

Productive Provider Newsletter

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Productive Provider Newsletter

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Productive Provider Newsletter

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Front Page

Its Just My Opinion

Every once in a while, I talk to someone involved in a practice that expresses frustration about some specialty providers that don't want to bill for Evaluation and Management (E/M) visits they provide. Often, this involves a provider in a surgical practice and granted, most of the revenue that they generate comes from the surgical procedures or interventions they provide. But is this good business?

In the book *Practice Enhancement: The Physician's Guide to Success in Private Practice*, the author states that "The art and science of practicing medicine is not a business, but there is a business involved in the peripheral aspects of ensuring that the service is delivered."¹

I think that most medical practitioners practice medicine because they enjoy helping people. They spend many years learning the art of medicine and mastering the science of medicine which allows them to care for the patients they see.

Unfortunately, harsh reality sets in when they open a practice and have to pay the costs of operating that practice. The overhead is enormous. Renting office space is just the beginning and we all know how expensive "medical" office space is. Beyond that has to be included costs of malpractice insurance, office staff, billing services, utilities and many other small things that often add up to a significant amount every month. Somehow, those bill have to be paid every month.

I remember quite a few years ago when a newly graduated and newly employed physician assistant called me and expressed absolute frustration with the surgical

See Opinion on page 2 . . .

Your Medical Record; Is it up to snuff?

There are probably as many formats for medical records as there are ways to run a practice. In my experience, the paper chart reflects this more than any other method of charting. The medical record comes under scrutiny when there is a question about medical care. This may come when another provider in your practice sees one of your patients, when medical records are transferred to another provider or practice, when your records are requested by an attorney or in a number of other circumstances. The question I ask is this; Do your medical records meet the grade? Here are some guidelines for medical records that you may find helpful.

The medical record should;

1. Be first and foremost a tool of clinical care and communication

A tool is something regarded as necessary to perform ones work. Without it, it would be difficult to do. Additionally, if someone were required to take over the care of your patient, the medical record should provide enough information and detail that any other provider would not have to start from scratch, so to speak, to continue managing the patient's medical care.

2. Be complete, logical and legible

Notes should be complete and current, easy to read and follow a logical format. Lab, radiology, consultations and other reports should be referenced and easy to locate in the chart. There should be a sense of order to the organization of the chart. Can it be read by someone other than the author?

See Medical Record 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;

Lehi, Utah May 6, 2006

**This workshop is being held
at the world famous Cabela's
- "The World's Foremost
Outfitter"**

CONFERENCE LECTURES;

**NPACE September 14, 2006
Chicago, Illinois
www.npace.org**

**AFPPA November 3, 2006
Phoenix, Arizona
www.afppa.org**

**The 2006 schedule is now open.
Need a conference speaker? Give
us a call. We'll talk!**



Opinion

practice that had hired him. Soon after starting work there, he discovered that the office used only two codes for office visits; 99203 and 99213. He was instructed to use only those two codes when he saw patients.

Now, this isn't quite the same as not charging at all, but it reflects a basic lack of understanding for the E/M coding system. Unfortunately, this lack of understanding seems to be common in one degree or another.

About two years ago, I was asked by an acquaintance of mine working in a large orthopedic practice to talk to the office manager about some billing and coding concerns. In the course of that conversation, I learned that there wasn't much consistency among the providers in this group when it came to documentation or billing. Some were using hand written charts. Some were dictating and one was using a self designed template sheet he had designed. There were several employees doing the billing and coding for the practice and they were kind of grouped together depending on the coding practices of the given providers. Again, it seemed obvious to me that there wasn't a lot of consistency here either, but that was the way they wanted it. They had to keep the surgeons happy.

I recently had a conversation with someone in a practice of highly specialized surgeons. I was told that these same problems existed in this group of specialists. One of the surgeons wasn't billing for any E/M services, only the surgical procedures he was providing. Is that fair to the other partners or associates in the practice? Is that being fair to himself? By neglecting this part the business side of practicing medicine, some of the costs of practicing medicine are being carried by the other providers in the group. At what cost?

