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PRODUCTIVE PROVIDER NEWSLETTER

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Published by: Jim Meeks, P.A.-C.

M.P.E.C.S.

**Medical Professional Education
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www.mpeccs.org

PracticeProfitability@mpeccs.org

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Welcome to our new subscribers who have signed up through www.mpeccs.org

It is **my pleasure** to again bring to you this free E-Zine called the *Productive Provider Newsletter*. Dedicated to bringing you thoughtful 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.mpeccs.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 an absolutely wonderful day.

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1. **Commentary (ranting)**
2. **Medical Decision Making**
3. **Being Human**

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1. **Commentary**

We as healthcare providers have **nothing to gain** when a patient or another party tries to take advantage of our caring nature, but we have **much to lose** if we do not stand firm in our convictions regarding **good business practices**. For this reason, it is right, just, and proper that we use every advantage we can gain, to appropriately maximize our personal and practice **profitability** through which, we can continue to **care for those in need**. After all, insurance companies, Medicare and Medicaid and other entities do everything in their power to **minimize the payments** they make to providers.

There is an **unfortunate mentality** that all too often rears it's ugly head, asserting that somehow, it is **immoral or unethical** to attempt to be financially profitable while caring for the sick, injured, or otherwise in medical need individuals we encounter on a daily basis. According to an old dictionary, **profit** is an advantage or benefit derived from an activity. Yet nowadays there are those that think **profit** a dirty word and do not understand it as the source of all human **growth and prosperity** and the means by which we can continue to do what we enjoy doing, **caring for our patients**.

We must remember that it is the profit we derive from our activity as healthcare providers that drives the overall **improvement in the health** of our own communities and ultimately, worldwide. Even free clinics, community health centers and other charitable institutions rely on the profits of other entities for support of their activity. Without it, they wouldn't exist. If the medical community hadn't been successful in generating profits sufficient to **allow for research** into products, drugs, treatments and every other facet of health care, we would be **generations behind** our current level of medical care.

Every year, **thousands of healthcare providers** from this country travel all over the world, often at their own expense, taking **much needed** modern and effective healthcare to the underprivileged and suffering masses of the world, with **little reward** other than the **personal satisfaction** of caring for those in need. Beyond that, many thousands more travel to this country seeking medical care they can get nowhere else in the world. Many receive that care for free.

Continual **media and government attention** is directed at the medical community, as if to imply that we somehow are the culprits in the cause of **rising health care costs** in this country and that a large number of providers are somehow **cheating the patient**, the government or insurance companies out of something. The perception that is left behind is that somehow, healthcare providers are getting rich on the backs of their patients. Never mind the **entitlement mentality** perpetuated by a government that tries to be everything to everyone and devalues **personal accountability** for lifestyle choices. In light of the continued decline in physician incomes in contrast to the **increased profits** of insurance companies and enormous CEO salaries in the insurance and private sectors, I believe that the blame lies elsewhere.

The **bureaucracy** of the government mandated **Evaluation and Management** coding guidelines, an **intrusion** into the everyday practice of medicine, is an excellent example of an idea (not necessarily a good one) gone bad. In an attempt to force **healthcare provider accountability** in the face of fraud and misguided fortune hunting by a very few dishonest providers, these requirements intended to lessen abuse, have served only to **add to the cost** of healthcare

in general by mandating a cumbersome system of documentation that **takes time away from patient care**.

In a **New England Journal of Medicine** article, Dean F. Sittig states in part; “. . . E&M guidelines for reimbursement are fatally flawed in that they assume a clinical encounter to be composed of individual data items, which taken in total, are somehow proportional to the overall complexity of the case. Furthermore, they distort the legitimate purposes of the medical record, which are to serve as an aid to the clinician’s memory of a particular patient and is a means to communicate among [providers] caring for the same patient.” *Proposed Medicare evaluation and management coding guidelines are fatally flawed.* [N Engl J Med 1998 Dec 3;339\(23\):1705-8](#)

Now, **please don’t misunderstand**, I firmly believe that **documentation** is paramount to **good health care**. My complaint is with the **confusion the current system creates**. It is, at times, **incomplete and illogical** and creates an atmosphere of **mistrust and misunderstanding** that ultimately lessens our ability to be personally or professionally profitable. In nearly every conversation I have with physicians, PAs, NPs, billing staff and office managers on this subject, there is an enormous amount of **frustration, aggravation and occasional outright anger** expressed by them at the complexity of the system, it’s flaws and the amount of time involved in making it all work so a provider can get paid for the services provided.

My goal is to try to help all healthcare providers **overcome the frustrations and confusion** associated with the current Medicare documentation guidelines. I don’t mind counting bullets so much, but the system is just plain confusing and difficult to use. It isn’t user friendly.

