



MPECS PRODUCTIVE PROVIDER Newsletter

By Jim Meeks, PA-C

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The Cancer Battle Continues: "High grade spindle cell sarcoma of the neural sheath"

This is a short update. I have undergone two rounds of chemotherapy which were mostly ineffective. In fact, from the time of the initial diagnosis in February to completion of the second round of chemotherapy at the end of March, additional lesions were found in my lungs and spine. I have just completed five weeks of radiation therapy on the primary tumor in the right axilla and of the lesion discovered in my T-8 vertebral body. I am scheduled for MRI and CT studies on the 9th and meet with the head of the Sarcoma Team later that morning to plan further treatment.

I have kept an updated blog posted with all the details and some fascinating images at: jimmeekshealth.blogspot.com

I have had a number of people ask about finances and some have contributed most generously to assist with the expenses of the treatments, travel and so forth. One associate suggested I start a "Hundred Dollar Club." Therefore, I have set up a "Cancer Support" page on the MPECS website for anyone that would feel comfortable contributing a hundred dollars. You can easily charge this to a credit card or debit card for convenience and shows up as a charge from MPECS on your statement. I express the deepest felt thanks for any contributions. They are sincerely and genuinely appreciated.

Another Question?

"I am a physician with a number of years of experience. Recently, our practice underwent a voluntary audit of our practice/provider evaluation and management coding. I always thought I was doing a good job. Instead, I was told that my documentation doesn't support the billing I submit. I was provided with some pages of instructions for billing, but it is all a bit confusing. Can you please help with some simple concepts?"

I am not surprised that you find it all a bit confusing. That has been a problem with evaluation and management (E/M) coding from the start. The purpose of E/M coding is to establish standard guidelines of documentation that in turn serve to support billings submitted for payment and can stand up to the auditing process. Unfortunately, it has been a very difficult road due to the complexity of patients, the numerous specialties and subspecialties of medicine and the individual style of everyone that practices medicine.

Great inroads in this process have been made with electronic health records (EHR). Yet, there is great variability amongst the many EHR products available. Again, individual style has a lot to do with that. Many practices still use paper charts for hand written or dictated notes.

Whatever the system, I strongly believe that every clinician needs to have more than a superficial understanding of E/M coding. It is essential knowledge. Yet, few clinicians invest the time and effort needed to acquire that knowledge. The MPECS E/M Coding Essentials workshop is designed specifically for that purpose.

It would be impossible for me to give you everything you need to know here in this article. The E/M coding process is complicated and intimidating to many. But, before you become discouraged by that statement, take heart in knowing that the basic elements of collecting history and doing a good exam you learned early in your medical training serve as the basis of E/M coding.

So how is it that we as clinicians seem to fail so miserably with documentation? The question posed by one of my readers above is a very common concern, "documentation doesn't support the billing" submitted. How does that happen?

I believe that one reason is that we are so pressed for time. The demands of a modern medical practice are immense. Somehow, somewhere, the bills have to be paid. That means that we have to see enough patients every day to generate the kind of income necessary to meet the costs of the practice. At the same time, we want to provide the best care possible to each and every patient. When we are pressed for time, documentation suffers.

At some point in our medical education we were taught the essentials of collecting a good patient history. We then learned how to perform a physical exam. Finally came the difficult task of medical decision making. We had to learn about disease processes and how to treat them. With practice, both didactic and clinical, we learned how to care for our patients.

I suspect that most of us have learned in similar ways. Then, when we enter practice and start caring for our own patients, we encounter the E/M coding system and we are all confused. I think that we can apply the same learning process to E/M coding and documentation.

My observations of many hundreds upon hundreds of charts over the years leads me to believe that our documentation is the reason we all struggle so much. As I mentioned above, we are pressed for time. We begin to learn short cuts in documentation, only recording what we feel are the "essential elements" related to our practice so that we can complete the chart and get on to the next patient. Specialists tend to do this even more so. These short cuts save time, but don't necessarily meet the criteria for documenting a higher level of care and billing for it.

If I could encourage you to take a step back and look at your documentation as part of the patient exam and treatment process, I'd have you try to look at it as the final element of your encounter. I try to do this in the exam room while still with the patient. I look over my notes (electronic or hand written - because I do both depending on where I am working).

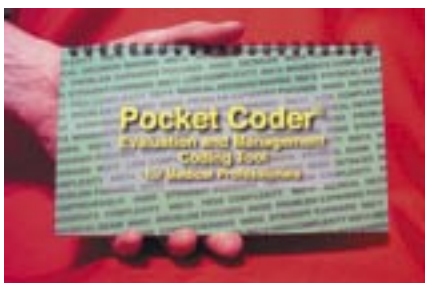
As I have written about a number of times before, there are specific elements that are looked for when audits are done. Lets first look at history. History collection consists of the history of present illness (HPI), review of systems (ROS) and the past medical history, social history



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If you are unsure of what constitutes history, exam and medical decision making (you are not alone), you should consider getting the **POCKET CODER** which outlines the specific elements of a patient encounter in an easy to understand matrix format.

