

Productive Provider Newsletter

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AT A GLANCE:

In this month's
*Productive
Provider
Newsletter*

FRONT PAGE:

It's Just My Opinion

So, where do we draw the line between appropriate and embellishment?

New Year Tips

Are you ready for the New Year? What have you done to get ready? Here are some tips that should help.



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Front Page

It's Just My Opinion

There seems to be some confusion about documentation for evaluation and management (E/M) encounters. On one hand, we hear that we should be careful not record too much information because it may appear that we are simply trying to achieve a higher level of service or pad the bill so to speak. Along with this, I hear comments from providers that have been told that they should never bill a Level 5 (such as 99215) because if they do, they are guaranteed to be audited. I have seen where some providers bill a Level 3 (99203, 99213, etc.) no matter what the circumstances are. I once reviewed charts for a provider that billed every established patient encounter at 99212, believing that he wouldn't get audited by doing so. All this confusion causes a fair number of providers to code incorrectly.

On the other hand, we are told that we should document collection or review of a complete History of Present Illness (HPI), Review Of Systems (ROS) and Past Medical, Family and Social History (PMFSHx) on every encounter in order to fully appreciate the Nature of the Presenting Problem (NPP). This is the concept put forth in the recent American Medical Association publication *Practical E/M* (AMA Press 2006) in consideration of the NPP.

An appropriate medical exam is essential to good medical care. Documentation of that exam is vital. Anyone that would embellish what is medically appropriate just to achieve a higher level of care should come under some scrutiny. So where do we draw the line between what is appropriate and what is embellishment? How do we decide exactly what will be allowed if we are audited?

Part of the confusion I think, comes when we try to take care of our patients the way we have been trained and the way that we feel is ethical and then discover that some exam, test

See "Opinion" on page 2 . . .

New Year Tips

Are you ready for the new year? What have you done to get ready? I'd like to make a few suggestions.

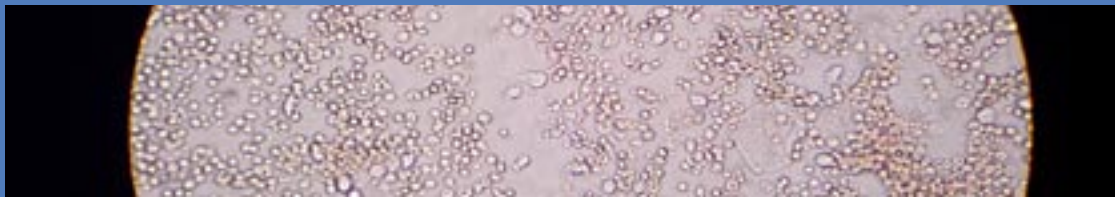
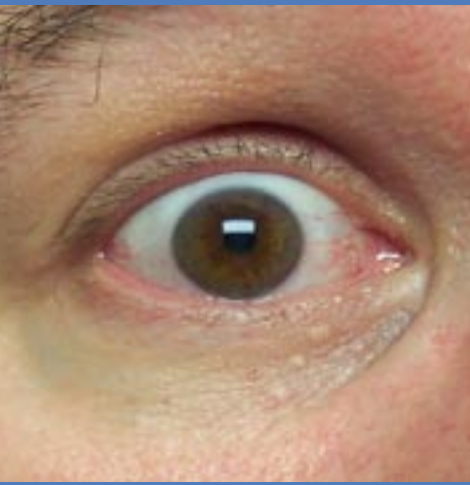
1. Current information. Make sure that you are using the latest editions of your CPT, ICD-9 and HCPCS books. If you are using electronic billing and charting, make sure you have invested in the latest versions of each. Doing so reduces the likelihood of rejected claims for services provided. When you factor in the amount of money it costs to research and re-file rejected claims, it doesn't take long to exceed the cost of updated books and software.

I once visited a practice that was using CPT and ICD-9 books that were three years old. The office manager mentioned to me that they sure got a lot of rejected claims. I suggested that they update their CPT, ICD and HCPCS books soon.

