care. This aim is achieved through CMS' QPP offering of two tracks that providers can enroll in (based primarily on eligibility) to receive MACRA provisions: the Merit-Based Incentive Payment System (MIPS)^{3,65,88,111,112,121,122} and an Alternative Payment Model (APM)^{88,123-125}. Both tracks are addressed further below.

Providers can enroll in MIPS or an APM in one of several ways^{3,123}:

- As a single clinician (with a single individual National Provider Identifier (NPI))
- As a group of ≥ 2 clinicians with 1 clinician who meets eligibility for the given track)
- As both an individual clinician and as part of a group
- As a virtual group, which can include "solo practitioners" with only 1 clinician in a practice and/or a group of clinicians, including 1 clinician who meets eligibility standards

Eligibility for either of the two Quality Payment Plan programs requires^{3,122,123}:

- Submitting a National Provider Identifier (NPI) and Associated Tax Payer Identifier (TIN)
- Enrolling in Medicare before January 1st of the fiscal year

- Meeting – or not meeting – QPP’s low volume threshold requirements:
 - ▶ Low volume thresholds are based on allowed charges for covered professional services, number of Medicare beneficiaries who receive service, and number of services provided
 - ▶ Clinicians and practices who exceed the low volume threshold (individually or in a group) are eligible to enroll in the Merit-Based Incentive Payment System (MIPS)
 - ▶ Clinicians and practices who do not exceed the low volume threshold are eligible to enroll in Alternative Payment Models (APMs)
 - ▶ **In general, APM eligibility precludes MIPS eligibility and vice versa**

MIPS: The Merit-Based Incentive Payment System

The Merit-Based Incentive Payment System (MIPS) is one of the two tracks outlined in the Quality Payment Program (QPP) that providers can participate in to receive MACRA provisions^{110,111}. MIPS eligibility is determined primarily by volume thresholds, which are based on allowed charges for covered professionals, number of Medicare beneficiaries who receive service, and number of services provided. Clinicians or groups who exceed CMS’ low volume threshold are eligible to enroll in MIPS. MIPS participants report data to the Centers for Medicare and Medicaid Services (CMS) for certain clinical measures and activities (as outlined below)^{3,111}.

MIPS streamlines multiple quality programs previously used before MACRA’s implementation, and uses new criteria to provide performance-based payment adjustments to eligible providers^{1,100,101,110,112,122,126,127}. MIPS maintains a continued focus on **quality, cost, and certified EHR technology (CEHRT) use** by rolling old quality programs (PQRS, Meaningful Use, and VBM) into a new 4-pillar structure^{3,110}.

Four main **pre-MACRA quality programs that MIPS updates, consolidates, and rebrands** are:

- The **Physician Quality Reporting System (PQRS)**^{68,100,101}
- **Clinical Quality Measures (CQMs)**^{68,100,101}
- Medicare’s **Meaningful Use Electronic Health Record Incentive Program (MU-EHR)**^{65,85,101}
- The **Physician Value-based Payment Modifier (VBM or VM)**¹⁰²⁻¹⁰⁵

These pre-existing programs (described further in Chapter 13 and below) served to regulate and reward provider **quality, cost, and certified EHR technology (CEHRT) use**. MIPS maintains this three-pronged focus by retaining PQRS², MU's³, and VM's *concepts*. However, MIPS replaces the old three-pronged conceptual terminology (of PQRS, MU, and VM) with a new focus on **four performance categories**, termed **The Four Pillars**, that providers report on for eligibility^{3,110,112}.

The **Four MIPS Pillars** (Performance Categories) are:

- **Quality**
 - ▶ Streamlines most of the Physician Quality Reporting System (**PQRS**)
 - ▶ Maintains an emphasis on quality care³
 - ▶ Clinicians and groups select and report on ≥ 6 quality performance measures from a list of 257 measures created by CMS, medical professionals, and stakeholders¹²⁸
- **Promoting Interoperability (PI)**
 - ▶ Streamlines Medicare's Meaningful Use (**MU**) EHR Incentive Programs
 - ▶ Focuses on patient engagement and electronic exchange of health information³
 - ▶ Providers submit a single set of PI objective measures that align with old PQRS and Clinical Quality measures required by Medicare's Meaningful Use EHR Incentive Programs. 17 measures are required; 2015 edition CEHRT must be used¹²⁶
- **Improvement Activities**
 - ▶ A new performance category that consolidates **parts of CQM, PQRS, and MU**
 - ▶ Aims to enhance care coordination and patient-clinician shared decision-making³
 - ▶ Providers submit performance data for 2 – 4 activities from an inventory of 118 different high- and medium-weighted options¹²⁷
- **Cost**
 - ▶ Replaces CMS' old Value-Based Modifier Program (**VBM or VM**)
 - ▶ Emphasizes the *value – rather than volume* – of patient care³
 - ▶ CMS uses Medicare claims data to calculate the cost of care provided to Medicare patients in relation to the resources clinicians use to care for Medicare patients¹

Like PQRS, MU, and VBM, each of the **Four MIPS Pillars** include specific reporting requirements, and are used by CMS to determine how providers receive MACRA provisions and Medicare payment. Requirements of each of these four pillars are addressed further below.

MIPS Scoring for Reimbursement

Providers who participate in MIPS receive Incentive Payments from Medicare for the 2 years following the Fiscal Year in which they enroll and participate in a MIPS program. The amount of monetary Incentive Payments a provider receives from CMS through MIPS is calculated by CMS using a **MIPS Score**, which can range of 0 (failure to report any measures) to 100 (the maximum score, indicating complete MIPS compliance). MIPS Providers can also earn **bonus points** (such as through reporting all data using a CEHRT) that can further enhance their score. MIPS Scoring is weighted, so providers receive scores in each of the Four MIPS pillars, and each of the four pillars holds a different weight in terms of a provider's overall score. As of 2019, the weights associated with each of the four MIPS Pillars are as follows:

- **Quality:** 45%¹¹²
- **Promoting Interoperability (PI):** 25%¹²⁶
- **Improvement Activities (IA):** 15%¹²⁷
- **Cost:** 15%¹

MIPS Pillar 1: Quality of Care (PQRS)

The MIPS **Quality Pillar** is a performance category that replaces the Physician Quality Reporting System (**PQRS**) addressed in Chapter 12 and rewards the **quality of care** provided to Medicare patients based on performance measures created by “CMS and other medical professional and stakeholder groups³.”

To meet MIPS' Quality Measure requirements, eligible participants must collect and report data to CMS on **≥ 6-7 quality measures** selected from a list of 260 categorized options^{3,111,112}.

The 260 different quality measure options are grouped into **6 different Measure Types**:¹²⁹

- **Efficiency** (which contains 7 different measure options)
- **Intermediate Outcome** (also contains 7 different measure options)
- **Outcome** (67 different measure options)

- **Patient Engagement Experience** (7 measure options)
- **Process** (170 different measure options)
- **Structure** (4 different measure options)

Providers are required to report on at least 1 Outcome Measure¹²⁸.

Some quality measures are also identified as **“high priority”** by CMS¹²⁹. Participant who are unable to report on an outcome measure may instead report on another “high priority” measure¹²⁸.

The 260 quality measures are also grouped into **Specialty and Subspecialty Measure Sets**. Each specialty measure set is geared toward a specific medical specialty or sub-specialty and contains between 2 – 73 different quality measures. Providers who choose to complete a specialty measure set must complete the set or select **≥ 6 measures from the set** to complete, collect data- and report on. Examples of specialty measure sets include:

- **Family Medicine** (which contains 73 different measure options)
- **Preventative Medicine** (contains 26 different measure options)
- **Pediatrics** (contains 22 different measure options)
- **Geriatrics** (contains 21 different measure options)

Data can be **collected** in a variety of different methods, depending on the measure type. Collection methods include:

- Administrative Claims
- CMS Web Interface
- Comma-separated values (CSV) files (such as spreadsheets or databases)
- Claims files (including Medicare B Claims)
- Electronic Health Records (EHRs)
- Registries

Data can also be **submitted** in several ways, depending on the size of the participant, including:

- Medicare Part B Claims (for small group practices and virtual groups)
- CMS Web Interface (for larger group practices and virtual groups)
- Authorized third-party intermediaries

Providers can also earn **“Bonus Points”** in the Quality Care Category by:

- Submitting all data using “end-to-end electronic reporting” with quality measure data directly reported from a certified electronic health record (CEHR) system (2015 edition)¹¹²
- Submit ≥ 2 outcome- or high priority measures¹²⁸

Complete lists of all 260 different quality measures can be found at:

- www.scribeACCELERATOR.com/resources/ModuleIII
- <https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019>
- Both lists can be tabulated by¹²⁹:
 - ▶ Measure Type
 - ▶ Specialty/Sub-Specialty Set
 - ▶ Priority Level
 - ▶ Collection Type
 - ▶ Data Submission Method
- These lists also show important coding identification information, including¹²⁹:
 - ▶ Quality ID and Clinical Quality Measure (CQM) ID⁹⁹
 - ▶ National Quality Forum (NQF) ID¹³⁰
 - ▶ Electronic IDs (eCQM ID, eMeasure ID, eNQF ID)¹²⁹
 - ▶ National Quality Strategy (NQS) Domain¹³¹



SuperScribe Applications:

Below are some examples of the 260 different **“high priority” Quality Measures** (categorized by measure type) that Family Practice Clinicians and Groups may choose to report on¹²⁸:

Quality Measures – Efficiency:

- Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse)
 - ▶ Clinicians report percentage of patients 18 y/o or older with a diagnosis of acute sinusitis who had a CT scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis

Quality Measures – Intermediate Outcome:

- Adherence to Antipsychotic Medications of Individuals with Schizophrenia
- Controlling High Blood Pressure
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)

Quality Measures – Outcome:

- Depression Remission at Twelve Months
- HIV Viral Load Suppression
- Optimal Asthma Control
- Pain Brought Under Control Within 48 Hours

Quality Measures – Patient Engagement Experience:

- CAHPS for MIPS Clinician/Group Survey

Quality Measures – Process:

- General Processes:
 - ▶ Advance Care Plan
 - ▶ Closing the Referral Loop: Receipt of Specialist Report
 - ▶ Documentation of Current Medications in Medical Record
- Diagnosis-Specific Processes:
 - ▶ Acute Otitis Externa (AOE) Therapy
 - ▶ Adult Sinusitis Antibiotic Treatment
 - ▶ Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
 - ▶ Medication Management for People with Asthma
 - ▶ Osteoarthritis (OA): Function and Pain Assessment
 - ▶ Otitis Media with Effusion: Avoiding Inappropriate Use of Systemic Antimicrobials
- Opioid Use and Misuse Processes:
 - ▶ Evaluation or Interview for Risk of Opioid Misuse

- ▶ Documentation of Signed Opioid Treatment Agreement
- ▶ Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)
- ▶ Opioid Therapy Follow-up Evaluation
- Preventive Processes:
 - ▶ Functional Status Assessments for Congestive Heart Failure (CHF)
 - ▶ Evaluation or Interview for Risk of Opioid Misuse
 - ▶ Appropriate Use of DXA Scans in Women < 65 y/o
- Pediatric-Specific Processes:
 - ▶ Appropriate Testing for Children with Pharyngitis
 - ▶ Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Geriatric-Specific Processes:
 - ▶ Communication with Care Providers in Managing Post-Fracture Care for Elderly
 - ▶ Falls: Plan of Care; Risk Assessment; Screening for Future Risk
 - ▶ Urinary Incontinence: Plan of Care for Women ≥ 65 y/o
 - ▶ Use of High-Risk Medications in the Elderly

Quality Measures - Structure

- Melanoma: Continuity of Care – Recall System
- Optimizing Patient Exposure to Ionizing Radiation
- Radiology: Reminder System for Screening Mammograms



SuperScribe Tip: Help Your Provider Meet MIPS Quality Standards!

The MIPS Quality Pillar holds the greatest weight in terms of its contribution to a provider or clinic's overall MIPS score. Therefore, it is especially important to help your provider meet MIPS Quality Standards. To do this:

- Identify which MIPS Quality Measures your provider or facility reports
 - ▶ We recommend this be done before starting your Stage II EHR Training
 - ▶ You may need to contact your Scribe Supervisor, Provider, or Administrative Staff
- During your EHR Stage II Training, ensure that you understand how to document each of these measures in your facility's CEHRT
- During each shift, remain attentive to these measures and document them thoroughly and accurately in the patient's EHR, as appropriate

MIPS Pillar 2: Promoting Interoperability (PI)

The MIPS performance category (Pillar) of **Promoting Interoperability (PI)** replaces Medicare's Meaningful Use **(MU)** EHR Incentive Program and rewards **electronic exchange of health information** and **patient-provider engagement**^{3,126}. This pillar requires and rewards *meaningful use* of ONC-certified electronic health record technology (CEHRT)^{3,65,66,110,111,132}. PI endorses comprehensive proactive sharing of patient information with other clinicians and the patient³.

To meet MIPS' PI Measure requirements, participants must "submit a single set of PI objectives and measures to align with 2015 Edition CERHT¹²⁶." There are 36 different measures available to select from and **9 of the 36 measures are required**¹³³. The different measures are weighted such that the 9 required measures achieve up to 70% of the total PI score. Participants may choose to report on any of the different 36 measures to increase their PI score above 70%^{126,133}.

The 36 different PI Measures are organized into **4 Objectives** (categories) as follows¹²⁶:

- **Electronic Prescribing** (which contains 4 different measure options)
- **Health Information Exchange** (contains 5 different measure options)
- **Provider-Patient Exchange** (1 measure)
- **Public Health and Clinical Data Exchange** (24 measures)

Participants must report on measures from each of the 4 PI Objectives¹²⁶.

All data within the PI Pillar must be **collected** using 2015 edition CEHRT and can be **submitted** online at qpp.cms.gov, either directly or by an authorized third-party intermediary¹²⁶.

Providers can also earn **“Bonus Points”** by submitting 2 optional measures^{126,133}:

- Query of Prescription Drug Monitoring (PDMP)
- Verification of Opioid Treatment Agreement

Complete lists of all 36 different PI measures can be found at:

- www.scribeACCELERATOR.com/resources/ModuleIII
- <https://qpp.cms.gov/mips/explore-measures/promoting-interoperability?py=2019#measures>
- Both lists can be tabulated by¹³³:
 - ▶ Reporting Category (Required, Exclusions, Bonus)
 - ▶ Objective
 - ▶ Performance Score Weight
- These lists also show the measure ID, which is important for coding and billing¹³³.



SuperScribe Applications:

Below we highlight the **required and bonus PI Measures** (categorized by objective type)¹³³:

PI Measures – Electronic Prescribing (E-Rx):

- **Required:** At least one permissible prescription written by the eligible clinician for a drug formulary and transmitted electronically using CEHRT (≤10% of PI Score Weight)
- **Bonus:** Query of the Prescription Drug Monitoring Program (≤5% Score Weight)
- **Bonus:** Verify Opioid Treatment Agreement (≤5% Score Weight)

PI Measures – Health Information Exchange:

- Support Electronic Referral Loops by:
 - ▶ **Required:** Receiving and Incorporating Health Information (≤20% Score Weight)
 - ▶ **Required:** Sending Health Information (≤20% Score Weight)

PI Measures – Provider-Patient Exchange:

- **Required:** Provide patients with electronic access to their health information (≤40%)

PI Measures – Public Health and Clinical Data Exchange:

- **Required:** Clinical Data Registry Reporting (0% Score Weight)
- **Required:** Electronic Case Reporting (0% Score Weight)
- **Required:** Immunization Registry Reporting (0% Score Weight)
- **Required:** Public Health Registry Reporting (0% Score Weight)
- **Required:** Syndromic Surveillance Reporting (0% Score Weight)

MIPS Participants are also required to comply with the following PI measures¹²⁶:

- Attest that HIT has not been tampered with or blocked
- Agree to cooperation with ONC Direct Review of CEHRT
- Conduct a security risk analysis in accordance with HIPAA Privacy and Security Rules



SuperScribe Tip: Scribes Help Providers Meet MIPS' Promoting Interoperability Standards!