Every **SOSE exam** is available now, and you can download them in PDF format for your perpetual use.

See information on the **PRODUCTS** page of this web site.

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SOSEs . . .

and family medical history (PMFSHx) of the patient. Ask yourself, how much of this history is recorded or updated in the current medical record? Would an auditor be able to tell that it had been updated or reviewed if previously recorded?

There are 8 specific (mandated) elements of documentation (location, quality, severity, duration, timing, context, modifying factors and associated symptoms) related to the HPI. Does the HPI in today's note contain enough information to stand alone? I mean, can some auditor reading the HPI figure out why you are seeing the patient in relation to the above elements?

The ROS consists of 14 elements or body systems (constitutional, eyes, ENT/mouth, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, integumentary, neurological, psychiatric, endocrine, hematologic/lymphatic and allergy/immunologic). Can you identify any kind of a review of any of those systems in your current clinical note? During chart audits and medicolegal case reviews, I have found sometimes that any ROS is difficult to identify even for the given system the patient is having problems with. I have concluded through personal observation, that most of us do some kind of a ROS when we are talking to our patients, we are just lousy at recording it. It is something we do almost unconsciously as part of our patient care. However, failure to record it or even the extent to which we do it is a common problem.

There are no prescribed elements for PMFSHx. However, the standard of care for all disciplines of medicine and medicolegal defense require that we understand who our patients are medically and what their risk factors are before we treat them. Understanding the patient in each of these areas is essential for good medical care. This information can be recorded on a "history sheet" in paper charts and is well covered in EHR systems. If the information is never collected and recorded somewhere in the first place, it can never be updated and reviewed. Most often, it is the updating and review of that information that falls short in medical chart audits.

Your physical exam counts for a lot. This consists of observations and exams. If you practice in an area of medical specialty, your exams are likely to be more focused on one or two body systems rather than a general body wide exam. This again is a critical area that we tend to fail in when it comes to documentation. Unfortunately, there is much confusion about this as well. Most providers tend to follow the elements of the "Multi-System Exam" as set forth in the 1997 guidelines (based on the number of "exam bullets" a provider documents). However, this type of exam doesn't fly very far with the medical specialties. Fortunately, the "Single Organ System Exam" addresses that concern fairly well. If you are unfamiliar with either of these terms, please review some of my previous newsletters where these are discussed in great detail.

Finally, once you have a good grasp of the patient's history and have performed an adequate and appropriate physical exam, you have to decide how to treat your patient. This is called the medical decision making (MDM) process and incorporates all of the information you have collected in the history and physical exam. You have to consider the nature of the presenting problem and decide how complex your patient is and at what risk you are putting the patient with your treatment program. Most of us don't record this process very well in our clinic notes and the MDM process is quite complex. Again, I have written about this extensively in the past. Please take the time to review those previous articles if you are not sure of the process.

Many EHR products are often based on templates designed to assist you with this documentation process. Paper charts present a greater challenge for documentation due to costs of dictation or time spent hand writing the notes. I think paper templates or forms are great and I have designed several for practices that tend to work well for their given circumstances. It is important to remember that it doesn't matter how good a form is. If a provider doesn't understand the elements of history, exam and medical decision making, or doesn't fill out the form with the correct information, it does nothing for the provider, the patient or the practice.

The final task for every provider is to take one or two minutes to review your encounter documentation to see if you have documented all of the correct elements of the encounter. Whether you use an EHR or some form of a paper chart, your documentation has to support the level of billing you submit. The mandated elements are fairly standard. Our ability to take the time to record them is the challenge. Good, compassionate care is our goal.

The MPECS **POCKET CODER**® is designed in a matrix format to allow any user to easily identify the necessary elements of history, exam and MDM for any level of E/M care. I have included a couple of examples below. Also, you will note that the nature of the presenting problem and time elements are also included at the bottom of each page of the **POCKET CODER**®.

Understanding these E/M concepts will go a long way to helping any provider of health care understand what is required for any given level of care. Your documentation will then support the level of billing you submit when based on these principles.

