

Productive Provider Newsletter

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M.P.E.C.S. Medical Professional Education and Consultation Services

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

Here is the latest issue of the *Productive Provider Newsletter*. This publication brings you timely, thoughtful and valuable information on the confusing topic of Evaluation and Management (E&M) coding. I hope that you find it useful and interesting.

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.mpecs.org.

Will you please forward this newsletter to your friends and associates and anyone you feel may be interested in learning more about E&M coding?

Thanks, enjoy this newsletter and have a great day.

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I was so confused. I needed something that would detail for me just what each of these terms meant.

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"It is not the critic who counts, not the man who points out how the strong man stumbled . . .

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All material contained in this publication is the original work of Jim Meeks, P.A.-C. unless otherwise noted. Quotations from and references to this material are encouraged and authorized as long as credit is given to the author, this newsletter by name and reference to the MPECS web site is included.

1. *Its just my opinion.*

What gives?

Some time ago, I received a call from a student of mine asking for some help. He had taken a position as a PA within a vascular surgery practice. After a few months, he was frustrated. The office policy, as he reported it, was that all established patient visits were to be coded at a Level 3 visit, a 99213 or lower. All new patient visits were to be coded at Level 2, a 99202 or lower. They weren't even using consultation codes. No variance was allowed from this policy.

When I asked him what the basis was for such a policy, he said he was told by the partner physicians that they didn't want to be audited. To reduce their risk of audit, they didn't want to code any higher than those two levels.

I asked my former student about his typical patients in this practice setting. He reported that most had multiple health problems and complicated histories before he ever saw them. Most were on several if not many medications and often were seeing a number of specialists in addition to their primary healthcare provider. A large number of patients were Medicare patients. The fact that they were being seen in his office meant that their health situation was such that they were in need of intervention that was probably going to be significant.

So, what gives? This practice had fallen victim to their fear of audit. They were willing to forego revenue they were entitled to for perceived safety from audit. The sad part is that this tactic does not offer protection. Instead, it is an almost sure fire way to bring on an audit, especially with Medicare. Without knowing it, they were setting themselves up for an audit based on their narrow use of evaluation and management CPT codes. At the same time, they were losing daily revenue they were entitled to by under coding for the care they were providing during office visits.

I have seen this before in surgical practices (as well as others). Some providers feel that the best place for them to generate income is in the OR, not in the office. While that may be generally true, it isn't necessarily the whole enchilada. A significant amount of revenue is generated by office visits, especially when correct coding is used.

In the case above, most patients as described by my former student, would qualify at much higher levels of acuity than those being used. Multiply that by the number of patients seen each day by each provider and that can be some significant revenue. I have seen published estimates that range from \$30,000 to \$100,000 per provider per year.

One more situation that totally baffles me. I once attended a presentation on coding by a former HCFA (now CMS) auditor. During this presentation, it was explained that proper coding should always be used (I've been saying that all along). The example cited was of a busy dermatologist that did a lot of excisions of suspicious skin lesions. A fair number of them were cancers, but the majority returned from pathology as benign.

We all know what a pain it is to bill for excisional biopsies. We have to wait for pathology reports before we submit the billings to insurance. If the lesion does turn out to be cancer, there is a specific code to identify the type of cancer. The payment is also better. However, if you do a lot of these, you may have a lot of procedure fees that you are sitting on for which you are waiting for the pathology reports to come back on. Sometimes, a lot of them can pile up. If your billing staff isn't right on top of things, you could really lose out on some payments if they get neglected or the pathology report results aren't forwarded to the billing staff.

The dermatologist in question decided that he would take a loss on the cancerous lesions and instead, bill all of lesions as benign suspicious lesions, thereby eliminating the back log on payments. There was much less paper work to keep track of. For a while, this seemed to work well.

There was no audit of this dermatologist. Instead, when it came time for him to renew his provider contract with the local *market dominant* insurance provider, he was denied renewal because they determined that he didn't do enough cancerous lesions in his practice to continue on their panel. Suddenly, he was without patients to see.

I've said it before. I'll say it again. It is in the best interest of every provider to understand correct coding principles. Even if you have an excellent billing staff and office manager, it is the responsibility of the person doing the work to be sure that the appropriate code is used.

The problem as I see it is that a significant number of providers, docs, PAs and NPs just don't take the time to learn. Evaluation and management coding is the most difficult of all coding issues to master. I know, I have been teaching it and lecturing on the topic for years and I still have to pull out my **Pocket Coder**® and review the requirements from time to time. It is just plain complicated. So complicated that even computer software doesn't always get it right. It's just my opinion.

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2. What does “Problem Focused” mean?

After a recent MPECS workshop, I had a participant ask me what does “Problem Focused” mean. That is an excellent question. I’ll try to answer that as best I can.

