Productive Provider Newsletter

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AT A GLANCE:

In this month's *Productive Provider Newsletter*

FRONT PAGE:

It's Just My Opinion
We face some interesting competition in keeping patients in our practices.

Give yourself a $25,000 raise!
. . . that by coding properly for patient encounters, they were able to realize $25,000 in additional billings "without adding patients, services or staff."

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It's Just My Opinion

I am really amazed at some of the situations I encounter as I talk to people about coding and billing issues. Not to long ago, I spoke with a healthcare provider that was employed to work in a family practice clinic. There were three or four providers working in this practice. Often, three were working at the same time in a small office that only had 4 exam rooms. This individual was relegated to a "modified closet" to use as an office. The explanation for this situation was to keep costs low.

I am sure that I don't have to tell you what a day in the life of one of these providers could be like, especially on one of those busy days we all have from time to time. What about the patients?

I once saw a newspaper comic that showed a patient checking in with the receptionist at a doctor's office. The receptionist informed the patient that he was 45 minutes late for his scheduled appointment. The patient's response was that since he always had to wait at least an hour to be seen anyway, he figured that now the wait should only be about fifteen minutes.

A couple of things come to mind here. First, what is a patient's perception of how our practices operate? Do we offer an efficient and courteous office experience? Or, are our patients met with a long wait in the waiting area followed by a nearly equal length of time waiting in the exam room? How does our staff handle these problems

See Opinion on page 2 . . .

Give yourself a $25,000 raise!

Who would turn down a raise? A rather rhetorical question, but valid none the less. The truth of the matter is that many medical practices walk away from money they have earned without giving it a thought. It is almost as if someone were offering $100.00 for a service only to have that practice say, "No thanks, I'll take only $80.00."

If the healthcare providers in your practice frequently down code office visits (or any other patient encounter) just to play it safe, they are walking away from money they have earned, leaving it on the table for the insurance company to keep.

An article in Medical Economics just last year[1], illustrated this point very well. This article sites government sources when it points out that in 2003 there were nearly one BILLION dollars in underpaid (under coded) claims submitted to Medicare. Now, that is just Medicare. I don't think anyone can guess how many under coded claims are submitted to all of the other insurance companies. The dollar value must be enormous.

The author reports that a group of doctors in a Louisiana multi-specialty practice were "stunned" to discover that by coding properly for patient encounters, they were able to realize $25,000 in additional billings "without adding patients, services or staff."

Certainly, there are many variables to consider when you look at the billings of any provider or practice. I am frequently amazed by how many providers admit to

See Raise on page 3 . . .

M.P.E.C.S.

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

MARK YOUR CALENDARS

PRACTICE PROFITABILITY WORKSHOPS and LECTURES:

MPECS is dedicated to making your practice of medicine more productive, more profitable and ultimately more enjoyable. The comprehensive MPECS 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!

MPECS workshops and lectures are now being scheduled;

UP-COMING MPECS WORKSHOPS;

Lehi, Utah May 6, 2006

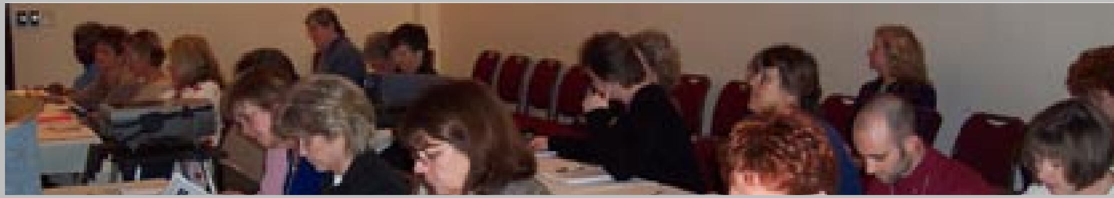
This workshop is being held at the world famous Cabela's - "The World's Foremost Outfitter"

CONFERENCE LECTURES;

NPACE September 14, 2006
Chicago, Illinois
www.npace.org

AFPPA November 3, 2006
Phoenix, Arizona
www.afppa.org

The 2006 schedule is now open. Need a conference speaker? Give us a call. We'll talk!



Opinion

when we are legitimately late due to some emergency? Are the patient's needs met? If not, how long will they keep coming to our practice?

Recent news reports have described a new type of medical facility that may be coming to your local grocery store. A walk in clinic that offers basic medical care for common problems such as a sore throat, a cold, cough or other minor complaints. The concept is one of convenience for the consumer. In my area, the insurance company that insures more lives than any other in the entire state, just announced that they are going to open one of these facilities in a local grocery store as a trial. If the concept is successful, they plan to expand the service. These services are offered at a lower co-pay for the insured and cheaper cash prices for the uninsured.

On the other end of the spectrum, we have been hearing about concierge medicine. A service where a patient pays an annual premium to a healthcare provider in exchange for nearly exclusive patient care. This is above and beyond what a patient may be paying for health insurance. The provider limits their practice to a few hundred patients and can then offer same day visits with no waiting, personalized care, longer appointments, accompaniment to specialist appointments and so forth.