The MIPS Pillar of Promoting Interoperability requires and reward providers who use Certified Electronic Health Record Technology (CEHRT) *meaningfully*. This pillar also encourages providers to meaningfully engage with the patient while using CEHRT. As a Clinical Scribe, you will enable your provider to achieve the MIPS PI Pillar Standard. When you document patient information into the CEHR, you are making this information available to other providers and to the patient, AND allowing your provider to focus on patient engagement.

MIPS Pillar 3: Improvement Activities (IA)

MIPS' third pillar – **Improvement Activities (IA)** – is a new performance category (as of 2017) that incorporates some Clinical Quality Measures (**COM**), parts of CMS' Patient Quality Reporting System (**PQRS**), and Medicare's Meaningful Use (**MU**) Incentive Program to maintain a **focus on how a provider improves patient care processes, engagement, and access to care**³. This is done through completion of an activity assessment inventory that allows providers to choose

which activities they would like to focus on and receive assessment in. These activities include enhancing patient care coordination, patient and clinician shared decision-making, and expansion of practice access³.

To meet MIPS' IA requirements, participants can choose from a list of 18 different activities to engage in- and report on^{127,134}. Each of the different activities are weighted either “high” (20 points) or “medium” (10 points). **Providers must submit one of the following combinations of activities** (performed for 90 continuous days) to earn a total of 40 points in this pillar¹²⁷:

- 2 High-weight activities
- 1 High-weight activity; 2 Medium-weight activities
- 4 Medium-weight activities

The 18 different IA Measures are organized into **8 Subcategories** as follows¹³⁴:

- **Achieving Health Equity** (which contains 7 different activity options)
- **Behavioral and Mental Health** (contains 10 different activity options)
- **Beneficiary Engagement** (24 activities)
- **Care Coordination** (18 activities)
- **Emergency Response and Preparedness** (2 activities)
- **Expanded Practice Access** (5 activities)
- **Patient Safety and Practice Assessment** (32 activities)
- **Population Management** (19 activities)

All data within the IA Pillar can be **submitted** online at qpp.cms.gov, either directly or by an authorized third-party intermediary¹²⁷.

Complete lists of the 18 different Improvement Activities can be found at:

- www.scribeACCELERATOR.com/resources/ModuleIII
- <https://qpp.cms.gov/mips/explore-measures/improvement-activities?py=2019#measures>
- Both lists can be tabulated by Activity Weight or Subcategory and show the Activity ID, which is important for coding and billing^{127,134}.



SuperScribe Tip: Scribes Can Help Providers Meet MIPS' Improvement Activities Standards!

As a clinical scribe, when you document in the patient's chart the provider discussed the impression and plan with the patient, this helps document the provider's satisfaction of "enhancing patient and clinician shared decision-making," which is an area of assessment in MIPS' Third Pillar of "Improvement Activities."

SuperScribe Applications:

Below are examples of the different high (h) and medium (m) weight **Improvement Activities** (grouped by subcategory) that Family Practice Clinicians and Groups may choose to report on¹³⁴:

Achieving Health Equity Improvement Activities:

- New Medicaid Patient Engagement and Follow-Up (high, h)
- Promote Use of Patient-Reported Outcome Tools (h)
- Comprehensive Eye Exams (medium, m)
- Leverage a Quality Clinical Data Registry (QCDR) to standardize screening processes (m)

Behavioral and Mental Health Improvement Activities:

- Implementation of Integrated Patient Centered Behavioral Health Model (h)
- Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse in Ambulatory Care Patients (h)
- Depression screening (m)
- Diabetes screening (m)
- EHR Enhancements for Behavioral Health data capture (m)
- Major Depressive Disorder (MDD) prevention and treatment interventions (m)
- Tobacco use (m)
- Unhealthy alcohol use (m)

Beneficiary Engagement Improvement Activities:

- Collection and follow-up on patient experience regarding beneficiary engagement (h)
- Engage Patients and Families to Guide Improvement in the System of Care (h)

Care Coordination Improvement Activities:

- Patient Navigator Program (h)
- Transforming Clinical Practice Initiative (TCPI)¹³⁵ Participation (h)
- Relationship-Centered Communication (m)

Emergency Response and Preparedness Improvement Activities:

- Participation in ≥ 60-day effort to support domestic/international humanitarian needs (h)

Expanded Practice Access Improvement Activities:

- Provide MIPS Participants with 24/7 Real-Time Access to Patient's Medical Records (h)
- Use of telehealth services that expand practice access (m)

Patient Safety and Practice Assessment Improvement Activities:

- Consultation of the Prescription Drug Monitoring Program (h)
- Consulting Appropriate Use Criteria (AUC)¹³⁶
- Using Clinical Decision Support when Ordering Advanced Imaging (h)
- Participation in Consumer Assessment of Healthcare Providers & Systems (CAHPS)¹³⁷ or other supplemental questionnaire (h)
- Patient Medication Risk Education (h)
- Percutaneous Coronary Intervention (PCI) Bleeding Campaign¹³⁸ (h)
- CDC Guideline Use in Clinical Decision Support to Prescribe Opioids for Chronic Pain¹³⁹ (h)
- Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event (m)
- Cost Display for Laboratory and Radiographic Orders (m)
- Implementation of fall screening and assessment programs (m)
- Participation in Quality Improvement Initiatives (m)

- Use of decision support and standardized treatment protocols (m)
- Use of Patient Safety Tools (m)

Population Management Improvement Activities:

- Anticoagulant Management Improvements (h)
- Glycemic management services (h)
- Participation in Systemic Anticoagulation Program (h)
- Rural Health Clinic (RHC), Hospice Item Set (HIS), or Federally Qualified Health Centers (FQHC) quality improvement activities (h)
- Use of Quality Clinical Data Registry (QCDR) for feedback reports that incorporate population health (h)
- Advance Care Planning (m)
- Chronic Care and Preventative Care Management for Empaneled Patients (m)
- Glycemic Screening and Referring Services (m)
- Implementation of episodic care management practice improvements (m)
- Implementation of medication management practice improvements (m)

MIPS Pillar 4: Cost

The MIPS **Cost** Pillar replaces CMS' old Value-Based Modifier (**VBM or VM**) Program, which measured quality and cost of care provided to Medicare patients through a Medicare Physician Fee Schedule (**PFS**)¹⁰². In this new approach to cost evaluation, CMS uses Medicare claims to calculate the cost of care provided by individual- or group participants (Medicare providers) either during one year, during one hospital stay, or during 8 episodes of care^{1,3}.

All MIPS-eligible clinicians and groups are evaluated on the same **10 Cost Measures**²:

- Elective Outpatient Percutaneous Coronary Intervention (PCI)
- Intracranial Hemorrhage or Cerebral Infarction
- Knee Arthroplasty
- **Medicare Spending Per Beneficiary (MSPB)**
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia

- Routine Cataract Removal with Intraocular Lens (IOL) Implantation
- **Screening/Surveillance Colonoscopy**
- Simple Pneumonia with Hospitalization
- ST-Elevated Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)
- **Total Per Capita Costs (TPCC)**

Above, we have bolded the three cost measures that are most likely to apply to Family Practice physicians and groups¹⁴⁰.

Because cost measures are calculated by CMS using Medicare Claims, **MIPS Participants do not need to collect or submit any data for this pillar**¹.

Complete lists of the 10 different Cost Measures can be found at:

- www.scribeACCELERATOR.com/resources/ModuleIII
- <https://qpp.cms.gov/mips/explore-measures/cost?py=2019#measures>
- Both lists provide descriptions of each of the 10 cost measures as well as Measure IDs².



SuperScribe Tip: Cost Counts!

When MIPS was first implemented in 2017, Cost was not factored into a participant's overall MIPS Score. This changed in 2018, and cost now contributes a weight of 15% to a participant's overall MIPS Score¹⁻³.

APMs: Alternative Payment Models

Providers, groups, or organizations who enroll in CMS' Quality Payment Program (QPP) but do not exceed CMS' Low Volume Threshold requirements for MIPS eligibility may enroll in an **Alternative Payment Model (APM)**^{68,123}. Like MIPS, APMs reward value and outcome by offering added incentive payments for providers who deliver high-quality and cost-efficient care^{115,123}. Unlike MIPS, APMs may apply to specific clinical conditions, care episodes, or populations, and typically apply to QPP participants who *do not exceed* CMS' low volume thresholds¹²³.

In general, five different types of APMs exist¹²³:

- General APMs
 - ▶ Meet the statutory definition of an APM

- ▶ Participants receive incentive payments to “provide high-quality and cost-efficient care¹²³” to CMS beneficiaries
- ▶ Apply to providers and organizations who do not exceed MIPS Low Volume Threshold
- MIPS-APMs
 - ▶ Applies to groups that do not exceed the MIPS low volume threshold but contain at least one MIPS-eligible clinician
- Advanced APMs (AAPMs)
 - ▶ Offers 5% incentive for achieving threshold levels of payments or patients
- Advanced MIPS-APMs
 - ▶ Advanced APMs (AAPMs) that contain at least one MIPS-eligible clinician
- Other-Payer and All-Payer Options
 - ▶ Other-Payer APMs refer to non-Medicare payment arrangements that meet criteria similar to Medicare’s AAPMs
 - ▶ All-Payer APMs apply to clinicians who participate in a combination of AAPMs with Medicare and Other-Payer Advanced APMs

Like MIPS, **APMs center around the 4 Pillars of Quality Care, Promoting Interoperability, Improvement Activities, and Cost.** However, the weight that each of these pillars hold in terms of their contributions to a participant’s overall scorecard differ from those used in MIPS. Most notably, Cost does not contribute to a participant’s overall APM Score. APMs also differ in the targets that CMS sets for participants to meet in order to qualify and receive MACRA provisions¹⁴¹. Below, we will provide a brief overview of MIPS-APMs for example.

MIPS-APMs

Merit-Based Incentive Program-Alternative Payment Models (MIPS-APMs) apply to groups that do not exceed the MIPS low volume threshold, but contain at least one MIPS-eligible clinician^{68,123}. Participants receive special MIPS-APM scoring under the APM scoring standard. Like MIPS and other APMs, MIPS-APMs base payment incentives on performance, cost utilization, and quality measures, and focus on the Four Pillars outlined by CMS (quality, promoting interoperability, improvement activities, and cost).

Like MIPS, the amount of monetary incentive payments a provider receives from CMS through a MIPS-APM is calculated by CMS using a **MIPS-APM Score**, which can range of 0 to 100. MIPS-APM Scoring differs from MIPS scoring in the weight that each individual performance category score contributes to the overall MIPS-APM score.

As of 2019, the MIPS-APM weights associated with each of the Four Pillars are¹⁴²:

- **Quality**: 50%
- **Performance Interoperability (PI)**: 30%
- **Improvement Activities (IA)**: 20%
- **Cost**: 0%

These weights differ from MIPS, which use the following weights: Quality: 45%; PI: 25%; IA: 15%; Cost: 15%.

Examples of MIPS-APMs can be found on the CMS website, and include¹⁴²:

- Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)
- Comprehensive ESRD Care (CEC) Model (LDO arrangement)
- Comprehensive ESRD Care (CEC) Model (non-LDO two-sided risk)
- Comprehensive ESRD Care (CEC) Model (non-LDO one-sided risk)
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Medicare Shared Savings Program Accountable Care Organizations – Track 1, 2, 3
- Next Generation ACO Model
- Oncology Care Model (OCM) (one-sided Risk Arrangement)
- Oncology Care Model (OCM) (two-sided Risk Arrangement)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- Maryland Primary Care Program
- Independence at Home Demonstration

Advanced APMs (AAPMs)

Advanced Alternative Payment Models (AAPMs) apply to participants who receive $\geq 50\%$ of Medicare Part B payments or see $\geq 35\%$ of Medicare patients through an AAPM entity, and use 2015 Edition Certified Electronic Health Record Technology (CEHRT) in $\geq 75\%$ of practices within the AAPM entity¹⁴³. In addition to receiving 5% bonus incentives, AAPM participants who achieve the above threshold levels of payments or patients also receive APM-specific rewards and are excluded from the MIPS reporting requirements and payment adjustments¹⁴³. Like MIPS-APMs, AAPMs do not weight the performance category of Cost, so this category does not affect participants' overall AAPM Score.

Examples of Advanced APMs can be found on the CMS website, and include¹⁴³:

- Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)
- Comprehensive ESRD Care (CEC) Model
- Comprehensive ESRD Care (CEC) – Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Next Generation ACO Model
- Medicare Shared Savings Program Accountable Care Organizations – Tracks 2 and 3
- Oncology Care Model (OCM) - Two-sided Risk
- Comprehensive Care or Joint Replacement (CJR) Payment Model (Track 1-CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- Maryland All-Payer Model (Care Redesign Program)
- Maryland Total Cost of Care Model (Maryland Primary Care Program)
- Maryland Total Cost of Care Model (Care Redesign Program)

Other APMs

Other-Payer APMs apply to participants who have payment arrangements with **non-Medicare Fee For Service (FFS) payers**, including¹⁴⁴:

- Medicaid
- Medicare Health Plans (ex: Medicare Advantage, Medicare-Medicaid Plans, 1876 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans)
- Payers with payment arrangements in CMS Multi-Payer 4 Models
- Other commercial and private payer arrangements that meet the criteria to be an Other-Payer Advanced APM.

Other-Payer APM eligibility requirements include¹⁴⁴:

- ≥ 50% of eligible clinicians in each entity group use CEHRT “to document and communicate clinical information.”
- Payments for covered professional services must be based on quality measures “that are comparable to the MIPS Quality performance category. There must be evidence-based, reliable, and valid quality measures, with at least one outcome measure if available on the MIPS measure list.”
- Participants must bear a certain amount of financial risk; for example, the actual expenditures must exceed expected aggregate expenditures.

All-Payer APMs apply to participants who participate in Advanced APMs both with other payers (such as those listed above for Other-Payer APMs) *and with Medicare*¹⁴⁴. These APMs consider the other payers a participant may engage with. All-Payer APM Eligibility is determined by two thresholds: patient count and payment amounts. Like other APMs, All-Payer APMs offer 5% incentive payments and exclusion from MIPS reporting and payment adjustments.

Review & Assessment

Review

The **Centers for Medicare & Medicaid Services (CMS)** is an agency within the U.S. Department of Health & Human Services responsible for administering several important health care programs and initiatives³⁸. The healthcare industry receives a large portion of its funding from CMS through these programs. Common CMS programs and initiatives include:

- **Medicare:** A federally funded program that provides health insurance to Americans over the age of 65 years old, and to younger Americans with disabilities or with End-Stage Renal Disease (ESRD, permanent kidney failure requiring dialysis or a transplant)^{41,42}.
- **Medicaid:** A program funded by both the federal and state governments for families and individuals with low income or resources^{43,44}. Medicaid is one of the largest payers for health care in the United States⁴⁴.
- **Children's Health Insurance Program (CHIP):** A program designed to cover uninsured children in families with low incomes, but that are not low enough to qualify for Medicaid^{108,109}.

