

Productive Provider Newsletter

June - July 2006
Volume 4, Number 5
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Productive Provider Newsletter

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Productive Provider Newsletter

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Front Page

It's Just My Opinion

In this section of the January 2006 issue of this newsletter, I discussed what I believe makes a good medical record. Since this newsletter is intended to address Evaluation and Management (E/M) coding issues for a broad scope of medical practices, from the private solo practice to large multi specialty practices, I tend to speak in broad terms. The January "Just My Opinion" article was reprinted in the May-June issue of ADVANCE for PAs and generated an interesting "Letter to the Editor" response. Look for the July-August issue of ADVANCE for that response.

I'd like to speak further on the topic of just what makes a good medical record. I do not advocate one form of medical record over another. Many practices still use paper charts and that is fine. Some are hand written, some dictated. Some providers have developed templates and word processing documents with shortcuts that work quite well. There are companies that produce a number of pre-printed forms that are quite effective in the office and in the ER.

The newest avenue for medical records is the Electronic Medical Record (EMR), a computer based data base that allows nearly instant access to the entire patient record. There are many companies that are producing EMRs. Many have come and many have gone, as with any software based product.

In my January "Opinion" article, I opined that EMRs were "flat out and in your face expensive." I have looked at the web sites for dozens of products. I have down loaded and tried a number of demos and I have ordered and run CD demos of many products. Expense is a very relative term. Just today, I found an offer for a free EMR download. I have seen EMRs

See Opinion on page 2 . . .

Medical Decision Making

Every day in our medical practices we document important aspects of each patient encounter one way or another (See this month's "Opinion" article). We do this for a number of reasons. Probably the first is to help us remember on the next visit what we did on the last visit. For me personally, that is an important reason. I don't have much of a memory when it comes to remembering what I prescribed or advised on previous visits.

Other obvious reasons for documentation are to provide good medical care and continuity of care. Patients may present with minor problems, but their overall history may be very complicated. The medical record is the tool we use to keep it all together, organized and accessible.

Another reason we document our patient encounters is to assist us in selecting the correct code for billing the encounter. The process of documentation is often driven by the various required elements needed to select the correct evaluation and management (E/M) code. The key elements or components are collecting and/or reviewing the past medical, family and social **History**, performing the appropriate physical **Exam** and **Medical Decision Making** based on the presenting problems, co-morbid conditions and treatment options.

Other elements of documentation that are considered to be contributing factors are **counseling, coordination of care, the nature of the presenting problem** and **time**. (If you have questions about time, please see the December 2003 issue of the *Productive Provider Newsletter*).

Some E/M codes require meeting the documentation criteria of **all three key components**. Generally, this is required for new patient encounters, emergency department visits, and most types of admissions. Other E/M codes require meeting the criteria in only **two of the three areas** (usually established patient or follow-up encounters).

See "MDM" on page 3 . . .



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;

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

CONFERENCE LECTURES;

NPACE September 14, 2006

Chicago, Illinois

www.npace.org



Opinion

that cost many tens of thousands of dollars. Most are at least several thousands of dollars. Then there are the licensing fees, service contracts, updates and a number of other costs not to mention the cost of the hardware.

I have been using one specific EMR in the practice where I am employed for the past three and a half years. I find it to be one of the best I have seen (and I am sure that others are equally good). It is not perfect, but I doubt that any one product is. I believe that is why there are so many products available and that is why there are so many ways to practice medicine and run a practice and decorate an office and so on. It is not my intention to endorse one product over any other nor any type of medical record over another. The practice of medicine tends to be an individual art. Documentation methods and preferences seem to be equally individualized.

The shortfall of any medical record is in the information that it *doesn't* contain. Many times, those shortfalls do not become apparent until there is a problem. I often see this when I am asked to review a medical record in a medical malpractice case.

One glaring example was a malpractice review of a medical record where the office visit was to be recorded on a preprinted form. There were blanks to fill in for the chief complaint and history of present illness. There were check boxes for the review of systems with space for notes if needed. Physical exam findings were documented by check boxes and supplemental notations if needed as well as space for interventions, labs ordered and so on. Overall, a practical form, well designed for the practice situation.

