

Productive Provider Newsletter

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*Productive
Provider
Newsletter*

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Front Page

Its Just My Opinion

The New Year is upon us. Are you ready?
Might I share a few thoughts regarding your medical records? There is a big push for converting to electronic medical records (EMRs). There are some significant costs associated with moving to EMR use in a medical practice. Flat out and in your face, EMR programs are expensive. Every practice has to ask if the cost to benefit ratio is justifiable in their particular setting.

I bristle a little when I hear that the government is leaning towards making EMRs mandatory for medical practices. Their motivation in doing so is probably based on a desire for more uniformity in provider documentation, but I suspect that accountability has a lot to do with it as well.

There are quite a few good products available for EMRs and I am not going to make this a review of them. Many excellent reviews have already been written and can be found in various professional journals.

My concern is with the medical record in general. As I have discussed many times in this newsletter for the past several years, documentation is the key to successful coding and subsequent billing. It is the medical record that we will turn to when we need to defend our medical decisions and treatments. The information contained therein can be absolutely essential if we are accused of medical malpractice.

See Opinion on page 2 . . .

Evaluation and Management Code Update

There are both significant and subtle changes in Evaluation and Management (E/M) codes this year. Previous articles in this publication have touched on the need for **staying current** with coding books. A current copy of CPT® 2006, ICD-9-CM 2006 and HCPCS 2006 are essential to successful coding and billing. Please see the **Productive Provider Newsletter** Index which is now posted on the MPECS web site, on the newsletter page. Go to www.mpecs.org/newsletters where the index and past articles are available.

We now have some coding criteria that have been **expanded** into a format of doing either detailed **or** comprehensive history, exam and medical decision making for one code. At first glance, this seems to make the coding process a little more complicated and confusing.

The first place you will probably encounter this is in the area of **Initial Hospital Care** where there are three levels to select from; 99221, 99222 and 99223. The first, 99221 is described as either detailed **or** comprehensive and reflects **expanded criteria** (see POCKET CODER page detail on page 3 of this newsletter) in history, exam and medical decision making documentation. The actual use of these expanded criteria should be easier for the provider, giving more flexibility in selecting this level and the documentation required to support it.

This expanded documentation criteria is also found in the first levels of **Observation or Inpatient Admits and Discharge** on the same day (99234),

See E/M update 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;

**Salt Lake City, Utah
May 6, 2006**

CONFERENCE LECTURES;

The 2006 schedule is now open. Please call to schedule a conference event in your area.

The MPECS web site lists the specific details for each **workshop** as it becomes available. Check back often. Register EARLY for significant workshop discounts.

Need a conference speaker? Give us a call. We'll talk!



Opinion

So, as you consider your medical records, EMR or paper, quality and content considerations are generally the same. My question would be to ask you what does make a **good** medical record? Let me make some observations with the intent of having you look at your current records in a preventative medicine way.

Is the medical record readily available? This certainly is an advantage that EMRs have. You don't have to go looking for the chart. I can't tell you how many times I have seen office staff members spend hours looking for a patient's chart. When you consider the cost per hour of having employees searching for a missing chart, it can be sobering. However, when the power goes out, an EMR system is largely dysfunctional until the power comes back on. You also have to consider costs of network maintenance. Maybe a paper chart isn't so bad, when you can find it. The bigger the practice, the more places you may have to look for the chart.

Are your medical charts organized in an easy to use format? The most organized paper charts I have seen include tabbed dividers on both sides of the folder. These dividers make it easy to find drug lists, progress notes, insurance information, lab reports, radiology reports and so forth. The problem I see with these is that these charts tend to get fat quickly and take up a lot more room in the filing room. The cost of all of the dividers can be substantial too. EMRs do a pretty good job of keeping track of all of this information as well, but the record will only be as good as the information put in it. If someone doesn't take the time to import or record data, it can be a big drawback. Sometimes, downloading reports into the EMR in a readable format can be a challenge too.