In the middle of these two types of medical care are the standard practices we are all so familiar with. Some function well. Others seem to struggle with every detail of making it through the day.

No matter what type of specialty or practice we may work in, we have to be aware of the customer (patient). In some areas of the country, insurance companies are limiting their panels and not allowing any additional providers into their system. We have seen this here in our area by the same insurance company that is experimenting with the grocery store clincs. At the same time, they have opened other urgent care facilities that soon evolved into family pracitce and work-med facilities as well. In the mean time, the independent practices are being squeezed by increased costs from every direction. Forced to see more and more patients and spend less and less time with each one just to keep the business part of the practice functioning and to pay the bills.

Ultimately, what may happen is that our patients may opt for one of these other options. Some because of the convenience of walk in service. Others for other reasons. The list of reasons patients may leave our practice is probably endless.

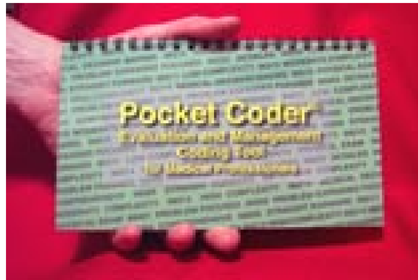
I recognize that some practices may not have to worry much, especially if they are the only game in town, but it pays to be aware of the current trends and patient concerns. Have you ever asked a patient why they come to your practice? Are they happy with the care and the SERVICE they get? Would they recommend your practice to a friend or family memeber? Have they ever felt like they were simply part of a "meat market" as they were run through the office visit?

I often ask new patients in our office how they found us and on repeat visits, I ask if they are satisfied with the care they receive. These questions serve two purposes. First, I ususally get some really excellent feedback and secondly, I believe that it shows the patient that I am interested in them beyond the co-pay and prescription pad.

I have seen some interesting patient encounters during my career. I'll never forget observing a provider walk into a patient room with the patient chart in hand, lean up against a counter across the room from the patient and began asking questions about their complaint. He wrote in the chart as the patient responded to his questions, never looking up. When he was satisfied with the information, he performed a very brief exam and returned to lean against the counter, this time with the prescription pad in hand. He wrote out a couple of prescriptions, handed them to the patient instructing them to "take these" and walked out of the room. I observed this not once, but many times in this practice.

Once in a while, I hear patient complaints about office staff. They seem to love

See Opinion on page 4 . . .



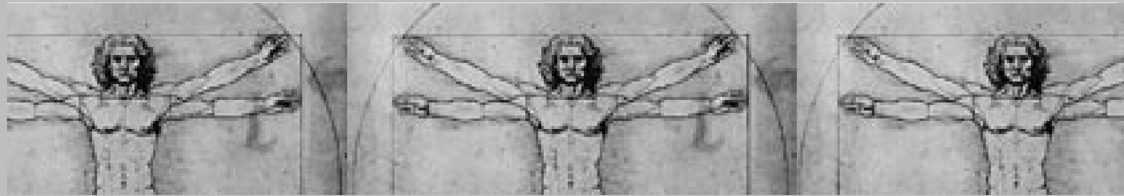
UPDATED CODER

Do you know the specific elements of documentation that determine which E/M code you should use? You are not alone if you are still struggling with this process. Updated with changes for 2006.

Get the new ***POCKET CODER***.

A pocket sized quick reference that you can easily refer to in the exam room, the hospital, care center or wherever you are seeing patients. Fully comprehensive, covering all practice settings, it will eliminate guesswork and down coding from your practice.

Order yours today online at www.mpecs.org/products. It is a must for every provider.



Raise . . .

being confused about Evaluation and Management (E/M) coding guidelines. A recent survey conducted by AdvancePracticeJobs.com revealed that 92% of respondents believe that E/M coding is confusing. The problem is when providers and practices allow that confusion to lead to under coding for E/M services.

Why all the confusion? I believe it is a result of the complexity of the E/M coding system. For every encounter, we are required to consider history of present illness, review of systems, past medical, family and social history, physical exam findings and medical decision making when we decide what code to use.

For a number of years, I have collected all kinds of charts and graphs, slide rules and protractor type coding tools. Everyone of these has lacked the information I thought was important, details on what elements are required for each type of encounter in a simple to understand format.

Computer programs for coding are a great help. They are very adept at counting the elements of the exam and all of the history information. The area where I have seen computer programs struggle is in the medical decision making (MDM) process because there are no elements to count. MDM is the most complex and often the most error prone area in the code selection process, not only for providers and billers, but for the computer software as well.

In my own practice where we use a very good electronic medical record (EMR) program, it has been my experience that about once a day, I will have to correct the EMR's coding recommendation. Most often related to some aspect of the MDM process. I recommend that you review "It Happened Again," an article I wrote in May 2005 for the Productive Provider Newsletter (www.mpecs.org/newsletter) that illustrates the potential cost of such errors in coding.