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a health care reform initiative that was signed into law in 2015 as part of the Patient Protection and Affordable Care Act (ACA)^{67,88,98}. MACRA created a new Quality Payment Program (QPP) that rewards quality health care provisions by emphasizing value over volume. Providers and hospitals who participate in QPP can enroll in the Merit-Based Incentive Payment System (MIPS) or in an Alternative Payment Plan/Model (APP/APM)⁶⁷.

- **Quality Payment Program (QPP):** a new medical payment system enacted by CMS in 2015 under MACRA that: changes the way Medicare rewards clinicians; streamlines multiple quality programs under the new Merit-Based Incentive Payment System (MIPS); and awards bonus payments for participation in eligible Alternative Payment Models (APMs)⁶⁷. Under the QPP, MIPS combines requirements previously included in 3 separate CMS programs: The Physician Quality Reporting System (PQRS); the Medicare EHR Incentive Program ("Meaningful Use"); and the Value-Based Payment Modifier (VBPM).
- **Merit-Based Incentive Payment System (MIPS):** One of two tracks outlined in the Quality Payment Program (QPP) that providers can participate in to receive MACRA provisions^{110,111}. MIPS streamlines multiple quality programs previously used before

MACRA's implementation (the Physician Quality Reporting System (PQRS); the Medicare EHR Incentive Program ("Meaningful Use"); and the Value-Based Payment Modifier (VBPM)). By rolling these old programs into a new "4 Pillar" concept, MIPS uses new criteria to provide performance-based payment adjustments to eligible providers who report data to CMS for certain clinical activities^{1,2,70,71,84,88-9}. MIPS maintains a continued focus on quality, cost, and certified EHR technology (CEHRT) use through its focus on 4 Pillars: Quality; Promoting Interoperability (PI)/Advancing Care Information (ACI); Improvement Activities; and Cost.

- The **Physician Quality Reporting System (PQRS)**: An old "pay for performance" program initiated by CMS in 2006 to financially reward providers for reporting specific healthcare quality data to CMS⁷³. CMS provided a list of quality measures that providers could choose to submit data on to receive monetary rewards for providing quality patient care. PQRS has now been rolled into MIPS' Quality of Care Pillar/performance category^{68,100,101,112}.
- The **Medicare and Medicaid Electronic Health Record (EHR) "Meaningful Use" Incentive Programs**: Old programs developed by CMS to "encourage clinicians and eligible hospitals to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record technology (CEHRT)⁸⁵." These programs provided large financial support, incentive, and rewards to physicians and hospitals who adopted and demonstrated "meaningful use" (MU) of ONC-certified health information technology (CHIT). These programs have now been rolled into MIPS' "Promoting Interoperability (PI)/Advancing Care Information (ACI)" Pillar/performance category³.
- **Alternative Payment Models/Plans (APPs)**: One of two tracks outlined in the Quality Payment Program (QPP) that providers can participate in to receive MACRA provisions^{110,111}. Applies to participants who do not exceed MIPS' low volume threshold requirements. Follows the 4 Pillar Structure of Scoring, with the exception that the performance categories hold different weights than those used in MIPS, and Cost is not weighted. APP Participants often receive 5% incentive payments and are often exempt from MIPS reporting and payment adjustments. Some APMs require CEHRT use by most clinicians or facilities within an entity.

Assessment

1. What are the Four MIPS Pillars?
2. What old quality programs are now rolled into the Four MIPS Pillars?
3. What are PQRS and Meaningful Use?
4. How do MACRA, QPP, MIPS, and APP all relate to one another?
5. How do PQRS and Meaningful Use relate to MACRA's MIPS program? What MIPS Pillars to PQRS and Meaningful Use map onto?
6. Is your provider or hospital enrolled in MIPS or an APM? If you do not know the answer to this question, how can you find out?
7. What measures and activities have your provider(s) or facility chosen to report on to meet QPP Eligibility Requirements? If you do not know the answer to this question, how can you find out?
8. How can you help your provider or hospital meet the QPP Standards for each of the Four MIPS Pillars?
9. Are PQRS and Meaningful Use still relevant to you as a Clinical Scribe? Why or why not, and How?
10. Identify 6 Quality Measures, 9 Promoting Interoperability Measures, and 4 Improvement Activities that you could help a provider meet in your role as a Clinical Scribe. How could you help your provider meet these Measures/Activities?

A stethoscope is positioned on a medical document. The document contains text such as 'HOSPITAL', '2345 STREET, 21', 'NNN TOWN, 321', and 'Billing State'. A blue rectangular overlay with rounded corners is in the lower-left, containing the number '14'. Another blue overlay at the bottom contains the title 'E/M Coding: ICD, HCPCS, & CPT'.

14

E/M Coding: ICD, HCPCS, & CPT

Introduction to E/M Coding: ICD, HCPCS, & CPT

Historical Introduction to Evaluation and Management (E/M) Coding

Quality health care delivery, receipt, and reimbursement relies on accurate communication and documentation, which requires uniformity and standardization in turn. Chapter 12 highlights many important

advances toward achieving uniform documentation standards, particularly as they pertain to medical coding, billing and reimbursement. Some important standardized documentation systems include:

- The **International Classification of Diseases and Related Health Problems (ICD)** used for coding and billing *diagnoses*^{28,29,32}
- The **Current Procedural Terminology code set (CPT)**, used for coding and billing *services and procedures*^{45,46}
- The **Healthcare Common Procedure Coding System (HCPCS)** used for coding and billing *medical services, procedures, and devices* (which incorporates the Current Procedural Terminology (CPT) code set), and is required by HIPAA^{4,13,14,18,19}.
- The **Evaluation and Management Coding System (E/M Coding, E&M Coding)**, a standardized coding system based on ICD- and HCPCS/CPT codes that enables CMS and other insurance providers to determine type, complexity, and severity of patient condition and visit to appropriately reimburse for medical services^{4,53}.

Here, we have selected the pertinent historical landmarks from Chapter 12 as they relate to Evaluation and Management Coding, which is the standardized coding system used by healthcare providers, coders, and insurance companies to appropriately document, code, bill and reimburse medical services^{4,53}. A more thorough timeline of these advances can be found under the resources tab of the CSAT website (www.scribeACCELERATOR.com).

In **1891**, the International Statistical Institute (ISI) laid the foundation for what is now the **International Classification of Diseases and Related Health Problems (ICD)**^{28,29,32}. The ICD coding system remains the national standard tool for medical diagnosis and is required by CMS for documenting and coding diagnoses and calculating Risk Adjustment Factor (RAF) scores^{20,28,29,32,145}.

In **1935**, the **Social Security Act** dictated Medicare reimbursement for all services – including

evaluation and management of medical services – to Americans over the age of 65 years old, and to young Americans with disabilities^{10,34}. The act also prohibited payment for a claim that was missing necessary information^{10,34}, thus setting the standard for documenting **Medical Necessity**, which remains a pillar of medical documentation today.

In **1966**, the American Medical Association (AMA) laid the foundation for the **Current Procedural Terminology code set (CPT)**^{45,46}. CPT provides standardized terminology and reporting guidelines for medical procedures^{45,46}.

In **1978**, the Health Care Financing Administration (HCFA, now the Center for Medicare and Medicaid Services, CMS) established the HCFA/Healthcare **Common Procedure Coding System (HCPCS)**, also called “**HICKS PICKS**”^{13,14,18}. Like CPT, HCPCS provides a standardized terminology and coding system for describing specific items and services provided in healthcare delivery and ensures payment claims are processed in an orderly and consistent manner^{13,14,18}.

In **1983**, CMS adopted the **Common Procedural Terminology CPT code system as part of the Healthcare Common Procedure Coding System (HCPCS)**¹³⁻¹⁵, and mandated that physicians use this system to bill for Evaluation and Management Services⁴.

In **1995**, the **Evaluation and Management Coding System (E/M, E&M Coding)** was established by the U.S. Congress as a new national standard set of coding guidelines for medical billing and reimbursement^{4,53}. **E/M Coding uses the ICD code set for diagnoses and the HCPCS (and CPT) codes for services and procedures**^{4,53}. The E/M Coding system is currently required by CMS, and is used by many private insurance companies as well⁵⁴.

In **1996**, the **Health Information Portability and Accountability Act (HIPAA)** was enacted to increase American health insurance coverage and health care provisions^{19,52,58,59}. In effort to combat insurance fraud, HIPAA focused on protecting patient rights and emphasized the importance of uniform standards for electronic health information transactions⁵². Specifically, **HIPAA required use of the HCFA's Common Procedural Coding Set** (HCPCS, which incorporates CPT codes) for all medical transactions involving health care information^{13,14,18,19}.

In **1997**, **Congress revised the Evaluation and Management coding standards**^{5,6,146}. Today, CMS formally accepts (and requires) either the 1995 or 1997 E&M Coding Guidelines for documenting all medical transactions for CMS billing and reimbursement⁴.

Today, congress continues to require use of the Healthcare Common Procedures Coding System (HCPCS) for all medical transactions involving health care information. Additionally, CMS

formally requires all medical transactions use either the 1995 or 1997 Guidelines for Evaluation and Management Coding and claims⁴. CMS' required use of E/M Coding falls within congress' mandatory HCPCS use, since E/M coding uses both the International Classification of Diseases (ICD) for diagnoses and the Healthcare Common Procedures Coding System (which uses Common Procedural Terminology codes) for medical services, procedures, and provisions. Therefore, the remainder of this chapter will provide an overview of E/M coding, focusing on ICD- and HCPCS/ CPT coding basics. Chapter 14 provides further detail with specific examples.

Conceptual Introduction to Evaluation and Management (E/M) Coding

Healthcare payers require reasonable documentation to ensure that a service provided to a patient is consistent with the patient's insurance coverage, and to validate the Medical Necessity and appropriateness of the service provided⁴⁻⁶.

The **Evaluation and Management Coding (E/M Coding) standards** establish a systemic medical billing process that practicing providers in the U.S. use to receive reimbursement for their services by Medicare and Medicaid programs, and by private insurance companies^{4,54}. The Evaluation and Management (E/M) Services Guide, first published by the Department of Health and Human Services in conjunction with the Centers for Medicare and Medicaid Services (CMS) in 1995, revised by congress in 1997, and most recently updated in 2017, provides standardized instruction on E/M Coding^{4,54}.

The E/M Services Guide identifies basic billing and coding criteria that all medical record documentation must meet; these basic requirements are identified below and are easily met in the SOAP note format addressed in Module II of this manual.

Documentation of each patient encounter should include⁴⁻⁶:

- Reason for the encounter (CC) and relevant history (HPI, PFSH, ROS), Physical Examination findings (PE), and prior diagnostic test results (Old Charts Review)
- Assessment, Clinical Impression, or Diagnosis
- Medical Plan of Care
- Date and legible identity of observer(s), including
 - ▶ Provider statement of identity and signature
 - ▶ See Scribe Attestations Box on the following page

Documentation for each patient chart should also clearly address⁴⁻⁶:

- Reason for ordering all diagnostic studies or ancillary services, unless otherwise easily identifiable (**Medical Necessity**)
- PMH, including all past and present diagnoses
- Health Risk Factors
- Patient progress, response to- and changes in treatment, and diagnosis revision
- Diagnosis and treatment codes (ICD-10-CM and CPT codes) used on health insurance claim forms or billing statements and rationale for using these codes, supported by documentation in the medical record

The E/M Services Guide also instructs that documentation should be complete and timely, with all medical records completed and made accessible to other care providers as soon after the encounter as possible⁴⁻⁶. This is in accordance with current Medicare documentation guidelines that charts should be completed within 48 hours¹⁴⁷.

Scribe Sense: Scribe Attestations

CMS' 2017 Evaluation and Management Guide instructs that medical documentation for each patient encounter include **date and legible identity of observers**, including provider statement of identity and signature⁴⁻⁶. Currently, explicit scribe attestations are not required by CMS^{22,23} even though clinical scribes *are* direct observers of the patient encounter in most cases.

Clinical scribes *are* required by the Joint Commission and HIPAA's Security Rule to use individually identifiable login information when accessing and documenting a patient's medical record^{24,25}. Moreover, all certified electronic health record systems and technology (CEHRT) log and track activity of all individuals who access the EMR, and system activity logs may be audited at any time²⁴.

Although CEHRT activity logs provide the date and identity of all observers of the patient's medical record, **Clinical Scribes are strongly encouraged to include an attestation on each medical record that specifies the date and scribe identity**³¹. An example may include:

*"I, [scribe name and credentials], personally scribed the services dictated to me by [name of practitioner and credentials] in this documentation on [date] for [patient's name]. [Include scribe's electronic signature and timestamp]"*³³.

Chapter 5 in Module I covers additional suggestions and requirements for provider signatures when working with medical scribes^{33,35,36}

Scribe Sense: Medical Necessity

Medicare compensation for a medical item or service is contingent upon proof that the item or service is “**reasonable and necessary**” for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,” in accordance with the Social Security Act of 1935 and CMS¹⁰⁻¹². The medical reason or necessity for which an item or service is administered must be clearly addressed in a patient’s chart, and this identification is termed **Medical Necessity**^{4,12}.

Medicare has several policies that describe documentation criteria requirements for demonstrating medical necessity. These policies include **National Coverage Determinations (NCDs)** and **Local Coverage Determinations (LCDs)**, which are available online^{26,27}. In general:

- **All medical services provided and billed must meet medical necessity requirements,** as governed by statutory-, regulatory-, manual-, and NCD/LCD policies⁴.
- **For each service billed, the specific sign, symptom, or patient complaint that makes the service reasonable and necessary must be clearly documented** and medical documentation must support the overall level of service provided to a patient and reported to a payer⁴.

More complex patient encounters typically require higher levels of complexity in medical decision making and more intensive medical care. These encounters require more thorough medical documentation to reflect and support the medical necessity of the higher level of service provided

Introduction: Determining Overall E/M Coding Levels (1 – 5)

Within the E/M Coding system, different core components of a patient’s encounter (as reflected in the medical record) are separately evaluated and are assigned separate E/M levels. Altogether, the different component levels are used to determine a medical record’s **overall E/M Coding level (1 – 5)**. The overall E/M Level that a patient encounter is coded at (1 – 5) is used to reflect the level of complexity and intensity involved in the patient encounter and care. More complex patient encounters typically require more complex medical decision-making and more intensive medical care. In turn, more intensive medical care typically confers higher levels and amounts of

services rendered to the patient and submitted to payers for reimbursement. Therefore, higher levels of patient complexity and care are associated with higher overall E/M Coding Levels, which require more thorough medical documentation.

The seven components of the medical record that define an encounter's overall E/M coding level are^{4,5}:

1. History*

- ▶ Including CC, HPI, PFSH, and ROS

2. Physical Examination*

3. Medical Decision-Making*

- ▶ Including Assessment, Clinical Impression or Diagnosis, and Medical Plan of Care

4. Counseling

5. Coordination of Care

6. Nature of Presenting Problem

7. Time

*Of these seven coding components, the first three components (history, physical examination, and medical decision-making) are the primary descriptors used to determine a medical record's overall E/M level of service^{4,5}. The four remaining components serve as modifying descriptors. For example, time becomes the key determining factor of overall E/M level for visits that consist primarily of counseling or coordination of care⁵.