2. Understand modifiers. Too many providers don't take the time to learn about and understand the use of modifiers. If you are seeing a patient for a general health concern that would generate a normal evaluation and management (E/M) code and then you are asked to treat a wart or remove an annoying skin tag or some other procedure during the same visit, that procedure is separate from the E/M visit. To get paid for the procedure and the E/M visit, you are required to use a modifier on the E/M code. In this case, the modifier is -25 to indicate a "Significant, separately identifiable evaluation and management service by the same physician (provider) on the same day of the procedure or other service."

There are 30 or so modifiers listed in Appendix A of the CPT book. Six of those modifiers apply directly to E/M coding. They are 21, 24, 25, 32, 52 and 57. Read through all of the modifiers in Appendix A to see which ones will apply to your practice. I would also recommend that you read the September and October 2005 editions of this newsletter where you will find a discussion about modifiers.

See "New Year Tips" on page 3 . . .



MARK YOUR CALENDARS

EVALUATION and MANAGEMENT CODING ESSENTIALS WORKSHOPS & LECTURES:

MPECS is dedicated to making your practice of medicine more productive, more profitable and ultimately more enjoyable. The comprehensive MPECS 4-hour **E/M CODING ESSENTIALS** 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
March 10, 2007
Monterey/Pacific Grove, CA
April, 2007

See the **EVENTS** page on the **MPECS** web site for details and registration information.

CONFERENCE LECTURES;

GAPA January 26, 2007
Atlanta, Georgia



Opinion

or procedure isn't covered by that patient's health care plan.

For instance, I saw a patient with epigastric pain. I got a complete history, did a medically appropriate exam and ordered some tests as would be indicated by the history, physical exam findings and the symptoms. In this case, those tests included an H. Pylori test. Just today, I was informed that the insurance carrier for this patient doesn't cover that test when done in the office. If I had sent the patient to the hospital lab for the test, I wouldn't be trying to explain to the patient why they were now responsible for the charge on this test.

For me, it would be easier to simply take care of my patients, do what is necessary and appropriate for the given circumstance and do the best I can every day. The reality is that it isn't always good enough.

From as far back as I can remember in my medical training, getting a good history was taught as the best tool in caring for a patient. I was taught that it would often help establish the diagnosis before performing the physical exam or obtaining tests. I have learned that this pearl of wisdom is often quite true.

Years ago, when I was teaching emergency medical dispatch courses for the National Academies of Emergency Dispatch (www.emergencydispatch.org), we talked about the "big picture." The dispatcher was taught that their role was to direct resources to emergencies and give assistance over the phone until help arrived. From their perspective, they could visualize all resources available and direct the nearest available units to any given situation.

This was illustrated by sharing all too common experiences of people that don't have the "big picture." For example, someone had been burning weeds in their back yard. The fire got away from them and had spread to a neighbor's fence, heading toward their house. Knowing that there was a fire station right down the street, this individual runs to the station only to discover that there is no one in the station at that moment. Perhaps they are on another call or simply out of the station doing inspections or something. Valuable time has been wasted as this person then runs back to his house and calls 911 for help.

Similar situations happen when someone calls a neighborhood hospital to request an ambulance only to discover that the ambulance doesn't come from the hospital. Again valuable time is lost. Lack of information, or not seeing the "big picture" severely limits the perspective of the individual involved.

In our daily medical practice, we can become victims of the same circumstance. If we are not getting an adequate history, we may end up focusing our efforts on the wrong problem.

The NPP is our "big picture" in medicine. Without collecting the correct information, we cannot completely appreciate the simplicity or complexity of any given patient. If we narrowly focus on the chief complaint of the day, we may miss any number of other illnesses or concerns that may ultimately be more critical.

A recent ER experience illustrates this quite well. A patient arrived asking to have an infected wound checked. During his intake at the triage desk, he was asked some preliminary questions and it was determined that he was having chest pain that had started a couple of hours before coming to the ER. He thought it was because of the infected wound and didn't mention it until asked. He was admitted with a probable myocardial infarct.

The NPP for this patient turned out to be high severity when the right questions were asked. It would have been low severity if attention had been directed only at his wound concerns.

Documentation is the key to success, but is viewed by some as a burden to their medical practice. The collection, review and documentation of a complete history may be neglected to the point of causing a life threatening situation to be missed or worse yet, ignored.

