

# Productive Provider Newsletter

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## M.P.E.C.S. Medical Professional Education and Consultation Services

Jim Meeks, P.A.-C.

Understanding Today's Healthcare,  
Serving Today's Patients,  
Meeting the Needs of Today's Practice.

**W**e continue to grow. Welcome to our expanding group of subscribers. Thank you for your interest.

It is my pleasure to bring to you the **Productive Provider Newsletter**. Through this publication, I attempt to bring you timely, thoughtful and valuable information on the confusing topic of Evaluation and Management (E&M) coding.

Please feel free to respond, comment and suggest on the content of this newsletter. For more information about me and on what I am doing, please visit me at [www.mpecs.org](http://www.mpecs.org). Also, feel free to forward this E-Zine to anyone you feel may be interested in learning more about E&M coding.

Thanks, enjoy this newsletter and have a great day.

### **AT A GLANCE:** In today's Productive Provider Newsletter

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**3. Becoming An Enlarger**

How To Become An Enlarger by Dr. John C. Maxwell

Productive Provider Newsletter

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## 1. Its Just MY Opinion

Earlier this month, I read a JAMA editorial comment by William G. Plested III, MD., Chair of the AMA Board of Trustees. The article was dated April 5, 2004. He raised some excellent points that I would like to comment on, just to express my opinion. Much of what he said is right on.

His comments focused on the “shocking state of physician reimbursement.” He mentioned the “peculiarly oppressive legal system that controls every facet of our professional lives.” This system, prevents him from making specific recommendations about what to do because any effort to do so could be construed to be a violation of antitrust laws.

He observes that giant insurance companies “merge to form what by any definition would constitute a monopoly. And then -- surprise -- they seem to adopt uniformly strict reimbursement policies.”

“Even the smallest evidence of concerted action by a group of physicians who are not legally affiliated would be met with immediate and crushing retaliation by federal regulators -- simply to send a message.”

He advocates that physicians (to me, this means all healthcare providers) perform a very personal and careful review on the subject of reimbursement. “Without a careful personal evaluation, how can anyone hope to understand if they truly are fairly paid or not?” Attention to developing a list of solutions is emphasized.

At this point, let me share three recent headlines that made me a little hot under the collar. Read these and see if you don't have some kind of gut response to the messages.

The first is from the Wall street Journal, April 16, 2004. **UnitedHealth first-quarter net rose 37 percent as medical claims eased.** “UnitedHealth Group Inc. has posted a 37 percent increase in first-quarter net income and raised its full-year earnings forecast, as insurance premiums have kept ahead of slowing increased in medical costs.”

**Minnesota HMOs find they're flush with cash.** “Blue Cross and Blue Shield of Minnesota has had such a good financial performance in 2003 that it now has too much money, with financial reserves that are \$30 million above a ceiling set by state law.” Minneapolis Star Tribune, April 16, 2004.

**At \$94.2 million, UnitedHealth Group CEO is Minnesota's highest-paid.** “The highest-paid corporate executive in Minnesota in 2003 was UnitedHealth Group Inc. Chairman and CEO William McGuire, who received \$94.2 million in total compensation from the nation's largest health-services provider, according to corporate documents.” Minneapolis Star Tribune, April 13, 2004.

I see headlines like these from time to time that really make me question the equity in the current “reimbursement” system. As the cost of doing practice continues to rise higher and higher, payment for services to healthcare providers continue to fall. It appears that at least some insurance companies and their executives are doing well, while you and I struggle to keep up to the cost of doing business.

I recently spoke to an individual in a practice that was trying to get all the providers in their clinic together with the billing staff to discuss superbills, coding and billing. There were problems with consistency between providers and their billing practices. The hope was that all the providers and the billing staff could learn to code consistently and correctly for services they provided. The result was that the practice hired a “billing expert” to deal with it.

What they appear to have failed to realize is that it is the providers that determine the level of payment for services by the level of care they provide and the level to which they document that care in the patient record, long before it ever gets to the billing office. If there is no effort to develop some consistency right at the point of service, all the billing experts on the block will not make much difference.

There is just too much guessing going on when it comes to coding for patient care services. It is the provider's responsibility to know which is the correct code, based on the care provided. Billing staff should be support for that process, not the sole source for it.

When I see headlines like the ones I have mentioned here, I am aggravated at the power over healthcare providers that the insurance industry seems to have, especially in areas where one large company seems to dominate the market. I sense similar frustration with the situation when I speak to providers and work with practices. Everywhere I go, it is the same.

I think it is time that every healthcare provider do as Dr. Plested recommends, perform a personal evaluation on your level of performance. Are you fully confident in your E&M coding? Are you relying on billing staff or even billing software to make your coding selections for your? Electronic charting helps, but so far, my experience shows me that these systems are not perfect yet. If you as a provider are not completely comfortable with selection of E&M codes, you are most likely selling yourself short when it comes to getting paid for the work you do.

Now is the time for you to invest in your success. Code correctly, code aggressively, code for PRACTICE PROFITABILITY.

It's just my opinion.

**ADVERTISEMENT:**

How often do you struggle with the choice between which levels of service to bill for? Is it a 99213 or is it a 99214? Do you know the specific elements of exam that determine which level to choose? Are you confident in your selection? Unless you have immediate access to a current CPT book, you risk potential down coding in your daily practice. Wouldn't it be great to have a quick reference that you could easily refer to in the exam room, the hospital, care center or where ever you are seeing patients?