Each of the seven components of the medical record (identified above) have specific coding criteria that determine that component's level of complexity (and the E/M coding level that component will be assigned). The E/M criteria used to determine each of the 7 components' coding level(s) are addressed in Chapter 15. Coding criterion within each of the seven encounter components are assessed and cumulatively used to assign each component of the medical record with its own coding level, and these component levels make up the overall E/M Coding Level of each patient encounter in turn.

Importantly, different care settings have different coding criteria for what constitutes a certain level of care (and E/M service level). Different care settings also have different numerical code sets used to specify the type of care a patient receives and the setting in which the care is

provided^{4,148}. The five numerical code levels used to code charts for patients who receive care in the various outpatient setting may be found online at:

- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf>¹⁴⁹
- https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html⁴

The different coding criteria associated with different care settings are addressed briefly in Chapter 15.

E/M Coding uses ICD and HCPCS CPT Code Sets

To ensure accurate billing, standard code sets are used in medical record documentation. Identifiable numeric- and alphanumeric codes are associated with individual services, procedures, treatments, devices, and diagnoses provided and assigned to the patient in each encounter.

Most Electronic Health Record Systems (EHRs) automatically associate appropriate codes with various services entered into a patient's chart during documentation. For example, when a scribe or provider enters a diagnosis into the appropriate portion of a chart, the EHR attaches the appropriate ICD code to the selected diagnosis.

After a patient encounter has been completely documented, a billing or coding specialist typically reviews the chart to ensure the correct codes have been selected. The specialist also ensures that medical record documentation supports the level of service reported to a payer in terms of quality and quantity. A medical scribe may also aid in performing this service; therefore, it is important for medical scribes to understand the code systems utilized in the Evaluation and Management (E/M) Coding system.

E/M Coding utilizes two different code sets within a given patient chart; the two code sets are used together in one chart. The two coding sets are:

- The **International Classification of Disease, 10th Revision – Clinical Modification (ICD-10-CM)** codes associated with *diagnoses*^{4,7-9}
- The **Healthcare Common Procedure Coding System (HCPCS, “HICK PICKS”)**'s codes associated with *medical services, procedures, and devices*^{4,12,13}. The HCPC System contains two levels of codes:
 - ▶ **Level I** HCPCS codes are identical to the **Current Procedural Terminology (CPT)** code

set and are used for documenting, coding, and billing medical and surgical services and procedures furnished by practitioners¹³⁻¹⁶.

- ▶ **Level II** HCPCS codes consist of non-CPT codes and modifiers used for non-physician services, products, and supplies (such as ambulance services and durable medical equipment, DME)¹³⁻¹⁵.

In brief, **ICD codes** are used internationally and within the U.S. to identify diagnoses; **HCPCS codes** (including Level I **CPT codes** and Level II HCPCS Codes) are used within the U.S. only to identify services, procedures, products, and devices rendered during an encounter^{4,7,8,12,13}.

- **HCPCS code services may be associated with – and often reliant upon – ICD codes for billing purposes.**

Together, ICD and HCPCS codes are used to code and assign each patient chart with an overall E/M level⁴⁻⁶. Both coding systems are discussed in greater depth in the following chapter.

Scribe Sense: E/M Coding uses ICD and HCPCS/CPT Code Sets

- **International Classification of Diseases (ICD)** code sets are typically associated with **diagnoses**. ICD provides a system of diagnostic codes for classifying diseases that may be used for diagnostic and billing purposes^{4,7-9}.
- **Healthcare Common Procedure Coding System (HCPCS, “HICK PICKS”)** code sets are used for coding and billing **medical services, procedures, and devices** provided in an encounter in the outpatient facility setting and in the office setting within the U.S.^{4,12,13}. The HCPCS consists of two levels of numeric and alphanumeric code sets:
 - ▶ **Level I** is a 5-character numeric code set identical to the **Current Procedural Terminology (CPT)** code set and is used for documenting, coding, and billing medical and surgical services and procedures furnished by practitioners¹³⁻¹⁶.
 - ▶ **Level II** consists of 5-character alphanumeric non-CPT codes and modifiers used for non-physician services, products, and supplies (such as ambulance services and durable medical equipment, DME)¹³⁻¹⁵.
 - ▶ In 1996, HIPAA mandated HCPCS use for all transactions involving health care information^{13,14,18,19}

International Classification of Diseases (ICD)

Chapter 12 highlights some historical landmarks in the development of the International Classification of Diseases (ICD) system, which are reproduced below:

In **1891**, the International Statistical Institute (ISI) charged a committee to prepare a classification of causes of death^{28,29}.

In **1893**, the ISI formally adopted the committee's *International List of Causes of Death*.

In **1900**, ISI held the first international conference to revise the *International Classification of Causes of Death (ICD-1)* prepared by the committee^{28,29}.

In **1948**, the World Health Organization (WHO) was entrusted with the ICD as its creation and published the 6th version, ICD-6, that incorporated both mortality and morbidity⁹.

In **1990**, The World Health Assembly formally endorsed the 10th version of ICD, **ICD-10**, which is the most current revision to date⁹. **The ICD-10 consists of 3 volumes^{7,29,32}:**

- **One volume contains procedure codes (ICD-10-PC)**
- **Two volumes contain diagnosis codes (ICD-10-CM)**

In **2008**, the U.S. Department of Health and Human Services proposed that the Clinical Modification of the **International Classification of Diseases and Related Health Problems, 10th Edition (ICD-10-CM)** formally replace the previously used ICD-9-CM diagnostic code sets for formal use in reporting diagnoses and procedures on health care transactions^{7,29}. This proposal was implemented by U.S. Congress in 2014^{7,29}.

In **2015**, the 10th revision (**ICD-10**) was fully adopted in the U.S., and its use is currently required by CMS and HIPAA^{28,29}.

International Classification of Diseases, 10th Revision (ICD-10)

The **International Classification of Diseases – Clinical Modification System for diagnoses (ICD-CM)** is recognized and used internationally by the World Health Organization (WHO)¹⁵⁰. Within the U.S., ICD-CM is used to classify diseases and other health problems recorded in health records, and to facilitate reimbursement and resource allocation decision-making. The 10th revision of the Clinical Modification of the International Classification of Diseases (**ICD-10-CM**)

was formally adopted for coding and billing diagnoses in the U.S. on October 1, 2015¹⁵⁰. **ICD-10-CM use is currently required by CMS and HIPAA^{28,29}**.

The ICD-10-CM coding system uses 3-7 alphanumeric digits and full code titles^{7,9,150}. In comparison to its predecessor, the ICD-9-CM system, the ICD-10 coding system requires a higher level of specificity in coding^{20,151}, as demonstrated in the SuperScribe ICD-10 Application Box below.

SuperScribe Application Box: ICD-10-CM Requires Specificity in Coding

In the **ICD-10 diagnosis code set**, characters in the code identify specific anatomical location. For example, **the following diagnoses had the same ICD-9 code, but different ICD-10 codes:**

- 3rd degree burn to the volar aspect of the right upper extremity (RUE).
- 3rd degree burn to the volar aspect of the left upper extremity (LUE).
- 3rd degree burn to the volar aspect of the RUE evaluated in an initial encounter
- 3rd degree burn to the volar aspect of the RUE evaluated at a subsequent encounter

Although the ICD-10-CM Code set has been formally adopted for use in the U.S. since 2015, some providers may not be attuned to the greater level of specificity required by the ICD-10 code set.

- For example, if a patient is seen for treatment of a right arm burn, then returns for treatment of a left arm burn, both encounters would have used the same ICD code under the old ICD-9 system. However, both encounters require separate ICD codes under the new ICD-10-CM system.
- Therefore, if your provider instructs you to document “3rd degree burn” or “3rd degree burn to the upper extremity” as the patient’s diagnosis for either of the two encounters, you could prompt your physician to comply with the greater level of specificity required under the ICD-10-CM System by asking whether s/he would prefer you to enter “3rd degree burn to the volar aspect of the RUE” for the first encounter and “3rd degree burn to the volar aspect of the LUE, initial encounter” for the second encounter.
- If the provider re-evaluates the RUE burn on the second encounter, this may require further documentation and a separate diagnosis and ICD-10 code.

Healthcare Common Procedural Coding System (HCPCS) & Current Procedural Terminology (CPT)

The International Classification of Diseases (ICD) codes outlined above are used and recognized internationally by the World Health Organization (WHO), and adopted nationally to identify *diagnoses*^{150,152}. the **Healthcare Common Procedural Coding System (HCPCS, “HICK PICKS”)** provides a national coding standard that is used within the U.S. for identifying **medical services, procedures, medications, and devices**^{4,18,51}.

The **HCPCS** consists of two levels of 5-character numeric and alpha-numeric code sets:

- **The Level I code set** contains the 5-character numeric **Current Procedural Terminology (CPT)** code set, which is maintained by the American Medical Association (AMA). The Level I CPT codes are used for documenting, coding, and billing medical and surgical ***services and procedures furnished by practitioners***¹³⁻¹⁶.
- **The Level II code set** consists of a set of 5-character alphanumeric non-CPT codes and modifiers that are maintained by CMS. Level II HCPCS codes are used for identifying ***non-physician products, supplies, and non-physician services*** (such as ambulance services and durable medical equipment, DME)¹³⁻¹⁵.

In 1996, HIPAA mandated HCPCS use for all transactions involving health care information^{13,14,18,19}. CMS' required use of E/M Coding falls within congress' mandatory HCPCS use, since E/M coding uses both the International Classification of Diseases (ICD) for diagnoses and the Healthcare Common Procedures Coding System (which uses Common Procedural Terminology codes) for medical services, procedures, and provisions.

As a clinical scribe working one-on-one with a practitioner, you will primarily use HCPCS Level I CPT code sets (as opposed to Level II non-CPT code sets). Therefore, this chapter will focus on CPT code sets, and often uses the term CPT interchangeably with “HCPCS Level I.”

HCPCS and CPT codes are designed to communicate uniform information about medical services and procedures among providers, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes¹³⁻¹⁶.

The E/M Coding system uses both the ICD-10 coding systems and the CPT coding system to provide a consistent coding and billing standard within the medical industry.

Review & Assessment

Review

1. **Medical Necessity** refers to the medical reason or necessity for which an item or service is administered; this must be clearly addressed in a patient's chart for the service to receive insurance compensation^{4,10-12}.
2. The **Evaluation and Management (E/M) Coding system** constitutes the standardized coding and billing system used by practicing providers and health care providers in the U.S. to receive reimbursement by the Centers for Medicare & Medicaid Services (CMS), and by most private insurance companies for services rendered during patient encounters⁴⁻⁶.
3. The E/M coding system is based upon two coding systems and sets:
 - The 10th Revision of the International Classification of Diseases – Clinical Modification (ICD-10-CM), used for identifying diagnoses
 - The Healthcare Common Procedural Coding System (HCPCS, “HICK PICKS”), used for identifying medical and surgical services, procedures, and furnishings, and which includes two levels of codes^{4,13,14,18}:
 - i. The Current Procedural Terminology (CPT) Coding Set (Level I) for medical and surgical services and procedures furnished by a practitioner
 - ii. The Level II Non-CPT Code Set for products, supplies, and non-physician services.
4. **International Classification of Diseases 10th Revision – Clinical Modification (ICD-10-CM):** The diagnosis classification system developed by the World Health Organization and adapted by the Centers for Disease Control and Prevention for use in all U.S. healthcare treatment settings. ICD-10-CM was formally adopted for use in the U.S. on Oct. 1, 2015^{28,29}.
 - Diagnosis coding under the ICD-10-CM system uses 3-7 alphanumeric digits and full code titles; the format is like that of ICD-9-CM.
5. **Healthcare Common Procedure Coding System (HCPCS, “HICKS PICKS”):** Standardized terminology and coding system used for describing specific items and services provided in healthcare delivery^{13,14,18}. The HCPCS provides healthcare practitioners and organizations with standardized guidelines for terminology and coding that can be used to report and bill for medical care, including: services, procedures, medications, and devices^{4,18,51}. The HCPCS also enables federal and private health insurance programs (including Medicare and

Medicaid) to ensure payment claims are processed in an orderly and consistent manner^{13,14,18}. The HCPCS consists of two levels of 5-character numeric and alpha-numeric code sets. **Level I** consists of the numeric Current Procedural Terminology (**CPT**) code set maintained by the American Medical Association (AMA) and is used for documenting, coding, and billing *services and procedures*^{13,14}. **Level II** consists of an alphanumeric code set that is maintained by CMS and used to identify *products, supplies, and non-physician services*^{13,14}.

6. **Current Procedural Terminology (CPT) Coding System:** The American Medical Association (AMA)'s copyright-protected coding system used within the U.S. to describe medical, surgical, and diagnostic services^{45,107}.
 - The CPT system is designed to communicate uniform information about medical services and procedures among providers, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

Assessment

1. ICD codes are used for which of the following:
 - a. Procedures
 - b. Diagnoses
 - c. Medications
 - d. Discharge instructions
2. True or False: ICD codes and CPT codes are used in the United States and internationally.
3. E/M standards and guidelines were established by Congress in 1995 and revised in 1997. CMS and many private health insurance companies require compliance with either the 1995 or 1997 Guidelines, both of which can be found online (separately or within the U.S. Department of Health and Human Services' 2017 Evaluation and Management Services Guide at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>)⁴⁻⁶. The main difference between the two guidelines is the examination component, in which “the 1995 guidelines allow more latitude for a detailed exam;” whereas the 1997 guidelines require “upwards of 12 “bullets” that may or may not be pertinent to the CC at each encounter,”¹².

You arrive to work to discover that the internet is down and you are unable to access your facility's EHR. Your Supervisor instructs you to use the 2017 E/M Services Guidelines (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>) to create a template for a level 5 E/M chart, with the following components:

- A prompt for the Chief Complaint
- Prompts for the 8 different HPI elements
 - ▶ with prompts for the number of elements needed to document an extended HPI
- Prompts for the 14 different body systems recognized in a ROS
 - ▶ Including normal elements/bullets within each body system
 - ▶ With prompts for the number of body systems (and elements/bullets within each body system) needed to document a complete ROS

- Prompts for a complete PFSH
 - Prompts for a complete Comprehensive General Multi-Systems Physical Examination
 - ▶ Using the template for a normal comprehensive general multi-system PE found in the 2017 E/M Services Guide (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>)
 - Prompts for elements needed to demonstrate each of the 4 different levels of Medical Decision Making complexity
 - ▶ (found on pg 13 of the 20017 E/M Service Guide)
 - Prompts for documenting additional elements of the Medical record:
 - ▶ Risk
 - ▶ Counseling
 - ▶ Coordination of Care
 - ▶ Nature of Presenting Problem
 - ▶ Time
4. In 2008, Drs. Joel Heidelbaugh MD and Margaret Riley MD (Department of Family Medicine at the University of Michigan Ann Arbor) and Judith Habetler, CPC, ACMCS, MHSA (Primary Care and OB/GYN Billing at the University of Michigan in Ann Arbor) published an article in The Journal of Family Practice titled “10 billing & coding tips to boost your reimbursement¹⁵³.” The article can be accessed free online at:
- <https://www.mdedge.com/familymedicine/article/63368/practice-management/10-billing-coding-tips-boost-your-reimbursement>
 - https://mdedge-files-live.s3.us-east-2.amazonaws.com/files/s3fs-public/Document/September-2017/5711JFP_Article2.pdf
- i. What are the 10 Tips suggested by Heidelbaugh, Riley, Habetler?
 - ii. Table 1 in the article shows CPT codes and documentation requirements for established patients for 5 different E/M Codes: 99211; 99212; 99213; 99214; 99215. What do the 5 different 5-digit E/M code levels signify (99211-99215)?
 - iii. Table 2 in the article shows CPT codes and documentation requirements for new patients for 5 different E/M code levels: 99201; 99202; 99203; 99204; 99205. How do these documentation requirements differ from those for an established patient?