To address the dilemma of what is appropriate and what isn't, I recommend the following. As far as it is practical, collect, update and/or review a **complete** history (HPI, ROS and PMFSHx) on every patient encounter. While this seems excessive to some, it is in the best interest of every patient. It is good medicine and meets the standard of care.

To streamline the process, use a printed form that the patient can fill out while waiting to be seen. It should contain easy to understand questions about today's complaint (HPI), medical history (PMFSHx) and a series of yes/no items for the ROS. Asking the patient to mark either yes or no for **each** ROS item is more appropriate than asking them to circle "any

See "Opinion" on page 4 . . .

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

M.P.E.C.S.

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



CODING TOOLS

Do you know the specific **elements of documentation** that determine which E/M code you should use? **You are not alone** if you are confused with this process.

See all of the MPECS **coding tools** on the MPECS web site. The **POCKET CODER**, the MPECS **Workshop Workbook**, several **Single Organ System Exam** tools and **Chart Auditing** forms are all available on the web site. Other tools are in the wings. Check back often. Refer a friend!

Order your Productive Provider coding tools today online at www.mpecs.org/tools. It is a must for every provider.



New Year Tips . . .

Additionally, there is a great book to help with understanding modifiers. Published by Ingenix (www.ingenix.com), the title of the book is appropriately named "Understanding Modifiers." I recommend it.

3. Practice documentation efficiency. It is unfortunate to discover that your documentation is lacking. It is more unfortunate to have that pointed out by an attorney representing a dissatisfied patient.

When I have reviewed medical charts for legal firms, I have discovered more often than not that the documentation is insufficient. Sometimes, it may be that there is no Review Of Systems (ROS), or the medical history sheet hasn't been updated for 5 or more years. Sometimes, the documentation is so poor that it is difficult to know what went on at all during an exam. Legibility is a challenge in hand written charts. Dictated charts sometimes are found to be missing a transcription or only have a partial note for a given date.

Some practices use preprinted forms with check boxes. These are great if there is enough room to make notes for clarification and detail. Electronic medical records are great too. It takes time to learn any system. That requires an investment up front in time and effort. The dividend in the end should more than pay for that investment as long as you select a product that will fit your practice. If you are considering an EMR, I recommend you start with products certified by Certification Commission for Healthcare Information Technology (CCHIT). You will find a list of certified products on their web site at www.cchit.org.

4. Self audits. Another consideration regarding documentation efficiency is chart auditing. I recommend that on a regular basis (perhaps monthly), every provider audit 5 - 10 randomly selected charts from the previous month's visits. Collect the explanation of benefits (EOB) form from the insurance companies along with any other supporting documents and review the charts. If you work in a practice with more than one provider, consider trading charts and auditing each other's charts.

Chart auditing is actually a much easier process than some people think it is. You should establish a standardized format of things to look for.

The first step should be to identify the site of the service (office, hospital, nursing home) and verify that the correct location identification code was used on the billing. Check for correct dates and identifiers for the person providing the service. Identify what codes were used in the billing process (CPT, ICD-9).

Is the chart legible? If not, that should be a priority for improvement.

Next, see if the documentation in the encounter note supports the level of care that was billed. Can you identify the history of present illness (HPI) and review of systems (ROS)? How many elements of each? Is the past medical, family and social history in the chart? If not, is contained in the note? Has it been updated? When and by whom?

How detailed are the physical exam notes? Are there a number of "normal" findings? Stating normal is fine, but the lack of detail by stating "normal" doesn't qualify for much if you are counting bullets. If you are using a form with check boxes for elements of the physical exam, it is better to have a box for each element of the exam than to have a box that simply states "normal." It doesn't change the exam, but it does add detail to the exam that qualifies for a higher level of service. Is there room on the form for additional notes and comments?

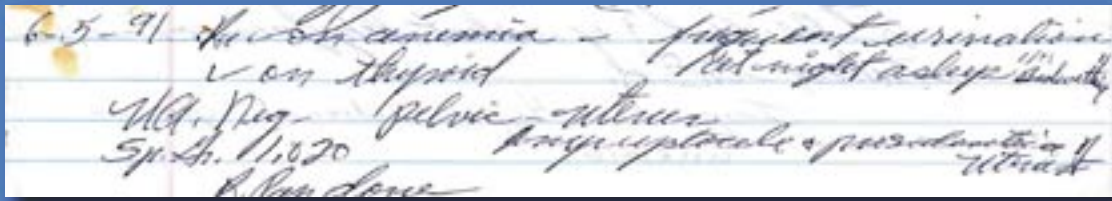
Consider the medical decision making (MDM); 1. The number of diagnosis and management options. 2. The amount and/or complexity of medical data reviewed. 3. The risk of complications and/or morbidity and mortality.