So what was wrong with it? In this case, on this particular date, most of the blanks had been left empty, check boxes were unchecked and the plan for follow-up was not documented. The patient had a fatal event within 48 hours of that visit and the family wanted answers. I suspect that the chart just didn't get finished. It has happened to all of us. We set the chart on our desk (with any number of other charts) intending to finish it at the end of the day (or whenever) only to have it picked up by someone else in the office doing their job (documenting labs, injections, whatever). The chart never gets finished or dictated.

Would this have been different with an EMR? There is no way to know. I suspect that an EMR would have prompted the provider with a list of uncompleted charts and that the chart would have been completed. But if it was just poor documentation, the method of documentation would have no bearing on the content. There are some providers that just don't document very well.

No matter what system is used in your practice, make sure that the information in it is complete and up to date. That is the basis of a good medical record, hand written, dictated, preprinted form or electronic record, they all need the information recorded in the first place and updated frequently in the second place. If that doesn't happen, then the medical record is not sufficient for the need, caring for the patient.

When you add in the inevitable "pay for performance" initiatives, I see no better tool than the EMR. Performance assessments have been around for some time in various forms. Insurance companies perform chart audits for that very purpose. Still, if the needed information isn't in the chart, it isn't a very good medical record.

If you are considering implementation of an EMR in your practice, I suggest you read the following article in Medical Economics Magazine:

Getting EMR up and running.

<http://www.memag.com/memag/article/articleDetail.jsp?id=108590>

It's just my opinion.

Jim Meeks, PA-C

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 Practice Profitability **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.



MDM . . .

Today, I'd like to focus on the **MEDICAL DECISION MAKING (MDM)** part of the E/M coding process. MDM is the most confusing and difficult part of E/M coding because it involves a decision process based on so many factors, not just counting bullets.

This is where it all becomes so confusing. Remember that MDM is the third key component of E/M coding (History, Exam, MDM). Determining the level of acuity within MDM is done by considering criteria in **three areas**.

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

There are **four levels** of MDM acuity, each determined by information from the three areas listed above. These are **Straight Forward, Low Complexity, Moderate Complexity and High Complexity**. When you determine the level of MDM acuity, you then use that with the other two areas of E/M coding (history and/or exam) to determine the level of care provided and the correct E/M code to use in billing.

I have included in this newsletter a page (page 5) that will be helpful for you to have in front of you as we discuss these areas of MDM. It would be helpful if you could print it out now and use it for reference as we go through this.

The MDM information is broken down into three tables corresponding to the above descriptions. **"Points"** are used in Tables 1 and 2 to help determine their respective level of acuity. In Table 3, no points are used. Instead, selection of the highest element of risk determines the level of acuity. I'll start by looking at Table 1.

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.

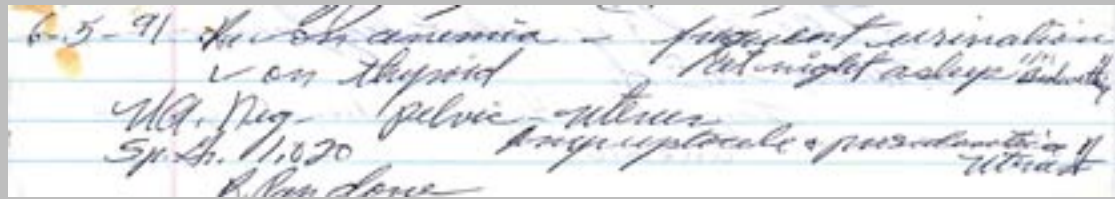
Established or previously diagnosed problems each receive one point of value (up to 4). If a patient is already being treated or for HTN, asthma, lupus, diabetes, anxiety or any number of other problems (even if by another provider), each problem qualifies for one point if is **reviewed or addressed** 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 management qualifies for 4 points or the "extensive" level of acuity. Please refer to the chart, it is fairly self explanatory.

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 requires the selection of **ONE SINGLE 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 apply to 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



MDM . . .

for **two chronic health problems**, benign essential hypertension and mixed hyperlipidemia. These conditions are controlled and stable on current medications and s/he hasn't been seen in your practice for 3 to 4 months. 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 problems). **Today's new problems**, sore throat and cough are **self limited** and are worth one point each, which brings the total to 4 points (in Table 1), an acuity of high complexity based on **extensive 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 would skip **table 2** and move on to table 3. Remember that in the MDM process, only two of the three areas need to be considered to make a determination of MDM acuity.