ESTABLISHED PATIENT OFFICE VISIT

COMPONENTS (History, Exam, Decision Making) Must meet or exceed 2 out of 3 components	LEVEL 1 99211	LEVEL 2 99212	LEVEL 3 99213	LEVEL 4 99214	LEVEL 5 99215
HISTORY		Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Chief Complaint/History of Present Illness (8)		Brief (1 to 3)	Brief (1 to 3)	Extended (4 or more)	Extended (4 or more)
Review of Systems (14)		N/A	Problem Pertinent	Extended (2 to 9)	Complete (10 or more)
1) Past Medical, 2) Family, 3) Social Hx's		N/A	N/A	Pertinent (1 out of 3)	Complete (3 out of 3)
EXAM	Supervision Only Health Care Provider presence not required for Level 1 visits	Problem focused Limited exam of affected body area or organ	Expanded Problem Focused Limited exam of affected body area or organ system and other symptomatic or related organ systems	Detailed Extended exam of affected body area(s) and other symptomatic or related organ systems	Comprehensive General multi-system exam or complete exam of single organ system
1995 Organ Systems (12) / Body Areas (10) 1997 Multi-system Exam Doc. Requirements		(1) / (1) 1-5 •	(2-7) / (2-7) 6-11 •	(2-7) / (2-7) 2 • in 6 areas or 12 •	(8-12) / (8-10) 9 areas, 2 • each
DECISION MAKING		Straight Forward	Low Complexity	Moderate Complexity	High Complexity
Number of Diagnosis		Minimal (1)	Limited (2)	Multiple (3)	Extensive (4)
Amount and / or complexity of data to be reviewed		Minimal or none	Limited	Moderate	Extensive
Risk of complications and / or morbidity or mortality (see table of risk)		Minimal	Low	Moderate	High
TIME (Face-to-Face) in minutes	5	10	15	25	40
TIME is the controlling factor only when counseling and/or coordination of care dominate (>50%) the provider/patient and/or family encounter					
PRESENTING PROBLEM	Minimal	Self Limiting or Minor	Low to Moderate	Moderate to High	Moderate to High
SEVERITY of reason for patient encounter with regard to disease, condition, illness, injury, symptom, sign, findings or complaint					

Consultations: Office / Outpatient / ER

COMPONENTS (History, Exam, Decision Making) Must meet or exceed 3 out of 3 components	LEVEL 1 99241	LEVEL 2 99242	LEVEL 3 99243	LEVEL 4 99244	LEVEL 5 99245
HISTORY	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Chief Comp./History of Present Illness (8)	Brief (1 to 3)	Brief (1 to 3)	Extended (4 or more)	Extended (4 or more)	Extended (4 or more)
Review of Systems (14)	N/A	Problem Pertinent	Extended (2 to 9)	Complete (10 or more)	Complete (10 or more)
1) Past Medical, 2) Family, 3) Social Hx's	N/A	N/A	Pertinent (1 out of 3)	Complete (3 out of 3)	Complete (3 out of 3)
EXAM	Problem focused Limited exam of affected body area or organ	Expanded Problem Focused Limited exam of affected body area or organ system and other symptomatic or related organ systems	Detailed Extended exam of affected body area(s) and other symptomatic or related organ systems	Comprehensive General multi-system exam or complete exam of single organ system	Comprehensive General multi-system exam or complete exam of single organ system
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DECISION MAKING	Straight Forward	Straight Forward	Low Complexity	Moderate Complexity	High Complexity
Number of Diagnosis	Minimal (1)	Minimal (1)	Limited (2)	Multiple (3)	Extensive (4)
Amount and / or complexity of data to be reviewed	Minimal or none	Minimal or none	Limited	Moderate	Extensive
Risk of complications and / or morbidity or mortality (see table of risk)	Minimal	Minimal	Low	Moderate	High
TIME (Face-to-Face) in minutes	15	30	40	60	80
TIME is the controlling factor only when counseling and/or coordination of care dominate (>50%) the provider/patient and/or family encounter					
PRESENTING PROBLEM	Self Limiting or Minor	Low	Moderate	Moderate to High	Moderate to High
SEVERITY of reason for patient encounter with regard to disease, condition, illness, injury, symptom, sign, findings or complaint					

POCKET CODER® highlights; This matrix format is designed for at a glance comparison of each level of care within a given area of service. The required elements of documentation for History, Exam, Decision Making are all outlined with additional criteria for Time and the Presenting Problem considerations as appropriate. The 1995 and 1997 exam elements are included for clearer understanding and selection of the correct exam level. These two pages (Established Patients and Consultations) represent only two of twenty-two pages of E/M coding information and services included in the POCKET CODER®. Other areas include; New Patient Office Visits, Initial Hospital Care, Subsequent Hospital Care, Observation Admits, Inpatient Consults, Nursing Home Care, Home care, Critical Care and others as well as Medical Decision Making tables, modifiers related to E/M services and much more.