The auditing process is easier if you have a good form to work off of. You can make one easily enough on your own computer. The "TOOLS" page on the MPECS web site offers a pad of 50 audit forms if you prefer to use something that is already designed. Using a form helps standardize the process from audit to audit and provides documentation of the process for reference when you look at trends and compliance. Remember to consider the overall Nature of the Presenting Problem (NPP).

Finally, you determine what code should be billed based on the audit information and see if the code originally billed is correct. If not, (this is the pay off) you now know what areas of documentation need improvement or correction.

5. Compliance Plans. When was the last time your compliance plan was updated? Who is the compliance officer in your practice? Do you even have a compliance plan?

There are seven areas of focus in an appropriate compliance plan. If your practice sees Medicare patients, you are required to have a written compliance plan. If you are ever



Opinion . . .

that apply," especially in a legal case. I have used different forms for different situations. If a patient was seen recently, I use a form with rephrased questions to collect the information from the perspective of "Since your last visit . . ." to assess the progress of the condition and to search for changes in medical history and ROS information since the last visit. Updates to family history are also obtained.

The ancillary staff in any practice can be trained to assist patients with this task and keep the patient flow going without too much trouble. If someone is having difficulty, your staff should be able to help them complete the form. Once the information is collected and the chart is updated, providers simply need to review the information on the form or in the chart and make notations as needed for clarification and documentation. A summary statement in the actual chart note suffices to identify that the information has been reviewed and updated. If your practice uses paper charts, a summary form located on one side or the other of the chart is a great tool. It should have space provided where anyone updating the information can initial and date it when changes or updates are made.

With this process completed, the "big picture" comes into focus for the provider. No matter what the chief complaint, you can then consider all co-morbidities for their impact on the chief complaint and your care of the patient is optimized. This doesn't mean that you have to treat all the conditions/co-morbidities identified. Documentation of their existence and management by another provider is sufficient. If a problem is identified that isn't being managed, initiation of treatment or referral as appropriate is warranted.

A patient that needs arthroscopy for a torn meniscus with no health history or problems is certainly far different from one that has a number of health problems (COPD, CHF, DM) or is taking a lot of medications or even aspirin. If that kind of information isn't collected and noted, it could have significant effect on the outcome of surgery. An orthopedic surgeon doesn't need to treat any of those co-morbidities, but if they exist, it is prudent to note if they are currently managed and by whom and if they are adequately treated before heading into surgery. Documentation of that information is essential.

All patients should have an appropriate work up that includes a complete history, physical exam and medical decision making. With this information, the "big picture" (NPP) is brought into focus for consideration and the patient gets excellent health care.

It's just my opinion.

Jim Meeks, PA-C

New Year Tips . . .

audited, it goes a long way towards your credibility if you do have a written plan. Even if mistakes have been made, having a plan that wasn't followed is much better than having no plan at all. The seven areas are;

1. A statement of commitment to compliance
2. Designation of a compliance officer
3. Outline of a compliance training and education program
4. Practice auditing and monitoring plan
5. Communications within the practice
6. Internal investigation and enforcement
7. Response to discovered errors and corrective procedures

The advantage of a written practice compliance plan is the same as an employee benefits manual or a policies and procedures manual in any practice. When a question comes up about how to proceed when some problem is discovered, a written plan gives you the direction needed to correct the problems. It also identifies someone that has authority to take the necessary action to protect the practice and the providers in the practice.

The new year is an excellent time to be proactive in your practice. You may be closer to compliance than you think. Start with a staff meeting where everyone is present and discuss your current billing practices. Talk about the seven areas of compliance above and start working on each. Make sure that your compliance officer has the tools and authority necessary to do the job. Everyone has to commit to the process and the concept of compliance.

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<http://members.AudioGenerator.com/st1.asp?c=387186>