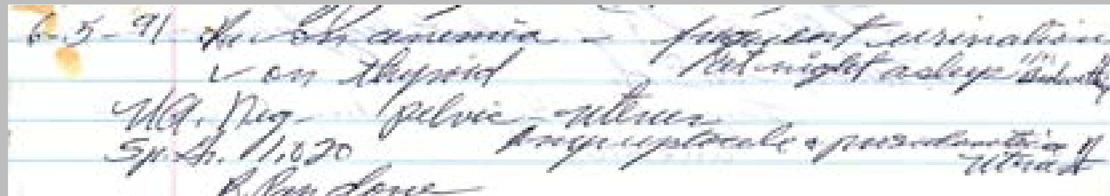
For some time, as I have taught E/M coding workshops, I have kept track of the reasons that providers and billing personnel under code for E/M services. I have identified 5 main areas;

- **Unfamiliarity** with the Evaluation and Management Coding system. Not knowing what the difference is between 99212 and 99213 or 99202 and 99203, etc.
- **Superbill ambiguity.** Vague or nondescript terms on superbills such as "brief," "limited," "extended" and so forth.
- **Fear of audits.** Statements like "I don't want to overcharge" and "I use the same code all the time so I won't get audited" are reflections of poor understanding of the coding process.
- **Lack of time.** A perceived lack of time to document essential information necessary for medically appropriate coding. Two extra minutes spent documenting elements of an encounter can result in significant return on the investment.
- **Lack of training.** Poorly trained or supervised coding and billing staff personnel are the problem. This includes providers too. If a provider doesn't understand what needs to be documented then the coding will be incorrect. It may be over coded or it may be under coded. Both results are detrimental to a successful medical practice.

There are many other areas that cause coding problems, too many to list here. It is essential that every practice understand the E/M system. The only way to do so is to learn how to use it. I have spent the past ten years teaching elements of documentation and coding as they relate to billing and building a successful medical practice. All while actively working in a day-to-day medical practice. I have a unique perspective you will not see many other places.

If you want to get a handle on E/M coding and significantly reduce or eliminate coding problems in your practice, here is your chance. On Saturday, May 6, 2006, I am hosting a comprehensive 4 hour coding workshop. I invite you to attend this

See RAISE on page 4 . . .



Raise . . .

essential event. The first hour is devoted to documentation and what is essential in the encounter note. The second hour focuses on E/M coding requirements. In the third hour, we discuss the MDM process in depth. And finally, we spend the fourth hour reviewing and auditing actual chart notes to determine correct E/M coding for the given circumstances. This is an awesome workshop that has been extremely well received. Check out comments from past participants at www.mpecs.org/feedback. Workshop registration and details are on the “EVENTS” page of the web site.

If you are not able to attend the May workshop, check the web site often for updated information on workshops. Ultimately, if your practice is struggling, you may not want to wait for another workshop to be scheduled. In that case, I do onsite practice workshops and consultations. See the CONSULTATIONS page on the MPECS web site.

Happy and productive coding!
Jim Meeks, P.A.-C.
MPECS
www.mpecs.org

[1] *6 Steps To Better Coding; Medical Economics, May 20, 2005, Dorothy L. Pennachio*

Opinion

the medical providers, but are often frustrated with the staff supporting them. I hear many complaints about the telephone systems. You know, the ones where you are instructed to dial extension “XX” to make an appointment, “YY” for billing and so on. Recently, there have been some commercials running on TV for a large national bank explaining that a real person is always available to speak with. Just dial “0” is the instruction, if you want to speak to a live operator. We could learn from that.

When you are running behind, have you ever stuck your head into the room of a waiting patient to offer an apology for their wait and assuring them that you are aware that they are waiting? It goes a long way in the customer service area. The medical staff in your office should be trained to do the same. If a patient is waiting longer than the usual time, someone should give them a brief explanation and assurance that they haven’t been forgotten.

Receptionists are busy. They have to deal with a lot of issues giving the term “multi-tasking” new demensional meanings. A key point that I have heard over and over deals with a patient being acknowledged when they walk up to the counter or window where the receptionist is. Even if the receptionist is on the phone or otherwise busy, a simple glance up from her desk with a smile and maybe a small hand gesture means an awful lot to patients. Without this simple act, some can be quite offended.

We face some interesting competition in keeping patients in our practices. It is something that every provider, physician, PA, NP or otherwise, needs to be keenly aware of. It is amazing to see what a few simple steps can do to keep patients loyal and connected to a practice. Ask the questions and listen to the answers. You too will be amazed.

It’s just my opinion.
Jim Meeks, PA-C

Comments, questions, objections or observations? We’d like to hear from you. Please submit any comments to us via the MPECS web site at PracticeProfitability@mpecs.org. We’d love to hear from you and about your unique experiences.

“Your presentation was wonderful. It was excellent and very useful for the clinician”

Workshop evaluation form comment. See the “Feedback Page” on the MPECS Web Site