For the time being, **all healthcare providers** should do everything in their power to **master the system** (flawed as it may be). There are ways in which we can maximize our personal and practice profitability within the current system and at the same time, overcome the confusion and frustration, and do so **without interfering with good patient care**. Until the current system is corrected, improved or otherwise replaced, we are obligated to do so.

The **MEDICAL DECISION MAKING** component of evaluation and management coding is probably the **most confusing aspect** of the entire process. It is the most difficult to understand and it is probably the most abused by the insurance industry. I will attempt to cast some light on this topic in the article below. Let me know what you think.

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**2. MEDICAL DECISION MAKING**

Every day in our medical practices, you and I go through the process of selecting a level of service (such as 99201, 99202, 99212, 99213, etc.) in the **EVALUATION AND MANAGEMENT (E&M)** coding system (this applies to all clinical settings; inpatient, outpatient, etc.). We are required to document elements of each patient encounter corresponding to the three **key components** of documentation. These key components are, **History, Exam and Medical Decision Making**.

Other elements of documentation that are **contributing factors** but not key components are counseling, coordination of care, the nature of the presenting problem and time. I will not discuss these today, but we will talk about **time** in a future issue of the *Productive Provider Newsletter*.

Some E&M codes require meeting the documentation criteria of **all three key components** (generally new patient encounters). Other E&M codes only call for meeting the criteria in **two of the three areas** (usually established patient encounters). Unfortunately, some insurance carriers do not always follow these guidelines. I’ll return to that thought in a few minutes.

Today, I’d like to focus on **MEDICAL DECISION MAKING (MDM)**. There are four recognized levels of MDM: **Straight Forward, Low Complexity, Moderate Complexity, and High Complexity**. Each of these is defined by considering **three areas** of decision making, but only **two of the three** need to be used to determine the level of acuity of any given patient encounter. This is where it all becomes so confusing. Try not to confuse the three components of E&M coding with the three areas of MDM. Remember that MDM is the third key component of E&M coding.

Before explaining all of the elements associated with MDM, let me digress and talk about when we are **required** to use MDM and when we are not required to consider it. You should understand that MDM can be used to your advantage, even when it isn’t required.

Use of the MDM component of E&M documentation is always **REQUIRED** in the following circumstances:

- a. office visits for **new patients**
- b. **emergency department** visits
- c. **initial hospital observation care or inpatient admits and discharges on the same day**
- d. **hospital observation** care
- e. initial inpatient **consultations**
- f. **consultations** in the office, outpatient setting or ER
- g. confirmatory **consultations**
- h. nursing facility services for **new or established patients** (certain

circumstances)

- i. domiciliary, rest home, custodial care services for **new patients**
- j. home visits for **new patients**

In all other patient encounter circumstances, usually with established patients, use of medical decision making is not required, but may be useful.

Remember that for encounters in the office, the hospital, follow up consultations, nursing homes, care centers and home visits where we already have an **established relationship with the patient**, we are required to meet the criteria in **only two** of the three areas of E&M documentation, i.e., history, exam, medical decision making. It is **our option** to select the two that define the **highest acuity** for the given visit and select the appropriate E&M code. Medical decision making is not required in these settings, but it may be to our advantage to use it.

In certain circumstances, meeting the criteria for history and medical decision making will qualify for a **higher level of acuity** (a higher E&M code) than the history and physical exam components of E&M. This would be particularly true in situations where you see a patient routinely for evaluation of medication effectiveness (anxiety/depression, HTN, Diabetes, etc.). For example, you review and update (if needed) the patient's medical, family and social history information, discuss effectiveness of the medications, side effects, adjust dosages, answer questions and review the vital signs taken by your nursing staff. You may not even touch the patient (although I recommend that we always do). In some patients, you **may qualify for a higher level of E&M acuity** by considering the MDM than you would by considering the exam component in this type of visit.

Lets see how this works. Medical decision making levels of acuity are determined by considering the criteria of **three areas**.

1. The number of diagnosis or management options
2. The amount and or complexity of data to be reviewed, and
3. The risk of complications and/or morbidity and mortality

I have attached to this newsletter a **PDF document** that will be helpful for you to have in front of you as we discuss these areas of MDM. The information is broken down into three tables corresponding to the above descriptions. "**Points**" are used in tables 1 and 2 to help determine the level of acuity. In table three, no points are used, selection of the highest element of risk determines the level of acuity. Let's look at table one.

**TABLE 1.** *The number of diagnosis or management options.* The number of points accumulated, determines the level of acuity. **Self limited or minor problems** will qualify for a maximum of 2 points no matter how many are addressed on a given visit.