- iv. Tip #7 suggests using a template for the “Welcome to Medicare” exam. What is a “Welcome to Medicare” exam? Is there a template that exists within your system’s EHR that you can use to document this exam (you may need to ask your Scribe Supervisor)? If not, create a template that you can use. What are the benefits and limitations of using templates for documentation? If you use a “Welcome to Medicare” exam template, identify 3 issues you would want to be cautious of when using this template.
 - v. This article focuses on documenting to help your physician “boost reimbursement;” however, reimbursement should not be the primary force that drives documentation for a Clinical Scribe. How can you use the 10 tips provided in this article to help your provider achieve **the most accurate documentation, billing, and coding possible** for each patient encounter?
5. E/M Coding uses ICD-10 codes for diagnoses and HCPCS codes for services, procedures, and other clinical furnishings. The HCPCS coding system contains two different levels of code sets: Level I and Level II. What are the primary differences between the two levels of HCPCS codes? How might you use each of the two different levels of codes in your role as a Clinical Scribe? Which level are you likely to use more often, and why?



15

E/M Coding in Depth

How Are E/M Levels Determined?

In the **outpatient setting**, ICD and HCPCS codes are used to code and assign each patient chart with an overall E/M level (1 – 5)⁴⁻⁶. This overall E/M Coding assignment demonstrates the complexity of the patient encounter, and is initially based upon 3 variable factors⁴:

- Patient status (new vs. established, within the last 3 years)
- Place of service (clinic, office, hospital)
- Type/Level of service (office visit, consultation, hospital admission, newborn care)

In addition to these 3 pertinent variable factors, E/M Levels of Service are further based upon 3 Key Components and 4 subsequent Contributory Factors identified in a patient's chart⁴⁻⁶ and outlined in the box below.

Pertinent Variable Factors:

- Patient Status (New vs. Established, within the last 3 years)
- Place of Service (Clinic, Office, Hospital; unlikely to vary within a setting)
- Type of Service (Office visit, Consultation, Newborn care)

3 Key Components:

- History (HPI, PMFSH, ROS)
- Examination (PE)
- Medical Decision Making (MDM) Complexity

4 Contributory Factors:

- Counseling
- Coordination of Care
- (With other providers or agencies by consultation or referral)
- Face Time (Spent with the patient, categorized into time intervals)
- Nature of Presenting Problem (Ranked from minimal to moderate severity)

Note: counseling, coordination of care and nature of presenting problem are not necessarily "hard requirements" for E/M Coding.

The 10 E/M Level determinants identified above are used to determine what level a chart will be coded at; this determines the amount of reimbursement a provider can receive for medical services rendered. Within the 10 E/M Level determinants above, further coding levels exist for each key component and contributory factor within a given level (as identified below).



SuperScribe Tips:

- **Documenting New vs Established Patients:**

Patient status (new vs established within the past 3 years) is one of the pertinent variable factors that determines criteria used to identify the E/M Level associated with a patient encounter⁴. A new patient is likely to require more complex medical decision-making and more intensive care initially than an established patient whose medical history a provider may be more familiar with. The E/M Service Guide uses the following definition to identify new patients:

- ▶ **New Patient:** individual who has not received any professional service from the physician, practitioner, or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

Because new patients have different documentation criteria for different E/M Coding levels, you will want to note in each patient's chart whether a patient is new or established.

- ▶ If your provider sees a patient who s/he has seen previously but who has lived in a different location for the past 4 years and was seen by a different group practice during that time, you will need to identify this patient as a “**new patient**,” and this patient will have different E/M documentation criteria than that of an established patient.
- ▶ If your provider sees a patient who s/he has never seen previously, but who was recently seen by a different provider from the same group practice last week, you would identify this patient as an “**established patient**,” even though s/he is technically new to the provider you are working with.

- **Documenting Type (E/M Level) of Service:**

Type (Level) of service is one of the three pertinent variable factors that determines criteria used to identify the E/M Level associated with a patient encounter⁴. Accordingly, code sets are organized into various categories and levels based primarily on the complexity of the patient encounter. Type/Level of service (and complexity of patient encounter) are determined primarily by three key components: history, examination, and medical decision-making (as addressed subsequently).

Coding Criteria for the 3 Key Components

Key Component #1: History

The “**History**” component of the patient’s chart (as identified by CMS for E/M Service purposes⁴) typically aligns with the “subjective” component of a SOAP note^{154,155} (introduced in Module II). E/M Services Guidelines identify 4 main components of the patient history⁴⁻⁶:

- **Chief Complaint (CC)**
Required in all charts
- **History of Present Illness (HPI)**
Contains 2 coding levels:
 - Brief
 - Extended
- **Review of Systems (ROS)**
Contains 3 coding levels:
 - Problem Pertinent
 - Extended
 - Complete
- **Past, Family, &/or Social History (PFSH)**
Contains 2 coding levels:
 - Pertinent
 - Complete

As indicated above, each of these 4 main components have different coding levels that are associated with different levels of complexity and have different documentation requirements in turn. The complexity of each of these 4 history components are used to determine the overall E/M level assigned to the patient history, which contributes to the overall E/M level assigned to the patient encounter in turn. Here, we provide a brief overview of the four different “history levels.” This overview is followed by an overview of the different documentation elements required in each of the 4 history components listed above.

For E/M Services purposes, the **History component** of a patient chart may be coded as “problem-focused,” “expanded problem-focused,” “detailed,” or “comprehensive,” depending on the level of content requirements the history meets⁴⁻⁶. The different coding levels for the key history component are identified below⁴⁻⁶.

Problem-Focused:

- Chief Complaint
- Brief HPI (1-3 elements)

Expanded Problem-Focused:

- Chief Complaint
- Brief HPI (1-3 elements)
- Problem-pertinent ROS (≥1 system documented)

Detailed:

- Chief Complaint
- Extended HPI (≥4 elements)
- Extended ROS (2-9 systems documented)
- Pertinent PMFSH (≥1 item from any history area)

Comprehensive:

- Chief Complaint
- Extended HPI (≥4 elements)
- Complete ≥10 system ROS or document “all other systems reviewed and are negative”
- Complete PMFSH (minimum of 1 item from 2 of the 3 histories)



SuperScribe Tip:

The different history levels can be intimidating, especially for new scribes. **When in doubt, err on the side of over-documentation.** Also, remember that medical documentation extends beyond the purposes of coding, billing, and reimbursement. **As a clinical scribe, your primary focus should always be to capture and document all information obtained by the physician,** regardless of whether it is required for coding and billing purposes. Some information may not be necessary for coding/billing, but may be important for future providers to have access to in order to best care for the patient²⁰.

Chief Complaint (CC):

According to E/M Service Guidelines, **Chief Complaint (CC)** is a required component of all patient histories, and is formally defined as ***“a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter⁴⁻⁶.”*** As identified in Module II, the CC is usually documented subjectively – in the patient’s words.

History of Present Illness (HPI):

Like the CC, the **History of Present Illness (HPI)** is a required E/M Service component of all patient histories⁴⁻⁶. E/M Guidelines formally define the HPI as: ***“a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present⁴.”*** E/M Service Guidelines identify 8 documentation elements that make up an HPI, which align with those identified in Module II⁴:

- Location (ex: lower left leg)
- Quality (ex: aching, radiating pain)
- Severity (ex: on 1 – 10 pain scale)
- Duration (ex: onset 3 days ago)
- Timing (ex: constant, intermittent)
- Context (ex: was moving furniture)
- Modifying Factors (ex: improved with ice and heat)
- Associated Signs and Symptoms (ex: associated numbness in toe)

E/M Service Guidelines identify two types/levels of HPIs that differ in their complexity⁴⁻⁶:

- **Brief HPIs** contain 1 – 3 HPI elements⁴⁻⁶
- **Extended HPIs** contain either:
 - ▶ ≥ 4 elements of the present HPI or associated comorbidities (according to 1995 documentation guidelines)⁶
 - ▶ ≥ 4 elements of the present HPI or the status of ≥ 3 chronic or inactive conditions (according to the 1997 documentation guidelines)⁵
 - ▶ As of 2013, providers may choose to follow either the original 1995- or the revised 1997 documentation guidelines for reporting services furnished to Medicare (but providers must choose 1, and may not use a combination of both guidelines)⁴.

Review of Systems (ROS)

The E/M Service Guidelines defines the **Review of Systems (ROS)** as: “an inventory of body systems obtained by asking a series of questions to identify signs and/or symptoms the patient may be experiencing or has experienced⁴.”

Acceptable Organ Systems (Oss) to document in the Review of Systems (ROS) include:

- Constitutional (fever, weight, etc.)
- Ophthalmologic (eyes)
- Otolaryngologic (ears, nose, throat)
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

E/M Service Guidelines identify three different ROS levels/types⁴:

- A **Problem Pertinent ROS**: “inquires about the system directly related to the problem identified in the HPI⁴.”
- An **Extend ROS** “inquires about the system directly related to the problem(s) identified in the HPI *and a limited number (2 – 9) of additional systems*⁴.”
- A **Complete ROS** “inquires about the system(s) directly related to the problem(s) identified in the HPI, plus all additional organ systems (≥ 10 systems)⁴.” Positive- and pertinent negative findings must be individually documented within each system. A notation indicating “all other systems are reviewed and are negative,” is also permitted.

Past, Family, and/or Social History (PFSH)

The E/M Guidelines defines the **Past, Family, and/or Social History (PFSH)** as “a review of three areas [in which]⁴:

- **Past History** includes experiences with illnesses, operations, injuries, and treatments
- **Family History** includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk
- **Social History** includes an age appropriate review of past and current activities.”

E/M Guidelines identify two levels of PFSH⁴:

- A **Pertinent PFSH:**
 - ▶ Provides “a review of the history areas directly related to the problem(s) identified in the HPI⁴”
 - ▶ Includes ≥ 1 item from any of the three history categories
- A **Complete PFSH:**
 - ▶ Requires “a review of all three history areas for services that, by their nature, include a comprehensive assessment or reassessment of the patient⁴”
 - ▶ Reviews 2 – 3 of the history categories comprehensively

In the office- and outpatient service settings, E/M Service Guidelines identifies different PFSH documentation requirements for new vs established patients⁴.

- **For established patients:** ≥ 1 specific item from 2 of the 3 history areas is required
- **For new patients:** ≥ 1 specific item from each of the history areas is required



SuperScribe Tips:

- **Documenting the Patient Histories:**

The Chief Complaint (CC), Past Medical, Family, and Social History (PMFSH), and Review of Systems (ROS) may be documented as separate elements or included in the History of Present Illness (HPI)⁴⁻⁶. However, most EHRs have separate sections for each of these elements.

- **Documenting “All other systems were reviewed and are negative” in the Review of Systems (ROS) qualifies the ROS as Comprehensive.**

- **Documentation by Ancillary Staff:**

According to the CMS, ROS and/or PFSH may be documented by ancillary staff or by the patient on a form, so long as they are accompanied by a notation supplementing or confirming that the information was reviewed and verified by the medical provider^{4,5}.

- **Document that the provider has reviewed data – such as previous PMFSH by:**

- ▶ Describing new information or noting “no change.”
- ▶ Noting the date and location of previously documented PMFSH.
- ▶ Documenting: “previous patient information including PMFSH was reviewed and updated.”

- **Documenting a Limited History:**

If the provider is unable to obtain a history from the patient due to the patient condition, the provider may report this and describe the way in which the patient condition limited the ability to obtain a complete patient history^{4,5}.

- ▶ For example, infant and pediatric patients will be unable to provide a history. In these circumstances, the history will likely be obtained by a parent, and the scribe may document: “Patient history limited due to patient age. Collateral information obtained from patient parent.”

Key Component #2: Examination

The “**Examination**” component of the patient’s chart – as identified by CMS for E/M Service purposes⁴ – aligns with the physical examination in the “objective” component of a SOAP note^{154,155}, as introduced in Module II. E/M Service Guidelines identify 2 different types of physical examinations⁴⁻⁶:

- **A General Multi-System Exam** is the examination type most likely to be used in the family practice setting, and involves examination of ≥ 1 organ system(s) or body area(s)⁴.
- **A Single Organ System Exam** entails a more extensive examination of a specific organ system⁴.

Both types of physical examination – the general multi-system exam and single organ system exam – each have 4 different levels that they may be coded as:

- A **Problem Focused Examination** entails “a limited examination of the affected body area or organ system⁴.”
- An **Expanded Problem Focused Examination** entails “a limited examination of the affected body area or organ system *and any other symptomatic or related body area(s) or organ system(s)*⁴.”
- A **Detailed Examination** entails “an *extended* examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s)⁴.”
- A **Comprehensive Examination** entails “a *general multi-system examination or complete examination of a single organ system* (and other symptomatic or related body area(s) or organ system(s)⁵)⁴.”

The criteria for each exam level (problem focused, expanded problem focused, detailed, and comprehensive) within each of the two types of physical examinations (general multi-system vs single organ system) differ primarily by the number of organ systems (OS) or body areas (BA) that need to be examined, and by the number of elements that need to be documented within each organ system or body area (OS/BA), as specified below.

General Multi-System Exam⁴:

- **Problem-Focused:** 1-5 elements in ≥ 1 organ system/body area (**OS/BA**)
- **Expanded Problem Focused:** ≥ 6 elements in ≥ 1 OS/BA(s)
- **Detailed:** ≥ 2 elements in each of ≥ 6 OS/BA(s) total OR ≥ 12 elements in ≥ 2 OS/BAs

- **Comprehensive:** identify all elements within $\geq 8^6 - 9^{5*}$ OS/BA(s), with a minimum of 2 elements per OS/BA.

*The original 1995 documentation guidelines state that a comprehensive general multi-system examination must include ≥ 8 OS(s); whereas the 1997 revision guidelines specify ≥ 9 OS/BA(s) must be included⁴⁻⁶. A practitioner may choose to use either set of guidelines, but must be consistent with either guideline set within a single medical record, and may not combine guidelines within a given record⁴.



SuperScribe Tip:

Within both physical examination types – general multi-systems exams and single organ systems exams – elements within a given OS/BA must be identified by separate bullets⁴.

Single Organ System Exam⁴:

- **Problem-Focused:** 1-5 elements within the selected organ system (OS)
- **Expanded Problem Focused:** ≥ 6 elements within the selected OS
- **Detailed:** ≥ 12 elements within the selected OS^{**}

^{**}Eye and psychiatric examinations need only include ≥ 9 elements

- **Comprehensive:** All elements within the system must be identified

Acceptable Organ Systems and Body Areas for Physical Examination Documentation

Acceptable Organ Systems (OS):

- Constitutional (vital signs, appearance)
- Ophthalmologic (eyes)
- Otolaryngologic (ears, nose, throat)
- Cardiovascular
- Respiratory
- Gastrointestinal

- Genitourinary
- Musculoskeletal
- Integumentary
- Neurologic
- Psychiatric
- Hematologic/Lymphatic
- Allergic/Immunologic

Acceptable Body Areas (BA):

- Head (including face)
- Neck
- Chest (including breasts and axillae)
- Abdomen
- Genitalia, groin, buttocks
- Back
- Extremities (each documented individually)



SuperScribe Tips:

- **Document normal- and abnormal findings in the physical examination⁴:**
 - ▶ All specific abnormal and relevant negative findings must be documented and described within the affected/symptomatic OS/BA(s)
 - ▶ A notation of “abnormal” without elaboration is not sufficient documentation for abnormal findings within an affected/symptomatic OS/BA.
 - ▶ Abnormal or unexpected findings in *asymptomatic* OS/BA(s) should also be documented
 - ▶ A notation of “negative” or “normal” *is* sufficient documentation for normal findings in unaffected/asymptomatic OS/BA(s).