First, we need to understand that part of the confusion we all have with the evaluation and management (E&M) coding system is that the descriptive terms like “Problems Focused” are ambiguous at best. I mean really, look at the terms that are used to describe each of the areas of history, physical exam and medical decision making,

HISTORY/PHYSICAL EXAM:

Problem Focused, Expanded Problems Focused, Detailed and Comprehensive

MEDICAL DECISION MAKING:

Straight Forward, Low Complexity, Moderate Complexity and High Complexity

For goodness sake, what does all of that mean anyway?

It was this terminology that prompted me to develop the **Pocket Coder**® in the first place. I was so confused. I needed something that would detail for me just what each of these terms meant. I started buying nearly everything I could find for E&M coding, but nothing I found answered my questions to my satisfaction.

Nearly 10 years ago, I attended a workshop put on by our local Medicare administrating agency. In that workshop, handouts were provided that attempted to explain all of these terms and definitions. I left that workshop still in a state of confusion, but at least I had something new to work with.

Over the next few months, I worked through each of the levels of criteria for established and new patients on a big yellow legal pad, one page for each level, using the Medicare handouts and all of the other things I had obtained. Once I did that, it started to make sense, slowly. But then, how could I make it practical for use in my practice? Well, that is how the **Pocket Coder**® came to be. It is a great tool and nearly everybody that has one has felt the same way. I highly recommend it to you.

OK, lets talk about “Problem Focused.” You will see this term used in two areas of E&M coding; history and physical exam. Level 1 (99201) for new patients and Level 2 (99212) for established patients.

A “Problem Focused” history consists of a very brief history of present illness (HPI). Documentation of one to three elements of HPI (there are 8 defined elements of HPI) satisfies that requirement. No review of systems (ROS) or past medical, family or social history (PMFSoHx) documentation is needed for this level of care.

A “Problem Focused” exam is also something very brief. Depending on which criteria you are using (1995 vs. 1997 guidelines), there are specific elements of exam that have to be documented. In relation to a new patient or established patient, the criteria is the same, just the code or level is different.

Under the 1995 guidelines, documentation of your examination of only one organ system or body area is required. That is it.

The 1997 documentation guidelines rely on documentation of more specific elements or bullets as they are commonly referred to. The “Problem Focused” exam therefore requires documentation of one to five bullet items from the list of bullets on the 1997 Multi-System exam. That is pretty easy. This really is a limited exam of a patient.

The only other concern you should have at this level is in the situation of a new patient. In that case, you always have to consider the medical decision making (MDM) component. At Level 1 (99201), MDM is

“Straight Forward.” That means only one diagnosis, minimal or no lab data and minimal risk of morbidity or mortality.

My feeling is that a Level 1 new patient or Level 2 established patient visit is very limited. Examples cited in the CPT book (see Appendix C) include things like single prescription refills for out of town visitors that forgot them, evaluation (not removal) of an unsightly pedunculated neck lesion on an established patient, evaluation of (not drainage) of a subungual hematoma, evaluation of diaper rash, removal of sutures placed by another provider, and others.

Personally, I use the 99212 code most often when I ask a patient to come back for a recheck of otitis media (or some other simple problem) after starting on high dose amoxicillin. Typically, I am going to look in the affected ear, not much more than that. If all is going well and I don't need to provide any other care, it is the perfect code.

Anything more than that will probably justify using a higher code.

During practice consultations and chart audits, I am frequently amazed at the number of 99212 codes I see used regularly for patient encounters (established patients) that are clearly of a higher level of care. Most often, this is because the provider selecting the level of care doesn't understand the E&M coding system and are trying to “play it safe.”

I once did a chart audit in a solo practice where the physician coded nearly 90% of his office visits at 99212. He had his fee set at \$60.00 for that level and he couldn't understand why he wasn't getting paid what he expected. After correcting his coding practices and his fee schedule, he noticed a dramatic change in his income, upward.

Correct coding is essential to the success of every practice and every provider. If you are unsure of your coding effectiveness, it is time to get some help.

PRACTICE PROFITABILITY WORKSHOPS:

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

The next MPECS workshop is scheduled in Salt Lake City on April 24, 2004. The web site has the current details. Mark your calendars and register early! Please visit www.mpecs.org for more information.

3: High Achievements and Failures:

“It is not the critic who counts, not the man who points out how the strong man stumbled, or where the doer of deeds could have done better. The credit belongs to the man who is actually in the arena; whose face is marred by the dust and sweat and blood; who strives valiantly; who errs and comes short again and again; who knows the great enthusiasms, the great devotions and spends himself in a worthy course; who at the best, knows in the end the triumph of high achievement, and who, at worst, if he fails, at least fails while daring greatly; so that his place shall never be with those cold and timid souls who know neither victory or defeat.” --Theodore Roosevelt

PLEASE SEND THIS ON . . .

If you like what you see here in the *Productive Provider Newsletter*, please recommend and forward this Newsletter to anyone that is interested in becoming more productive in his or her medical practice. Providers, billers and office managers alike are enjoying this publication.

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