**Established or previously diagnosed problems** each receive one point of value (up to 4). If a patient is already being treated or for HTN, asthma, lupus, diabetes, anxiety or any number of other problems (even if by another provider), each problem qualifies for one point if they were **reviewed or addressed** during your visit. This only requires a simple notation in your documentation that the patient has the condition(s), the status of the condition(s) (in remission, stable, uncontrolled, etc.) and a comment about who is treating it (if it isn't you). Certainly if you are recording all the medications a patient takes and why, even if you are not the prescriber, that qualifies as part of that review.

A new problem (not self limited or minor), **unidentified or undiagnosed previously**, is a higher acuity type of problem. If after your history and physical exam, you establish a diagnosis **without** the need of any additional evaluation, diagnostic studies, etc., that qualifies for 3 points or the "multiple" level. However, if you order or plan to perform **additional** assessments, consultations, or diagnostic studies, that level of work qualifies for 4 points or the "extensive" level of acuity. Please refer to the chart.

**TABLE 2.** *The amount and/or complexity of data to be reviewed.* This is a simple and straight forward **list of items that you might review** on a patient encounter. **All lab reports** reviewed earn one point. **All radiology reports** reviewed earn one point. **All medical diagnostic studies** reviewed earn one point. If you **personally view and interpret** any specimen, image, or tracing previously interpreted by another provider, that earns 2 points. A **discussion or consultation** with the person who performed or interpreted a study earns one point. Your decision to **obtain old records** and/or **additional patient history** from another source earns one point. And finally, documentation of a **summary of findings** from a review of old records and/or additional history earns 2 points. Adding all of these elements together determines a minimal, limited, multiple or extensive **level of acuity** in table 2.

**TABLE 3.** *The risk of complications, morbidity and/or mortality.* This table only requires the **selection of ONE ELEMENT** to determine the level of acuity. It may be the presenting problem, a diagnostic procedure or a management option. Please note that **two or more stable or chronic illnesses** are considered moderate risk under presenting problems. **Prescription drug management** is considered moderate risk under management options. These two examples easily describe a large number of the patients we see every day in our practices. Please take a few minutes and read through all of the elements of risk in table 3.

**So, how does this all come together?** Lets run through a **typical patient encounter**. In this example, our patient is established in the practice. S/he is currently being managed for **two chronic health problems**, benign essential hypertension and mixed hyperlipidemia. These conditions are controlled and stable on current medications. Today, the patient has a **new concern**. Over the past 4 to 5 days, s/he has developed a scratchy throat and annoying dry cough that interferes with sleep.

At face value, and without going into the details of history, physical exam and treatment, lets look at this office visit in the venue we have been talking about, MDM. This patient has **two chronic illnesses**, HTN and hyperlipidemia, each worth one point in table 1 on the MDM sheet I have provided (Established, previously diagnosed). **Today's new problems**, sore throat and cough are **self limited** and are worth one point, which brings the total to 3 points (in table 1), an acuity of moderate complexity based on **multiple diagnosis**. This assumes that **notation is**

made in today's note of the chronic conditions and their status.

Since there isn't likely to be a lot of data to be reviewed in today's example, I think that we can skip **table 2** and move on to table 3. Typically, in the office setting, table 2 doesn't count for much in the way of establishing a higher level of acuity. In contrast, in the hospital, when a patient is admitted through the emergency department, there are frequently a number of **labs, x-rays and other studies** that may need to be reviewed. A **consultation** with the ER provider, radiologist, etc., can quickly add up to a **higher lever of acuity** in table 2.

Table 3, **level of risk**. Our patient has **two stable chronic illnesses**, this qualifies as a **moderate risk** in the presenting problem section of table 3. Coupling that with the **multiple diagnosis** (3) determination from table 1, this patient visit is determined to be of **MODERATE COMPLEXITY**.

If in your practice setting, you or your staff (or the patient) routinely updates the patient's **medical, family and social history** and that is documented in the patient chart along with a **history of present illness** (requires documentation of at least four elements of HPI) for today's visit and a **review of systems** of two or more effected areas (ENT and pulmonary in this case for example), the patient encounter we have just described, qualifies as a 99214 Level 4 visit **before you enter the exam room** and see the patient. The key to success in every patient encounter is complete documentation of the event. I cannot emphasize strongly enough the **importance of updating** the medical, family and social history on every visit. Follow that with a **medically appropriate HPI and ROS**, and you will have a higher acuity patient encounter.

Now, to wrap this long article up, let me discuss one more topic. Earlier, I mentioned that **insurance companies** abuse the system. What I mean is that they don't always apply the **E&M guidelines** as they are intended to be. This is an important principle that **we all need to understand** and isn't directly related to MDM, but is **vital to our success** as healthcare providers.