Typically, in the office setting, Table 2 doesn't count for much in the way of establishing a higher level of acuity. In contrast, when a patient is admitted to a hospital, there are frequently a number of **labs, x-rays and other studies** that may need to be reviewed. A **consultation** with a specialist, the ER physician, radiologist, etc., can quickly add up to a **higher level 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. If you as a provider provide a new prescription for the new problem, or, if you change the dosage or strength of an existing medication, that is prescription drug management which also falls under the **moderate risk** section of MDM.

If you will look across the **Presenting Problem** sections on **Table 3**, you will see a number of situations where your patients will frequently present as either a moderate or high risk patient on this aspect alone. Medication management can be **high complexity** if monitoring of serum blood levels is needed.

So, when you consider **extensive diagnosis** (4) determination from Table 1 and the **moderate risk** in Table 3, the MDM acuity for this patient encounter is determined to be of **MODERATE COMPLEXITY**. It isn't high complexity because the level of risk is only moderate, so the maximum acuity possible is moderate.

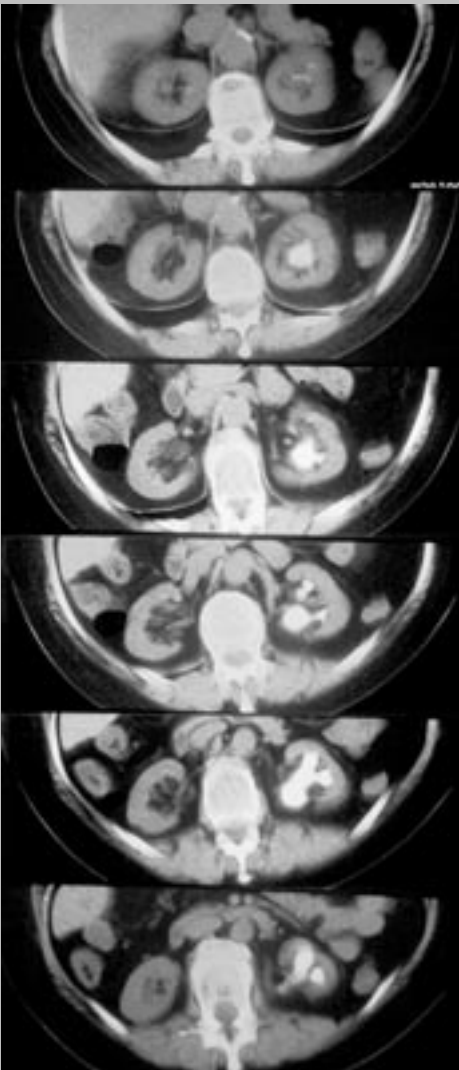
The next step is to consider the MDM with the other criteria of E/M coding, history and physical exam to determine the level of care. For an established patient, you must meet or exceed the criteria in two of the three key areas to decide which E/M code is correct.

If in your practice setting, you or your staff routinely update and/or review 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 appropriate areas (e.g., ENT and pulmonary), 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 correct information gathered/considered/reviewed.

Now, if your patient didn't have two pre-existing health problems, the MDM acuity would be considered as **LOW COMPLEXITY** because of the self limited nature of the **type of complaints** and **low risk** management options. If you happen to write a prescription, that would raise the risk to a moderate level, but the **presenting problem** is still low risk and therefore the overall MDM still only qualifies as **LOW COMPLEXITY**.

So there you have it, **Medical Decision Making**. This is a **very important** part of our everyday practice. Unfortunately, I think that all too often, we are so **confused** by MDM that we don't fully consider it. It isn't just the number of diagnosis a patient has. It is so much more than that.

Keep in mind, that the nature of the presenting problem may often determine the level of care long before we put our hands on the patient and do a physical exam. A good medical record supports that. Documentation that is current, complete, accurate and accessible is essential.



“This workshop, by far, has been the most helpful and understandable . . .”

Workshop evaluation form comment. See the “Feedback Page” on the MPECS web site.

MEDICAL DECISION MAKING CRITERIA CHART; MPECS CHART AUDITING FORM, Page 2

DECISION MAKING: There are four recognized levels of medical decision making: **Straight Forward**; **Low Complexity**; **Moderate Complexity**; and **High Complexity**; each with three components. Use the following 3 tables to determine the level of medical decision making documented in the medical record. Record that in the bottom section of this page under Medical Decision Making.