Key Component #3: Medical Decision Making (MDM) Complexity

The “**Medical Decision Making (MDM)**” component of the patient’s chart – as identified by CMS for E/M Service purposes⁴ – aligns with the “assessment” component of a SOAP note^{154,155}, as introduced in Module II. E/M Service Guidelines define medical decision making in reference to “the complexity of establishing a diagnosis and/or selecting a management option⁴,” which is determined by considering three main factors⁴:

- **Number of possible diagnoses and/or management options** that must be considered to provide quality patient care. This factor accounts for the complexity of the “differential diagnosis” identified in Module II, and encompasses coordination of care, and selecting a care plan. This factor may be coded as 1 of 4 different levels:
 - ▶ Minimal
 - ▶ Limited
 - ▶ Multiple
 - ▶ Extensive
- **Amount/complexity of data to be reviewed**, including medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed in order to provide quality care to the patient. This factor may be coded as 1 of 4 different levels:
 - ▶ Minimal
 - ▶ Limited
 - ▶ Moderate
 - ▶ Extensive
- **Risk of significant complications, morbidity, and/or mortality**, “as well as comorbidities associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or other possible management options⁴.” This factor may be coded as:
 - ▶ Minimal
 - ▶ Low
 - ▶ Moderate
 - ▶ High

Similar to the patient “history,” the complexity of each of these 3 MDM components are used to determine the overall complexity of the medical decision making involved in a patient encounter, which determines the MDM’s E/M level and contributes to the overall E/M level assigned to the patient encounter in turn. Here, we provide a brief overview of the four different “medical decision making levels.” This overview is followed by an overview of the different documentation elements required in each of the 3 MDM components listed above.

For E/M Services purposes, the **medical decision making component** of a patient chart may be coded as “straightforward,” “low,” “moderate,” or “high.” Qualifying criteria for each level of Medical Decision Making complexity are specified below⁴⁻⁶.

Straightforward:

- Minimal diagnoses or management options
- Minimal or no data to be reviewed
- Minimal risk for significant complications, morbidity, or mortality

Moderate:

- Multiple diagnoses or management options
- Moderate amount of data to be reviewed
- Moderate risk for significant complications, morbidity, or mortality

Low:

- Limited number of diagnoses or management options
- Limited amount of data to be reviewed
- Low risk for significant complications, morbidity, or mortality

High:

- Extensive number of diagnoses or management options
- Extensive amount of data to be reviewed
- High risk for significant complications, morbidity, or mortality

The criteria for determining what constitutes each of the different levels of a given component of medical decision making are less clear-cut than those identified for the different levels in the patient’s HPI or ROS. However, CMS does offer some guidelines regarding how these different levels can be identified. These guidelines will be addressed below.

MDM Factor #1: Number of Possible Diagnoses and/or Management Options

According to the E/M Guidelines, the **number of possible diagnoses and/or management options** accounts for the complexity of the “**differential diagnosis**” identified in Module II, and encompasses coordination of care, and selecting a care plan⁴. This factor may be coded as 1 of 4 different levels⁴:

- Minimal
- Limited
- Multiple
- Extensive

The E/M Guidelines do not offer specific service- or documentation guidelines for distinguishing each of the four different E/M levels of service identified above⁴. However, they do identify three main factors that contribute to the number of possible diagnoses and/or management options to consider⁴:

- The **number and types of problems addressed during the encounter**
- The **complexity of establishing a diagnosis**
- The **management decisions made by the physician**

The following guidelines are also offered in regards to the way in which this overall factor may be coded⁴:

- The **differential diagnosis** (addressed in Module II) is often a strong indicator of the level of complexity this category will be coded as.
- Medical decision-making for a **diagnosed problem** is generally easier than decision making for an identified by **undiagnosed problem**⁴. Therefore, undiagnosed problems are likely to involve higher levels of E/M service in this category.
- The **number and type of diagnosed tests performed** may also indicate the number of possible diagnoses considered
- A problem’s **response to treatment** often indicates its complexity: problems that are improving or resolving are typically less complex than those that are worsening or failing to change as expected

- The need for **consultations or advice from other health care professionals** typically indicates a greater complexity of diagnostic or management problems.

E/M Guidelines also offer several **documentation requirements** in this category⁴:

- In order to meet E/M Coding criteria, medical documentation for each patient encounter must **identify an Assessment, Clinical Impression, or Diagnosis**, and must reveal the involvement of each component (assessment, clinical impression, and diagnosis, respectively) in determining patient care management or further evaluation (the Plan). These components should be documented within the Medical Decision Making portion of a patient's medical record. Specifically⁴:
 - ▶ For a **presenting problem with an established diagnosis**, documentation must indicate whether the problem is:
 - Improved, well controlled, resolving, or resolved
 - Inadequately controlled, worsening, or failing to change as expected
 - ▶ A **presenting problem without an established diagnosis** must be identified in the Differential Diagnosis (DD) or Clinical Impression as “possible,” “probable,” or “[to be] ruled out.”
- **Initiation of – or changes in – treatment**, “which includes a wide range of management options such as patient instructions, nursing instructions, therapies, and medications⁴,” contribute to the overall complexity of this category and must be documented.
- All **referrals, consultation requests, and advice sought** from other health care professionals must be documented and must include who or where each referral or consultation was made to, and who advice was requested from.



SuperScribe Tip:

The complexity level involved in the **number of possible diagnoses and/or management options to consider** is often influenced by the following factors⁴:

- Length and complexity of the differential diagnosis
- Whether an identified problem is diagnosed- vs undiagnosed
- The number and type of diagnostic tests performed
- A problem's response to treatment
- Consultations or advice sought from other healthcare professionals

As a clinical scribe, it is important to thoroughly and accurately document these elements within the MDM- or A&P/I&P portion of a patient's chart (as dictated by your provider) to clearly and accurately convey the level of complexity involved in the provider's MDM.

MDM Factor #2: Amount/Complexity of Data to be Reviewed

The **amount and complexity of data to be reviewed** also contributes to the complexity of the physician's medical decision making process, and includes review of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed in order to provide quality care to the patient. This factor may be coded as 1 of 4 different levels⁴:

- Minimal
- Limited
- Moderate
- Extensive

The E/M Guidelines do not offer specific service- or documentation guidelines for distinguishing each of the four different E/M levels of service in this category⁴. However, they do identify three main factors that contribute to the amount/complexity of data to be reviewed⁴:

- "A decision to **obtain and review old medical records and/or history** from sources other than the patient ...increases the amount and complexity of data to be reviewed
- **Discussion of contradictory or unexpected test results** with the physician who performed or interpreted the test indicated the complexity of data to be reviewed

- [If] the physician who ordered a test **personally reviews the image, tracing, or specimen** to supplement information from the physician who prepared the test report or interpretation [this] indicates the complexity of data to be reviewed⁴.”

E/M Guidelines does also offer several **documentation requirements** in this category⁴:

- Document the **type of service** for all diagnostic services ordered, planned, scheduled, or performed *at the time of the E/M encounter*
- Document the provider's **review of laboratory, radiology, and/or other diagnostic tests**.
 - ▶ “A simple notation such as ‘WBC elevated’ or ‘CXR unremarkable’ is acceptable⁴.”
 - ▶ A provider's dated initials on a report containing the results is also acceptable.
- Document the provider's **decision to obtain old records or additional history** from sources other than the patient to supplement information obtained from the patient.

SuperScribe Tip:

The complexity level involved in the **amount and complexity of data to be reviewed** is often influenced by the following factors⁴:

- Decision to obtain and review old medical records and/or history
- Type of service for all diagnostic services ordered, planned, or scheduled
- Discussion of contradictory or unexpected test results with the conducting physician
- Personal review of diagnostic tests results ordered during the E/M encounter

As a clinical scribe, it is important to thoroughly and accurately document these elements within the MDM- or A&P/I&P portion of a patient's chart (as dictated by your provider) to clearly and accurately convey the level of complexity involved in the provider's MDM.

MDM Factor #3: Risk of Significant Complications, Morbidities, & or Mortalities

The **risk of significant complications, morbidities, and/or mortalities** also contributes to the complexity of the physician's medical decision making process. This factor includes "comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or other possible management options⁴," and may be coded as 1 of 4 different levels⁴:

- Minimal
- Low
- Moderate
- High

In this MDM factor, the E/M Guide does offer some specific documentation guidelines for distinguishing each of the four different E/M levels of service in this category⁴. Specifically, the guidelines identify three main categories of risk that contribute to the overall complexity of this factor⁴:

- Risk of the **presenting problem(s)**, which is based on "the risk related to the disease process anticipated between the present encounter and the next encounter⁴"
- Risk of **selecting diagnostic procedure(s)**, which is "based on the risk during and immediately following any procedure or treatment⁴"
- Risk of selecting **possible management options**, which is also based on the risk "during and immediately following any procedure or treatment⁴"

The guidelines offer a table that can help determine "whether the level of risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high⁴." The table is offered with the caution that "because determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk." We have reproduced CMS' Table of Risk below; the original format can be found in CMS' 2017 Evaluation and Management Services Guide (pgs. 16 – 17) at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>.

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> 1 self-limited or minor problem (ex: cold, insect bite, corporis) 	<ul style="list-style-type: none"> Lab tests w/ venipuncture CXR EKG/EEG UA US KOH prep 	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings
Low	<ul style="list-style-type: none"> ≥ 2 self-limited/minor problems 1 stable chronic illness (ex: well-controlled HTN; non-insulin dependent diabetes; cataract; BPH) Acute uncomplicated illness or injury (ex: cystitis; allergic rhinitis; simple sprain) 	<ul style="list-style-type: none"> Physiologic tests not under stress (ex: pulmonary function tests) Non-cardiovascular imaging studies w/ contrast (ex: barium enema) Superficial needle biopsies Clinical lab tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter drugs Physical therapy Occupational therapy Minor surgeries w/o identified risk factors IV fluids without additives
Moderate	<ul style="list-style-type: none"> ≥ 1 chronic illness w/ mild exacerbation, progression, or side effects of treatment ≥ 2 stable chronic illnesses Undiagnosed new problem with uncertain prognosis (ex: breast lump) Acute illness w systemic sx (ex: pyelonephritis; pneumonitis; colitis) Acute complicated injury (ex: head injury w brief LOC) 	<ul style="list-style-type: none"> Most moderate-level procedures are unlikely to be performed in a family practice clinic Physiologic tests under stress (ex: cardiac stress test; fetal contraction stress test) Diagnostic endoscopies w/o identified risk factors Deep needle or incisional biopsy Cardiovascular imaging w/ contrast but w/o risk factors Obtain fluid from body cavity (thoracentesis, culdocentesis) 	<ul style="list-style-type: none"> Prescription drug management Closed fx or dislocation tx w/o manipulation Therapeutic nuclear medicine IV fluids with additives Minor surgery with risk factors Elective major surgery (open, percutaneous, or endoscopic) w/o risk factors

<p>High</p>	<ul style="list-style-type: none"> • ≥ 1 chronic illness w/ severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (ex: progressive severe rheumatoid arthritis; acute renal failure; psychiatric illness w/ potential threat to self or others; peritonitis, multiple trauma; PE) • Abrupt change in neurologic status (ex: seizure; TIA; weakness; sensory loss) 	<ul style="list-style-type: none"> • Cardiovascular imaging studies with contrast with risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography 	<ul style="list-style-type: none"> • Elective major surgery (open, percutaneous, or endoscopic) w/ risk factors • Drug therapy requiring intensive monitoring for toxicity • Parenteral controlled substances • Decision not to resuscitate or to de-escalate care because of poor prognosis • Emergency major surgery
<p>*note: high risk encounters are unlikely to be seen in the family practice setting</p>			



SuperScribe Tip:

If your provider sees a patient with ≥ 2 **stable chronic illnesses** OR who presents with a **new undiagnosed problem with uncertain prognosis** (such as a lump in her breast), you will want to ensure these “**moderate**” **levels of risk** are supported with enough documentation in the history and physical to receive the appropriate E/M Level of Coding. These moderate risk levels could result in “moderate” levels of medical decision making, which could result in the encounter being coded as an E/M Level 4 chart overall.

E/M Guidelines do also offer several **documentation requirements** in this category⁴:

- Document all “**comorbidities/underlying diseases** or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality”

- For all **surgical or invasive diagnostic procedures** that are⁴:
 - ▶ **Ordered, planned, or scheduled** at the time of the E/M encounter:
 - Specifically document the **procedure type**
 - ▶ **Performed** at the time of the E/M encounter:
 - **Document the procedure**
 - ▶ **Performed on an urgent basis** at the time of the E/M encounter:
 - Document all **referrals for- or decisions to perform the procedure** urgently

As identified above, different presenting problems may connote different levels of possible risk for complication, morbidity, or mortality associated with possible diagnoses.

For example, TJC and CMS's focus on Heart Failure measures identify a set of cardiac risk factors that may be used to rule in– or out– risk for cardiac etiology in a patient presenting with chest pain. These risk factors are identified below, and should be addressed explicitly in the HPI or MDM portion of the note for any patient presenting with chest pain.

CARDIAC RISK FACTORS

- History (Hx) of Obesity
- Hx of Coronary Artery Disease (CAD)
- Hx of Diabetes Mellitus (DM)
- Hx of Hypertension (HTN)
- Hx of Hyperlipidemia
- Hx of Tobacco Use
- Family History (FHx) of CAD with onset < 55 y/o



SuperScribe Tip: Cardiac Risk Factors

The **presence or absence of cardiac risk factors** will almost always contribute to the provider's medical decision making, helping the provider rule-in or out cardiac etiologies for the pain.

For this reason, the **presence or absence** of cardiac risk factors should be documented for any patient present with chest pain.

Likewise, a set of risk factors exists for Pulmonary Embolism (PE) and Deep Vein Thrombosis (DVT), and should be addressed explicitly for any patient presenting with or complaining of chest pain with shortness of breath, shortness of breath alone, or if any of the risk factors identified below are present.

PE/DVT RISK FACTORS

- Hx of Chronic Obstructive Pulmonary Disease (COPD)
- Hx of chronic lung disease
- Birth control use
- Hormone replacement therapy treatment
- Recent surgeries or travels
- Hx of tobacco use
- Past medical or family history of PE, DVT, or blood clotting disorders

As a scribe, you will want to familiarize yourself with the Risk Factors associated with various systemic diagnoses. Specifically, you will want to familiarize yourself with Cardiac Risk Factors, as well as Risk Factors for PE/DVT.