A **classic example** would be when you see an **established patient**, review and update the **medical history, document HPI and ROS**, and do a **detailed exam** (12 or more bullets in the Multi-system criteria). Logically, this qualifies for a 99214 E&M code without consideration of MDM. However, if in your billing, you only list bronchitis, URI or another similarly **simple diagnosis**, insurance companies will often **reduce your level** of visit to a 99213 payment and inform you that the level of billing submitted isn't **supported by the documentation**.

**Here is the rub**. Since the insurance company doesn't have access to the patient's medical record by which they could assess your level of work, they automatically (software based analysis system) **use MDM as the criteria** to determine the **level of acuity** on all of your billings and will **adjust your payments** accordingly.

To **correct this problem**, I recommend that you be as **descriptive** as you can with **diagnosis**. Instead of listing a diagnosis that describes a collection of symptoms, like URI, it is better to **break it down** into symptoms such as ear pain, coryza, sore throat/pharyngitis, and cough (or whatever descriptions apply). While URI may encompass all of the above symptoms/conditions and be the correct diagnosis, it isn't as descriptive and the insurance company software will arbitrarily **minimize the acuity** of a visit based on the **number of diagnosis** submitted with the billing. They will not consider the work you actually do at the time of the visit.

This **unwritten rule** applies to all situations. If you break down a diagnosis from a single comprehensive word to separate descriptive elements, you will find that you will have a greater chance of **being paid according to your work**.

So there you have it. **Medical decision making**, in a very large nutshell. This is a **very important** part of our everyday practice. Unfortunately, I think that all too often, we **tend to neglect** this part of coding and we **fail to use it** when it will be most beneficial to us, and the success of our practice.

It certainly is easier to explain in person. A face to face discussion is always much easier. I hope that I will have to opportunity to do just that. Until then, take a moment or two to review the details of this article and see if it doesn't improve your coding. Remember, documentation is the key to successful coding and billing.

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MPECS is dedicated to making your practice of medicine **more productive, more profitable and ultimately more enjoyable**. We have developed a comprehensive 4 hour workshop that focuses on the specifics of documentation and coding with a thorough review of **Medical Decision Making**. We have developed a number of excellent products designed to improve your documentation and coding. Every product we offer is the result of actual clinical needs by practicing providers.

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3. BEING HUMAN:

10 Rules for Being Human

Author unknown

- 1. You will receive a body.**

You may like it or hate it, but it's yours to keep for the entire period.

2. You will learn lessons.

You are enrolled in a full-time informal school called "life".

3. There are no mistakes, only lessons.

Growth is a process of trial, error, and experimentation. The "failed" experiments are as much a part of the process as the experiments that "work".

4. Lessons are repeated until they are learned.

A lesson will be presented to you in various forms until you have learned it. When you have learned it, you can go on to the next lesson.

5. Learning lessons does not end.

There's no part of life that doesn't contain its lessons. If you're alive, that means there are still lessons to be learned.

6. "There" is no better place than "here".

When your "there" has become "here", you will simply see another "there" that will again look better than "here".

7. Other people are merely mirrors of you.

You cannot love or hate something about another person unless it reflects to you something you love or hate about yourself.

8. What you make of your life is up to you.

You have all the tools and resources you need. What you do with them is up to you. The choice is yours.

9. Your answers lie within you.

The answers to life's questions lie within you. All you need to do is look, listen, and trust.

10. You will forget all of this.

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**WORKSHOPS:** Do you struggle with Medical Decision Making? With evaluation and management codes in general? Attend an **MPECS workshop** where we focus on issues of documentation, physical exam criteria, medical decision making, chart auditing and other issues that are essential to **maximizing your personal and practice success.**

I will gladly bring a workshop to your community. Please contact me via my website for more details. Also, please **visit the website** often to check and see when and where workshops are being scheduled. Happy coding!

Our comprehensive 4-hour documentation and coding workshops have been very successful. The comments and evaluations from participants are **all very positive.** Those in attendance have **overwhelmingly appreciated** the information presented. Currently, the next workshop is scheduled in conjunction with the **AFPPA** conference in San Antonio, Texas in November. Another Utah workshop is scheduled in February 2004. I'd love to bring a workshop to your area.

If your local, state or national association is looking for CME activities, topics, lectures, workshops, **I can help!** If you are interested in becoming more productive and thereby more successful in daily practice, let me help. Forward this E-Zine newsletter to your State CME chair. Contact me via [www.mpecs.org](http://www.mpecs.org).

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Jim Meeks, P.A.-C.  
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