Some really important information that I always look for in any chart is the current and past medication/adverse reaction list and the past medical history and current problem list. Again in EMRs, this information is usually readily available, but isn't always updated as often as it should be. The problem I see here is that in some ERM systems, this information is automatically added to a note or brought forward from a previous note. When this happens, it doesn't tend to get updated. Once in a while, I will find a statement about a particular problem that says onset was "3 days ago" repeated over and over in a series of notes that can go on for months.

In paper charts, I have seen many formats for information sheets containing this essential medical and historical information. What I often see here is that this information is filled out with great detail on a first visit with new patients. After that, the form tends to get neglected and isn't current very often. That can be a problem in a medicolegal situation. I once reviewed the medical record of a patient in a malpractice case where a patient died from a massive GI bleed after being started on indomethacin for gout. The patient in this case had been a patient in the given practice for some twenty years, but his medication/adverse reaction information sheet was nearly empty. Buried in the chart some 12 years before was a note that said the patient got stomach pain when he took aspirin and had had a minor GI bleed several years before. The information sheet didn't reflect any of that information.

I recommend that when you do update a medication/adverse reaction/medical history sheet, you record the date and who the person doing the updating is. Documenting this on the sheet itself and in the note on the date of a patient encounter is good practice. If the information is reviewed, but no changes are needed, you should still date and initial that event on the information sheet and include it in the chart note for that day.

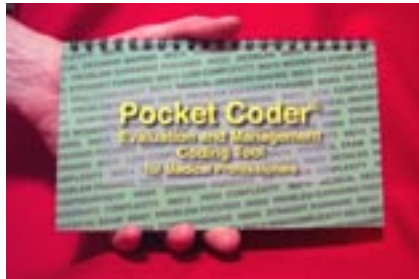
Charting is often perceived by many of us as a burden. In reality, a few minutes paying attention to the details will often save time in the future and helps prevent medical errors and poor outcomes to treatment. EMRs are great tools and eventually will replace the paper chart. Take your time and be sure the product you select meets your needs. There is no need to compromise when so many products are available.

Its just my opinion. Jim Meeks, P.A.-C.



E/M update continued . . .

Hospital Observation Care (99218) and for Initial Nursing Facility Services (99304). They all require documentation of three out of three components; history, exam and medical decision making.



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.



INITIAL HOSPITAL CARE per day

COMPONENTS (History, Exam, Decision Making) Must meet or exceed 3 out of 3 components	LEVEL 1 99221	LEVEL 2 99222	LEVEL 3 99223
HISTORY	Detailed or Comprehensive	Comprehensive	Comprehensive
Chief Comp./History of Present Illness (8)	Extended (4 or more)	Extended (4 or more)	Extended (4 or more)
Review of Systems (14)	Extended (2 to 9) OR Complete (10 or more)	Complete (10 or more)	Complete (10 or more)
1) Past Medical, 2) Family, 3) Social Hx's	Pertinent (1 out of 3) OR Complete (3 out of 3)	Complete (3 out of 3)	Complete (3 out of 3)
EXAM	Detailed OR Comprehensive Extended exam of affected body area(s) and other symptomatic or related organ systems (2-7) / (2-7)	Comprehensive General multi-system exam or complete exam of single organ system	Comprehensive General multi-system exam or complete exam of single organ system
1995 Organ Systems (12)/Body Areas (10) 1997 Multi-system Exam Doc. Req.	2 • in 6 areas or 12 •	(8-12) / (8-10) 9 areas, 2 • each	(8-12) / (8-10) 9 areas, 2 • each
DECISION MAKING	Straight Forward OR Low Complexity	Moderate Complexity	High Complexity
Number of Diagnosis	Minimal (1) or Limited (2)	Multiple (3)	Extensive (4)
Amount and / or complexity of data to be reviewed	Minimal or Limited	Moderate	Extensive
Risk of complications and / or morbidity or mortality (see table of risk)	Minimal or Low	Moderate	High
Unit or Floor Time in minutes	30	50	70

2006 **POCKET CODER** page detail for **INITIAL HOSPITAL CARE per day** showing expanded documentation criteria for Level 1 patient encounters.