SuperScribe Tip: Documenting Risk Factors in the Provider Note

A phrase such as the one below may be used in the **HPI** or **Medical Decision-Making (MDM)** section of a provider note to address the risk factors associated with PE/DVT for any patient presenting with – or complaining of – **chest pain with shortness of breath, shortness of breath alone, or extremity pain concerning for DVT:**

- **PE/DVT RISK FACTORS:** There is no known Hx of COPD or any chronic lung diseases. Pt denies taking any birth control or hormone replacement therapies, or any recent surgeries or travels. Pt denies any Hx of tobacco use. There is no known PMH or FH of PE, DVT, or any blood clotting disorders.

As you become familiar with the common chief complaints and diagnoses encountered at your facility, you may notice common health risk factors that your providers screen for. As you identify health risk trends, you may want to create template phrases such as the two identified above to use in patient charts to aid in more rapid documentation. You may want to ask your providers if they have any health risk templates or phrases already created that they would like you to use in your documentation.

By documenting the presence or absence of all health problems the provider inquires about during the H&P, you can aid your provider in documenting all health risk factors.

Coding Criteria for the 4 Contributory Factors

E/M Levels of Service are also determined by the contributory factors identified below. It is important to note that coordination of care and nature of presenting problem are not necessarily required for E/M Coding.

Contributory Factor #1: Counseling

In relation to office E/M Service documentation guidelines¹⁵⁶, **counseling** can be defined as: “a discussion with the patient and/or family concerning the patient’s evaluation, management, risk of treatment, prognosis, and other relevant issues¹⁵⁶.”

Medicare’s documentation guidelines further describe counseling as a discussion with the patient and/or family regarding one or more of the following¹⁷:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management or treatment options
- Instructions for management or treatment and/or follow-up
- Importance of compliance with chosen management or treatment options
- Risk factor reduction
- Patient education

Counseling often includes the patient in the medical decision making process, which is a core feature of patient centered care^{157,158}. Counseling can contribute to an encounter’s overall E/M service level either directly or indirectly. Three common types of counseling encountered in the family practice setting are:

- **Updating the patient on the encounter progress**, including: diagnostic results, clinical status and prognosis, care process, management options, recommendations for treatment/care, and possible risks. This type of counseling may be documented in a progress note within the patient’s medical record as follows:

“I updated the patient on [the patient prognosis/care process/management options/risks]. [Include any additional discussions with the patient]. Patient understands and agrees.”

- **Counseling the patient on possible risks** for significant complications, morbidities, mortalities, and comorbidities pertaining to the presenting problem(s), diagnostic procedures, and possible management options. This type of counseling may be documented in a progress note within the patient's medical record as follows:

"I counseled the patient on the risks and benefits of [a prognosis, procedure, or possible management options], including [risks and benefits discussed]. I feel that the [specific risks/benefits addressed] outweigh the [specific risks/benefits addressed]. I recommend [document provider's recommendation]. The patient understands and agrees with this plan."

- **Providing information to facilitate autonomy, self-care and health promotion**¹⁵⁹. This type of counseling often meets MACRA Quality Payment Program criteria^{115,129,134}. Additionally, CMS often has structured guidelines that must be met in order for this type of counseling to qualify as a billable service¹⁶⁰.
 - ▶ For example, for **Smoking and Tobacco-Use Cessation Counseling** to qualify as a billable service according to CMS¹⁶⁰.
 - The patient must **use tobacco**, regardless of whether signs or symptoms of tobacco-related disease exist
 - The patient must be **competent and alert when counseling is provided**
 - The counseling must be furnished by a qualified physician or Medicare-recognized practitioner

In general, patient education counseling may be documented in a progress note within the patient's medical record as follows:

"Given [reason/medical necessity for counseling; ex: 'patient's history of tobacco use'], [name and credentials of individual who provided the counseling; ex: 'I, Dr. J, MD'] counseled the patient on [patient education provided; ex: 'the health risks of tobacco use and tobacco use cessation']. The patient was competent and alert during the counseling."

Contributory Factor #2: Coordination of Care

In relation to office E/M Service documentation guidelines¹⁵⁶ **coordination of care** may be defined as the provider's "contact with other health care providers on behalf of the patient¹⁵⁶."

Medicare's documentation guidelines for coordination of care are similar to those for

counseling¹⁷. Specifically, coordination of care may constitute a discussion *with other health care providers on behalf of the patient* regarding one or more of the following¹⁷:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management or treatment options
- Instructions for management or treatment and/or follow-up
- Importance of compliance with chosen management or treatment options
- Risk factor reduction
- Patient education

Two formal types of care coordination include **consultations** and **transfers of care**. These care coordination services are associated with specific CPT codes, and therefore are also associated with specific service- and documentation guidelines^{45,161}. 2010 edition of the Current Procedural Terminology (CPT, maintained by the American Medical Association (AMA)) provides the following definitions for these two types of services:

- **Consultation:** *“A type of evaluation and management service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient’s entire care or for the care of a specific condition or problem. ... A physician consult may initiate diagnostic and/or therapeutic services at the same or subsequent visit¹⁶¹.”*
- **Transfer of care:** *“The process whereby a physician who is providing management for some or all of a patient’s problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility, and who, from the initial encounter, is not providing consultative services. The physician transferring care is then no longer providing care for these problems, though s/he may continue providing care for other condition(s) when appropriate¹⁶¹.”*

The AMA also provides the following instructions for **differentiating the two services**:

- *“Consultation codes should not be reported [if a] physician [agrees] to accept transfer of care before an initial evaluation... [However, consultation codes] are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of the site of service¹⁶¹.”*

In order for a service to be considered a consultation, the following criteria must be met and documented¹⁶²:

- The **need for the consultation** must be documented by the consultant in the patient's medical record, and included in the patient's medical record of the requesting provider
- A **request for a consultation** must be made and documented by the consultant and included in the patient's medical record by the consultant and requesting provider
- The name and specialty of the consultant should also be included
- An **opinion must be rendered by the consulting practitioner**. This opinion – along with any other service provided – must be documented in the patient's health record
- **A written report of the consultant's findings and opinion or recommendation** must be communicated back to the requesting practitioner, and should be documented in the patient's medical record.
- The **three key components** of an overall E/M service level – **history, examination, and medical decision making** – must also be documented for a consultation to meet service billing requirements *unless time is determined to be the controlling factor for the E/M level assignment, as discussed below.*



SuperScribe Tip: The “4 R’s” for Documenting Consultations

When documenting a consult, it can be helpful to remember the billing documentation requirements in terms of “the 4 R’s¹⁷.”

- The **request** for the consult (from the requesting physician)
- The **reason** the consultation was requested
- The consulting physician's **rendered services**, including:
 - ▶ History
 - ▶ Examination
 - ▶ Medical Decision Making
 - ▶ Consultant's medical opinion/recommendation
 - ▶ Any additional services rendered
- A **report** of communication of the medical opinion/recommendation provided by the consulting physician to the requesting physician.

SuperScribe Tip: Documenting Coordination of Care

During a patient's encounter, the provider may seek the input of a specialist for any number of different reasons:

- A radiologist may be consulted for his or her expertise in interpreting radiology findings
- For new patients, a patient's old primary care provider (PCP) may be consulted to provide his or her particular opinion on the management of a patient
- A cardiologist may be consulted for advice on how to manage a patient with complicated cardiac symptoms
- A psychiatrist may be consulted to provide input on the risk for harm a patient may cause to him or herself, or for medication management.



SuperScribe Tip:

If a patient requires transfer to another care facility, such as transfer to an emergency department or hospital admission, it will be important to identify and document:

- The admitting provider
- Whether a specialist has been requested for consult
- Whether the admitting provider or specialist has any particular requests or recommendations on consult.

A provider may also consult non-provider specialists, which may include:

- A pharmacist for medication management
- A social worker for input on how to manage long-term care of a patient

Many EMR systems have special methods for documenting consultations. If your EMR does not have a special method for documenting consultations, a note in the Assessment portion of the patient's medical record may suffice. Such a note may appear as follows:

- 14:24 Dr. Jones of Cardiology paged/called. Consult requested.
- 14:30 I consulted Dr. Jones of Cardiology who states [note advice or counsel provided] and recommends [document care or service recommended by the specialist if applicable].

Consultations or Care Transfers may also be used to coordinate patient care after leaving the outpatient facility setting. For example:

- For cases in which a patient is transferred directly to a different care setting, such as in the case of a patient who is admitted into a hospital:
 - ▶ An admitting provider may be consulted by your provider, and may be requested to admit the patient (into the hospital, for example)
 - ▶ An admitting provider may agree to admit a patient, but may request a specialist on consult
- Your provider may be consulted by another provider, and may be requested to see a patient who is being discharged from another service setting (such as a hospital or emergency department) to establish primary care.
- Your provider may transfer care of a patient directly to another provider



SuperScribe Tip: The “4 R’s” for Documenting Care Transfers

The “**4 R’s**” for Coordinating Patient Care¹⁷ should also be documented when transferring patient care from one provider to another (with a few variations, as italicized below):

- The **request** for the care transfer should be documented, including:
 - ▶ The time and date the request was made
 - ▶ The name and credentials of the provider making the request
 - ▶ The name and credentials of the provider to whom the request is being made
- The **reason** the care transfer is being requested
- Any **recommendations for services rendered**, including
 - ▶ Consultations
 - ▶ Diagnostic Studies
 - ▶ Medical Plan of Care
 - ▶ Any additional services recommended

A **report** of communication of the medical opinion/recommendation from the physician coordinating the transfer of care

Contributory Factor #3: Facetime

Time spent on each encounter also contributes to the overall E/M service level an encounter may be coded as. In general, greater amounts of face-to-face time spent with a patient correlate with higher E/M coding levels. However, time can also include work done before, during, and after the encounter⁴. Time is grouped into intervals, which differ according to setting⁴. For this reason, it is important to document the amount of facetime the provider spends with the patient, if dictated by the provider.

Time is not typically a *key* factor in terms of its contributions to the overall E/M Service level an encounter is coded as. However, **for encounters in which counseling and/or coordination of care dominate the encounter and comprise > 50% of the time spent in the encounter, time becomes the controlling factor in determining the encounter's overall E/M service level** (and overrides the 3 key E/M service level factors of history, examination, and MDM)⁴.

In these instances, **the following information must be documented** in order qualify time as the key factor in determining the overall E/M Level of service associated with the encounter¹⁵⁶:

- Overall amount of facetime spent during the encounter
- Amount of time spent involved in counseling or coordination of care
- Nature of counseling or coordination of care
- Any applicable history, examination findings, and medical decision making
- Place and type of service provided

Note: dictation time or time spent obtaining, reviewing, or interpreting previous records or test results may not be included in the time spent counseling or providing coordination of care¹⁷. For this reason, it is important to distinguish when documenting counseling/coordination-of-care-dominated encounters that the time spent involved in counseling/coordinating care is facetime rather than clerical time.

Unless otherwise specified by a provider or by an EHR system template, this information may be documented in a note within the Assessment portion of the patient's medical record as follows:

- **Total time for the encounter:** 30 minutes
- **Counseling &/or Coordination of Care time required,** excluding time spent obtaining, reviewing, and interpreting previous records and tests: 20 minutes
- **Place & type of service:** New patient office visit.

Contributory Factor #4: Nature of Presenting Problem

The Nature of a Presenting Problem can be classified simply as “minimal,” “minor,” “moderate,” or “high severity,” as shown below.

- Minimal: May not require the presence of a provider for treatment.
- Self-limited or Minor: Runs a defined course and is transient or has good prognosis.
- Low Severity: Low risk for morbidity without treatment; full recovery without functional impairment expected.
- Moderate Severity: Moderate risk for morbidity or mortality without treatment; uncertain prognosis or increased probability of prolonged functional impairment.
- High Severity: Risk of morbidity without treatment is high; moderate to high risk for mortality without treatment or high probability of severe prolonged functional impairment.

Note: the nature of a presenting problem directly contributes to the overall E/M level an encounter is coded and billed as. This factor is very similar to that of “**risk for significant complications, morbidities, and/or mortalities**” associated with the **presenting problem(s)**, which is identified in the MDM section above. Both factors are based on “the risk related to the disease process anticipated between the present encounter and the next encounter⁴.” See the information on “Risk associated with Presenting Problem(s) in the section on “MDM Factor #3: Risk of Significant Complications, Morbidities, &/or Mortalities” for further information.



SuperScribe Tip: Review E/M Level Criteria for Each Patient

With your many other responsibilities as a medical scribe, E/M Levels of coding may not be at the forefront of your mind during a shift. It may be helpful to review each patient chart briefly at the end of your shift or before your provider signs each note to ensure all E/M Level coding criteria is met. You may want to keep the **E/M Levels Chart** included in **Appendix A.VI** on your person during each shift for reference.

Review & Assessment

Recommended Resources

1. CMS' 2017 E/M Services Guide:

- CMS: Center for Medicare & Medicaid Services. Evaluation and Management Services Guide. Medicare Learning Network (MLN); U.S. Department of Health and Human Services (DHHS), ed. ICN: 006764. <http://www.cms.gov/> Center for Medicare & Medicaid Services (CMS); 2017⁷.
- Most up to date E/M Service Guidelines for coding and billing
- Includes 1997 and 1995 Guidelines
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>

Review

1. E/M Coding assignments are initially based upon 3 Variable Factors with 3 Key Components and 4 subsequent Contributory Factors identified in a patient's medical record:

3 Variable Factors

- Place of Service
 - ▶ Office, Hospital
- Type of Service
 - ▶ Office visit, Consultation, Hospital Admission, Newborn Care
- Patient Status
 - ▶ New vs. Established

3 Key Components

- History
 - ▶ CC
 - ▶ HPI
 - ▶ ROS
 - ▶ PFSH
- Examination (PE)
 - ▶ General multi-system
 - ▶ Single organ system
- Medical Decision Making (MDM) Complexity
 - ▶ Number of possible diagnoses and/or management options
 - ▶ Amount/complexity of data to be reviewed
 - ▶ Risk of significant complications, morbidity, and/or mortality

4 Contributory Factors

- Counseling
- Coordination of Care
 - ▶ Consultation
 - ▶ Transfer of Care
- Face Time
 - ▶ Controlling factor if counseling/care coordination dominate the encounter
- Nature of Presenting Problem
 - ▶ The presence or absence of specific Clinical Risk Factors may influence or define the nature of a presenting problem

2. Risk is a Determinant for Medical Necessity of Diagnostic Studies. Cardiac and PE/DVT Risk Factors should always be documented whenever included in within a patient's differential diagnosis or in a provider's medical decision making process:

- **CARDIAC RISK FACTORS:** History of Obesity, CAD, DM, HTN, Hyperlipidemia, and Tobacco Use; FHx of CAD with onset < 55 y/o.
- **PE/DVT RISK FACTORS:** History of COPD, chronic lung disease(s), birth control use, hormone replacement therapy treatment, recent surgeries or travels, tobacco use; PM or FH of PE, DVT, or blood clotting disorders.