COMPONENTS

Must meet or exceed **2 of 3** components below

1. Number of Diagnosis or Management Options (see table 1)

2. Amount and/or Complexity of data to review (see table 2)

3. Risk of Complications and/or morbidity or mortality (see table 3)

	Straight Forward	Low Complexity	Moderate Complexity	High Complexity
	1 (minimal)	2 (limited)	3 (multiple)	4 (extensive)
	0 - 1 (none or minimal)	2 (limited)	3 (moderate)	4 (extensive)
	Minimal	Low	Moderate	High

TABLE 1 / DIAGNOSIS and MANAGEMENT

Type of Problem	Determination Method	Value
Self limited or minor	1 for single problem or 2 if the patient has two or more minor problems	1 or 2
Established: previously diagnosed	+ 1 for each additional problem previously diagnosed and addressed or reviewed on current visit + 1 for each established problem inadequately controlled, worsened or failed to improve as expected	1 ea.
Previously unidentified or undiagnosed, H & P provide enough information	Maximum score is 3 for problems of this type, no matter how many are identified on visit	3
Previously unidentified or undiagnosed, you order or plan to perform additional assessment, consultation or diagnostic studies	One problem of this type qualifies as extensive	4

Element Value Totals: 1 = minimal, 2 = limited, 3 = multiple, 4 = extensive

TABLE 2 / AMOUNT and/or COMPLEXITY of data to be reviewed

Data Information	Value
One or more lab tests requested or reviewed	1
One or more radiology tests or services requested or reviewed	1
One or more medical diagnostic studies requested or reviewed	1
Direct visualization and independent interpretation of a specimen, image or tracing previously interpreted by another physician	2
Discussion of results with the physician who performed or interpreted a study	1
Decision to obtain old records and/or additional history	1
Summary of review of old records and/or additional history to supplement information from the patient	2

Element Value Totals: 1 = minimal, 2 = limited, 3 = multiple, 4 = extensive

TABLE 3 / TABLE OF RISK

LEVEL OF RISK	Minimal	Low	Moderate	High
Presenting Problems	<ul style="list-style-type: none"> One self-limited or minor problem, e.g. cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness, e.g. well controlled hypertension or non-insulin dependent DM, cataract, BPH Acute uncomplicated illness, e.g. cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g. lump in breast Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonia, colitis Acute complicated injury, e.g. head injury with brief LOC 	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g. multiple trauma, acute MI, pulmonary embolus, arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status e.g. seizure, TIA, weakness or sensory loss
Diagnostic Procedures	<ul style="list-style-type: none"> Lab tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, e.g. echocardiogram KOH prep 	<ul style="list-style-type: none"> Physiologic tests not under stress, e.g. pulmonary function tests Non-cardiovascular imaging studies with contrast, e.g., barium enema Superficial needle biopsies Clinical lab tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Physiologic tests under stress, e.g. cardiac stress test, fetal contraction-stress tests Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsies Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac catheterization Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> Cardiovascular imaging studies with contrast with risk factors Cardiac electrophysiological tests Diagnostic endoscopies with risk factors Discography
Management Options	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings 	<ul style="list-style-type: none"> Over the counter drugs Minor surgery with no risk factors Physical therapy Occupational therapy IV fluids without additives 	<ul style="list-style-type: none"> Minor surgery with risk factors Elective major surgery (open, percutaneous, or endoscopic) with no risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fractures or dislocations without manipulation 	<ul style="list-style-type: none"> Elective major surgery (open, percutaneous or endoscopic) with risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

Table of Risk: Select one or more elements that apply to the current patient presentation. The element with the highest acuity is the one that determines the level of risk.



MDM . . .

It is important to understand that doing extra elements of exam in order to bill a higher level of office visit is unethical. Medical necessity is key to the correct physical exam. Understanding the E/M coding process including **MEDICAL DECISION MAKING** is key to the coding correctly for all patient encounters in every setting.

Every provider should have a **working knowledge** of the E/M coding process and especially MDM. Electronic coding and billing software do a pretty good job of recommending billing levels, but the problems I have seen in software and billing almost always centers around MDM, for various reasons. If you don't know the criteria for MDM determination, you'll never know if your computer is coding correctly.