Additionally, each of these areas (in the previous two paragraphs) of patient encounter have two higher levels of code for comprehensive visits (see example above; 99222 & 99223). The differentiating factor in these higher levels is the **medical decision making** process reflecting the emphasis this has on the overall patient care encounter.

Every healthcare provider needs a **fundamental understanding** of medical decision making and the three areas it encompasses;

Number of diagnosis or management options

Amount and/or complexity of data reviewed

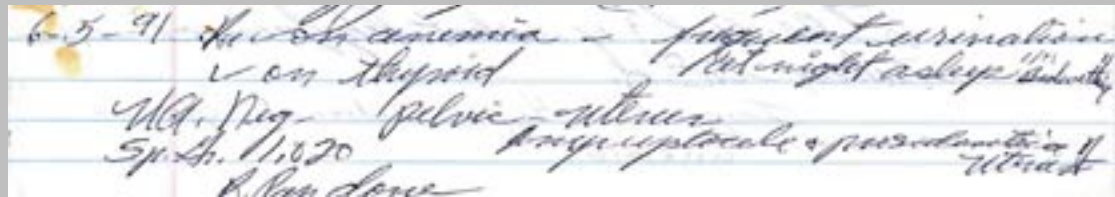
Risk of complications and/or morbidity or mortality

Medical Decision Making is explained in detail in previous articles of this newsletter which you will also find in the MPECS web site newsletter index (www.mpecs.org/newsletters).

Several CPT codes have changed too. **Initial Nursing Facility Services** codes 99301, 99302 and 99303 have been **eliminated** and 99304, 99305 and 99306 have replaced them.

Code 99318, Other Nursing Facility Services, has been **added** for annual exam services; "Evaluation and management of a patient involving an annual nursing facility assessment, which requires [a detailed history, comprehensive examination and medical decision making that is of low to moderate complexity.] Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving."

Codes for **Subsequent Nursing Facility Care** 99311, 99312 and 99313 have been **replaced** by 99307, 99308, 99309 and 99310 reflecting further expansion of the codes in this area of patient care providing 4 levels of coding versus the 3 levels previously available. The discharge codes 99315 and 99316 remain unchanged.



E/M update continued . . .

The three codes for **Domiciliary, Rest Home, Custodial Care Services** (99321-99323) for **new patients** have been expanded to five levels using codes 99324-99328. The three levels of coding for **established patients** (99331-99333) have increased to four levels using codes 99334-99337.

Finally, some codes have been **eliminated** completely. **Follow-up Inpatient Consultation** codes 99261, 99262 and 99263 have been deleted. Instead, follow-up visits by specialists should be billed using 99231, 99232 or 99233 for Subsequent Hospital Care. **Confirmatory Consultation** codes 99271-99275 have also been eliminated. Specialists should use an appropriate E/M code dependant on the setting and type of service provided.

All of these codes are fully explained in the **2006 CPT®**. You should review each of them and the specific criteria related to each of these codes. Make sure that your practice coding books (CPT, ICD-9 and HCPCS) are current for 2006.

The updated MPECS **POCKET CODER** (www.mpecs.org/products) combines E/M codes with federal documentation guidelines/criteria in a **visual matrix** designed to give you the ability to see each of the codes and specific required documentation in a unique **side by side format** which provides healthcare and billing professionals with the ability to select the appropriate E/M code more efficiently and with greater confidence.

Understanding how to combine the CPT codes with the governmental documentation requirements has always been a challenge for the healthcare professional and their billing staff. Making sense of it all is an ongoing problem for all of us.



"I have been using [the] Pocket Coder for over a year now and my gross reimbursement has increased by about 36%. Thank-you Jim."

MPECS Web site Guestbook comment.

"You cannot bring about prosperity by discouraging thrift. You cannot strengthen the weak by weakening the strong. You cannot help the wage earner by pulling down the wage payer. You cannot further the brotherhood of man by encouraging class hatred. You cannot keep out of trouble by spending more than you earn. You cannot build character and courage by taking away man's initiative and independence. You cannot help men permanently by doing what they could and should do for themselves."

-- Abraham Lincoln