3. To attain the highest E/M Coding Level (Level 5) when prudent, all 3 key component qualifiers below must be achieved:

HISTORY:

- HPI must contain ≥ 4 elements
- ROS must contain 10 organ systems
- PFSH must contain 2-3 pieces of information

PHYSICAL EXAMINATION:

- General Multi-System Examination must contain $\geq 8 - 9$ Organ Systems

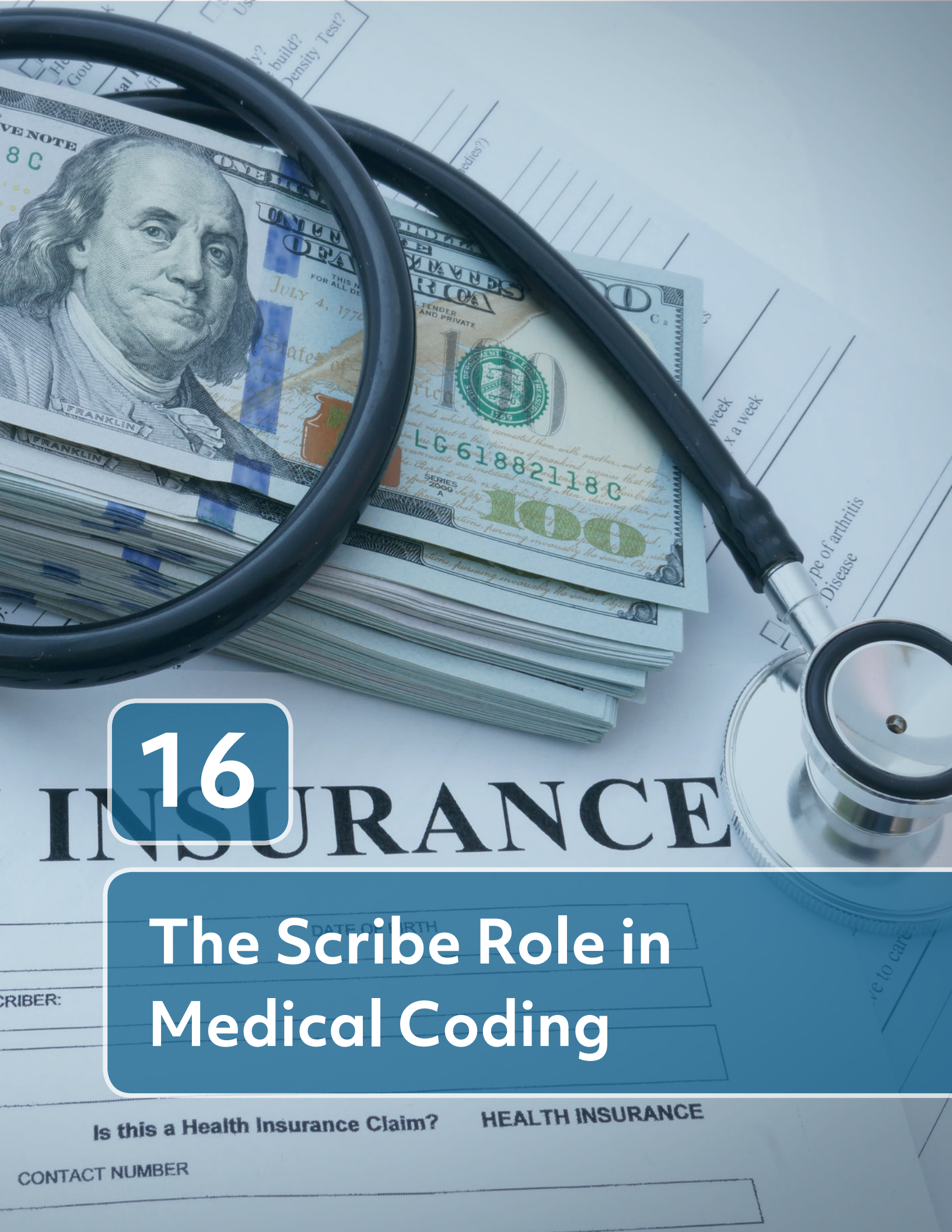
MEDICAL DECISION MAKING:

- Extensive number of diagnoses (including a DD) or management options
 - ▶ Differential Diagnosis identified
 - ▶ All presenting problems with- and without established diagnoses are identified as such, and their control- and likelihood of contributing to the definitive diagnosis are identified with proper E/M terminology
 - ▶ Management Options considered and selected are identified, including all initiation of- and changes in treatment
 - ▶ All referrals and consultations made are documented, including who the communication was made to
 - Extensive amount or complexity of data
 - ▶ Old records are reviewed, pertinent information is updated
 - ▶ New diagnostic studies are reviewed and documented appropriately
 - ▶ Diagnostic studies and findings are discussed with other providers and with patient
 - ▶ Risks (co-morbidities/procedures ordered or performed) are documented
 - High Risk of Complications or death if condition goes untreated
 - ▶ One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment are thoroughly documented
 - ▶ Acute or chronic illnesses or injuries that threaten life or body function are documented
 - ▶ Abrupt changes in neurological status are thoroughly documented
 - ▶ All surgical or invasive procedures considered, planned, ordered, &/or performed are thoroughly documented
4. The 3 variable E/M factors, 3 key E/M components, and 4 E/M contributory factors^{7,86,87} are used to determine what level a chart will be coded at. This determines the amount of reimbursement a provider can receive for medical services rendered. Within the 10 E/M Level determinants above, further coding levels exist for each key component and contributory factor within a given level.

Assessment

1. Your provider sees a patient who s/he has seen previously but who has lived abroad for the past 4 years and was seen by a different group practice during that time. Would this patient be considered a “new” or “established” patient? Why? What documentation guidelines must you meet to ensure this patient’s care receives full reimbursement?
2. Your provider sees a patient who s/he has never seen previously, but who was recently seen last week by a different provider from the same group practice. Would this patient be considered a “new” or “established” patient? Why?
3. List the number of elements required in the comprehensive documentation of the following portions of a provider note:
 - HPI:
 - ROS:
 - PMFSH:
 - PE:
4. What are the E/M Guideline requirements regarding documenting the provider’s:
 - a. Assessment/Clinical Impression/Diagnoses
 - b. Initiation of-, changes in-, and patient/problem response to treatment
 - c. Consultations, referrals, and advice sought
5. What are the E/M Guideline requirements regarding documenting the provider’s:
 - a. Decision to obtain and review old medical records and/or history
 - b. Discussion of contradictory or unexpected test results with the conducting physician
 - c. Personal review of diagnostic tests results ordered during the E/M encounter
6. What are the E/M Guideline requirements regarding documenting the provider’s:
 - a. Assessment of risk related to the disease process of the presenting problem(s)
 - b. Decision to order, schedule, or perform diagnostic or invasive procedures
 - c. Assessment of risk immediately following any diagnostic procedures
 - d. Assessment of risk associated with possible management options
 - e. Consideration of comorbidities or underlying disease or factors

7. A patient receives an EKG. What chart level is required for this patient?
8. What are “The 4 R’s” that must be included when documenting a consultation or transfer of care?
9. You see a patient who is a 2 pack/day smoker x 10 years and mentions feeling shorter of breath recently. The provider spends most of the encounter counseling the patient on smoking cessation, and in the provider’s encounter he dictates for you to document. What pieces of information regarding the patient’s history, the provider’s MDM, and the overall encounter will be important for you to document in the patient’s chart? If you are unsure of some of these pieces of information, how can you verify them?



16

The Scribe Role in Medical Coding

Is this a Health Insurance Claim?

HEALTH INSURANCE

CONTACT NUMBER

Tying It All Together

“If a service was not documented, it was not performed⁴.” This simple healthcare adage conveys the importance of thorough and accurate documentation in the healthcare setting, which is critical for accurate billing and insurance compensation, legal protection from malpractice, and logical explanation of the provider’s assessment and plan for other providers. The scribe’s fundamental role

is to ensure that all services rendered during a patient’s encounter are properly documented in the patient’s chart. Services may range from obtaining a history and physical exam (H&P) and consulting a specialist to obtaining and interpreting laboratory and radiology studies or prescribing prophylactic or prescription medications.

All of these services require accurate documentation, and the documentation must accurately reflect the quality of the service⁴. For example, when obtaining a physical examination (PE), a provider may perform a Comprehensive Multi-System Examination that examines at least 2 elements within

“If a service was not documented it was not performed”

– CMS’ 2017 E/M Service Guide⁴

at least 9 different organ systems, or a provider may perform a Comprehensive Single-Organ Examination, examining all identifiable elements within one single organ system. On an abdominal examination, palpitation for masses may constitute one element and auscultation of bowel sounds may constitute another element within the examination of the abdomen. Alternatively, the provider may perform a simpler Problem-Focused Single Organ System Examination, examining only one or two elements within one organ system.

A provider may select a given level of examination based on the patient’s specific symptomatology and presentation. The number of possible diagnoses and number of management options considered primarily govern the provider’s decision to perform a more or less comprehensive or focused examination. This decision is further influenced by the patient’s chief complaint and subjective needs, the complexity of the patient’s past medical history and risk factors for significant complications or co-morbidities, which may entail specific management options, as well as other important variables considered and typically identified in the provider’s Assessment. All of these considerations require thorough documentation.



SuperScribe Tips for Success:

- **DOCUMENT EVERYTHING** that is **PERFORMED**.
- If you are unsure: **ASK!**
- If you don't have enough information: **ASK!**
- **IF YOU ARE AFRAID TO ASK:** Designate a “time for questions” with your provider.

SuperScribe Application: The Importance for Thorough Documentation

If a patient with multiple co-morbidities including liver failure, renal insufficiency, diabetes mellitus (DM), and a history of alcohol abuse presents to your outpatient facility and complains of **syncope**, the provider may determine that a **complete multi-system examination** is required to assess the effects of the patient's various co-morbidities in order to determine an appropriate **plan of care**.

The provider will want to examine the patient's abdomen for signs of liver problems, including **hepatomegaly** or **abdominal distension**. The provider will want to assess the patient's skin for **jaundice**. A **psychiatric examination** may be important to determine any effects of alcoholism including intoxication or withdrawal symptoms such as **delirium tremens (DT's)**, hallucinations, or **withdrawal seizures**.

Beyond the physical examination, the provider will likely order a large battery of laboratory studies, including **CBC, CMP, UA, LFTs, Urine Drug Screen**, and **Cardiac Enzymes** to **rule out cardiac etiology** of the syncope. The provider will order an **EKG** in accordance with **TJC's Core Measures**, and may also order **imaging of the abdomen** to further assess the size and shape of the liver and kidneys.

This thorough examination requires a more thorough encounter, with more thorough services rendered to the patient than, for example, a healthy young woman who presents with an earache. All services provided for any patient should be accurately documented in the patient's chart; in the case of the patient with multiple co-morbidities, the provider will want documentation to reflect the more thorough physical examination performed, the higher **level of complexity** involved in his or her **Medical Decision Making (MDM) process**, and justification for all diagnostic studies ordered and reviewed, including **TJC compliance in obtaining an EKG for a syncopal patient**.

In this case, the amount of compensation the provider receives for his or her time and services will depend upon accurate documentation reflecting all services rendered. If the scribe neglects to document the skin portion of the physical examination the provider will not receive compensation for that service. Moreover, any other provider may question why that provider did not check the skin for jaundice. Some of the laboratory studies the provider orders may be questioned regarding their **necessity**, given the assumption that the provider did not bother to check for jaundice on the skin examination. As we will see in **Module IV**, the provider could risk conviction of **malpractice**.

Likewise, if the patient history of renal insufficiency is not properly documented in the patient's **Past Medical History (PMHx)** the provider's skin examination for jaundice may not seem necessary, nor will the Liver Function Tests (LFTs) or any subsequent imaging the provider orders. If the medical necessity of these services is not properly documented, the services may not receive adequate compensation from insurance companies or other health care services. Again, the provider may risk conviction for **malpractice**.

For these reasons, your **thorough and accurate documentation** as a scribe is critically important to your provider's legal protection.

As a scribe, it is not your job to determine the level of evaluation and management a patient receives; this decision is the provider's responsibility. Neither is it your responsibility as a scribe to determine which E/M level a chart will be coded and billed at; this is the responsibility of your facility's coding and billing staff.

However, it is important for you as a scribe to be aware of the different E/M criteria as you document each chart. It is critically important for you as a scribe to ensure all E/M criteria the provider obtains is documented within the chart. Moreover, you may prompt a provider who seems to be missing some certain criteria (a piece of information in the history, for example) to ensure the appropriate E/M criteria is met.

With your many other responsibilities as a scribe, E/M Levels of coding may not be at the forefront of your mind during a shift. It may be helpful to review each patient chart briefly at the end of your shift or before the provider signs each note to ensure all E/M Level coding criteria is met. The E/M Level Coding Chart in A.VI may also provide a helpful tool to keep on your person as you begin your clinical training and work.

Review& Assessment

Recommended Resources

1. CMS' 2017 E/M Services Guide:

- CMS: Center for Medicare & Medicaid Services. Evaluation and Management Services Guide. Medicare Learning Network (MLN); U.S. Department of Health and Human Services (DHHS), ed. ICN: 006764. <http://www.cms.gov/> Center for Medicare & Medicaid Services (CMS); 2017⁷.
- Most up to date E/M Service Guidelines for coding and billing
- Includes 1997 and 1995 Guidelines
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>

Review

1. As a medical scribe:
 - It is not your responsibility to determine the level of workup a patient receiving care from your provider should receive; this is the provider's responsibility.
 - It is not your responsibility to determine which E/M level a chart will be coded and billed at; this is the responsibility of your facility's coding and billing staff.
 - It IS important for you to be aware of the different E/M criteria as you document each chart so that you can better help your provider ensure complete and accurate documentation and E/M coding and billing.
2. According to the Center for Medicare & Medicaid Services (CMS) 2017 Evaluation and Management (E/M) Service Guide: "If a service was documented it was not performed?"
 - The role of a Clinical Scribe is to assist the provider in ensuring all services that *are* performed are appropriately documented in the medical record.
3. The following suggestions are provided for clinical scribe documentation:
 - **DOCUMENT EVERYTHING that is PERFORMED.**
 - If you are unsure: **ASK!**
 - If you don't have enough information: **ASK!**
 - **IF YOU ARE AFRAID TO ASK:** Designate a "time for questions" with your provider.
4. Additional resources that can be helpful for appropriate medical documentation and coding are available in the appendix (Appendices A.III – A.VII) and in the resources tab of the CSAT website at: www.scribeACCELERATOR.com. These include:
 - Appendix A.III. Family Medicine Documentation Basics
 - ▶ Provides important "How To" information for family medicine scribes
 - Appendix A.IV Documentation Basics for Common Chief Complaints in Family Medicine
 - ▶ Includes common orders and workup services to anticipate and important components to include in documentation to demonstrate medical necessity for most services that are likely to be ordered and rendered and meet E/M criteria.

- Appendix A.V. Documentation Basics for Preventive Measures in Family Medicine
- Appendix A.VI E/M Level Coding Criteria
- Appendix A.VII. Hierarchical Condition Category Coding and Risk Adjustment Factors (HCC and RAFs)

Assessment

1. How do the contents of this chapter apply to you as you prepare to begin your role as a Clinical Scribe? What are 5 actions you can take to help prepare for success and ensure the most thorough and accurate documentation?
2. The timeline in Chapter 12 mentions concepts of HCC and RAF. These concepts are also addressed in Appendix A.VII. What are HCC and RAF? How do they apply to you as a clinical scribe? How do they relate to E/M Coding?
3. Review Appendices A.III – A.VII.
 - a. What are 5 tips that you found helpful in Appendix A.III?
 - b. What are the common chief complaints identified in Appendix A.IV?
 - c. What are the Preventive Measures identified in Appendix A.V?
 - d. Print out the E/M Level Coding Chart (Appendix A.VI) and save this (in print or in an electronic format that is compliant with your facility's HIPAA policies) that you can use in your role as a clinical scribe. Where will you save this? How will you use this?

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