The POCKET CODER© is the answer! It is perfect for your daily practice. It will solve your E&M code questions and eliminate down coding from your practice. Order yours today on line at [www.mpeccs.org](http://www.mpeccs.org).

## 2. OK, one more time.

Just a couple of weeks ago, I had the distinct pleasure of speaking at the California Association for Nurse Practitioners (CANP: [www.canpweb.org](http://www.canpweb.org)) conference in Monterey, California. Not only was the location a great place to visit, but what a wonderful group of healthcare providers. The three hour session was full of interaction and great learning. I sensed a real interest on the part of those attending in how to improve their coding.

There is so much confusion about E&M coding. The complexity of the coding system really becomes evident during these sessions. It is always a great experience to work with practicing providers on this important topic.

One topic that comes up everywhere is that of TIME. A couple of months ago, I did a lengthy article on time in this Productive Provider Newsletter and I do not want to repeat the entire article here. What I would like to do is clarify one question that I hear over and over.

Each of the evaluation and management codes (99201, 99211, 99202, 99213, . . . ) for office visits, have a time assigned to them. For example, the time for a 99213 level of care is 15 minutes. For a 99214, it is 25 minutes.

Some hospital visits, consultations, nursing home visits and other encounters also have time assigned to their respective CPT code. These times are conveniently listed in the POCKET CODER©. You can also find them in your current copy of CPT 2004.

Here is the question I hear all the time. "If I only spend 13 minutes with the patient, do I have to bill a level 99212 because I didn't spend 15 minutes with the patient to qualify for a 99213?"

The simple answer is a flat out **NO!**

If you do the work for a 99213, no matter how much time is spent doing it, you bill for that level of care. Time is not the determining factor. There are no minimum time requirements for any patient encounter.

Time is the **controlling factor** ONLY when counseling and coordination of care dominate (>50%) the provider/patient and/or family encounter. That is the key. If you spend 7 minutes (or whatever) doing your exam and 25 minutes counseling the patient or a care giver, or coordinating care for the patient, you have just spent 32 minutes providing care. You can then use time as the criteria for selection of the correct E&M code.

Thirty two minutes exceeds the 25 minutes listed for a 99214 level office visit of an established patient. If you have documented your time and the content of the counseling and coordination of care, you can then use the 99214.

This should never be construed to mean that in order to qualify for 99214 service, you are required to spend 25 minutes with the patient. As long as you meet the criteria for collection/review of history, exam and/or medical decision making for that level, time is NOT considered in selecting the level of care.

One recommendation I do make is that if you are going to use time as the factor for selection, you document your start time and stop time in the patient record. That way, if anyone ever questions your method for determining how much time you spent with the patient, it is documented. There is no written requirement to do so, but I highly recommend it.

I hope this information is helpful.

## PRACTICE PROFITABILITY WORKSHOPS:

MPECS is dedicated to making your practice of medicine more productive, more profitable and ultimately more enjoyable. My comprehensive 4-hour PRACTICE PROFITABILITY workshop focuses on exactly what you need to know, the specifics of documentation and coding. If you ever find yourself questioning which E&M code you should use, you need this workshop!

The next MPECS workshop is scheduled in Salt Lake City on April 24, 2004. The web site has the current details. Mark your calendars and register early! Please visit [www.mpecs.org](http://www.mpecs.org) for more information.

Other conferences where I will be speaking:

- Society of Urologic Nurses and Associates Conference, October 25, 2004, Orlando, Florida
- Association of Family Practice Physician Assistants Conference, Nov. 3-7, 2004, San Antonio, Texas

## 3: *Becoming An Enlarger:*

How To Become An Enlarger by Dr. John C. Maxwell

Former NBA star Bill Russell won nine consecutive NBA titles as a player and added two more titles as a player/coach. I wasn't surprised to hear what he said about great team players: "The most important measure of how good a game I played was how much better I'd made my teammates play."

One of the qualities of a great team player, you see, is that they enlarge others. Bill Russell isn't just a large man; he's a man who enlarged others. He made them better.

Here are five characteristics of people who enlarge others.

1. Enlargers value their teammates. When you think about your teammates, place a "10" on their heads. If we think of others as 10s, we'll do everything to add value to them. Our behavior is totally different when we think of someone else as a two. . . .

2. Enlargers know and relate to what their teammates value. Here's how you can tell if you value people: Do you value people who won't benefit you or only those who might contribute in some way to your success? Great team players truly value others as people. . . .

3. Enlargers add value to their teammates. Whatever the project, task or situation, enlargers find ways to make others around them better because they approach life as a win/win situation. They realize that making others better isn't just better for others, it's better for everyone.

4. Enlargers make themselves more valuable. You cannot give what you do not have, so self-improvement precedes team improvement. The first step toward improving the team is to improve yourself. I've been teaching leadership for 20 years and I've written 20-some books. Here's what I know--the only way I can keep leading is to keep growing. . . .

5. Enlargers initiate. Enlargers believe in others before they believe in themselves, serve others before they serve themselves, and add value to others before they add value to themselves. See the common thread? The word "before."

Initiate. Enlarge. Be a great team player.

. . . Adapted from Dr. John C. Maxwell's e-newsletter ([www.maximumimpact.com](http://www.maximumimpact.com))

### **Please, PASS IT ON!**

If you like what you see, please recommend and forward this newsletter to anyone that is interested in using Evaluation and Management codes more effectively, and in becoming more productive in his or her medical practice.

If you are receiving this as a forwarded message, and you want your own subscription, visit our web site at [www.mpecs.org](http://www.mpecs.org) and sign up on the "Site Mailing List."