E/M codes in surgical practices are a challenge. When we are anticipating surgery, we have to take into consideration the "global surgical period" for the given procedure, especially when we are dealing with Medicare patients. This may range from 10 to 90 days. If the decision for surgery is made on the day before or the day of surgery, an E/M code for initial hospital admission or consultation is used with modifier -57 for major surgeries or modifier -25 for minor surgeries. The E/M service should still be billed.

But that isn't the only time E/M services are provided by surgeons. There are a number of times that patients are evaluated in a surgeon's office, for various reasons. Tests and studies may be ordered in an attempt to establish an accurate or final diagnosis. Maybe the options for surgical intervention are presented, risks discussed and the patient wants to think about it for a few days. These types of visits should be assigned and appropriate E/M code and the services billed for. After all, the work was done, expert advise provided.

The cost for not billing for these services may be substantial. I met an ENT surgeon that was having office visits in excess of 50 per day, three days a week and surgery two days a week. Can you imagine if he didn't charge for those office visits?

Lets say that a surgeon sees 30+ patients in the office only two days a week and is in the OR three days a week. Certainly, a large part of what he produces is going to be generated in the OR. Some of those patients he is seeing in the office are obviously going to be follow-up visits in the "global surgical period" and those visits are included in the operative charges. It is those other office visits that are the ones I am thinking about. Maybe half are patient visits not directly related to a surgical procedure. If they are new patients, they could be coded anywhere from 99201 through 99205.

For the sake of simplicity, I will say that the average E/M charge for this type of visit is \$50. If we calculate that out, say about 30 patients a week at \$50 each would be about \$1,500.00. When you extend that out to a year (I'll say about 45 weeks to allow for vacations and conferences, etc.), well that becomes a significant amount. How does \$67,500 sound?

Depending on the provider, the practice and the actual numbers, that could be



Medical Record Should . . .

3. For each patient encounter, document or provide reference to:

a. date and legible identity of the health care professional

This is a big problem, especially in practices where any number of providers may see a patient. This is very important information, especially the identity of every person making any note in the chart.

b. the chief complaint and/or reason for the encounter and, as appropriate, HPI and past history (relevant PMFSHx)

Each note should be able to stand alone. This doesn't require a rewriting of previous notes on follow-up visits. But, enough information should be included or referred to, so that it is clear to anyone reading the note as to why the patient is being seen. If past medical, family and social history (PMFSHx) are included on a flow sheet as part of the medical record, these should be updated and/or reviewed as appropriate. The visit note should reflect when the PMFSHx is reviewed and/or updated and by whom.

c. physical exam findings

Document all physical exam findings. If you do the exam, you should document the findings; normals and abnormal are part of the exam.

d. prior diagnostic test results and reasoning for new or additional tests, procedures, referrals, etc.

Results of tests should be easy to locate in the chart. Your office notes should reflect that results were reviewed and why any additional tests, procedures, referrals, etc., are ordered or scheduled.

e. assessment, clinical impression or diagnosis

Your clinical impression of what the diagnosis is today. That may change in the future as more information is obtained (labs, radiology, etc.). Symptoms are perfectly fine if a more specific diagnosis has not yet been made. For example, abdominal pain of the right lower quadrant (a symptom) may become acute appendicitis (a diagnosis) after lab work is done and a CT of the abdomen is obtained. It is appropriate to call it abdominal pain until you know what the official diagnosis is. In some cases, that takes a while.

f. plan for care and follow up

Be sure that whatever instructions you give for follow-up are documented in the chart. If a patient fails to follow-up as instructed and has a bad outcome, a one sentence follow-up note can be a malpractice case lifesaver.

4. Identify past and present diagnoses and conditions, health risk factors, allergies to medications and immunization status

A patient information sheet is the perfect place for this information. Personally, I like to have it right on top when I open a patient chart. I can review it (and update it) easily on every visit if needed. Unfortunately, it only works if it is updated regularly.

5. Identify current medications

*The patient information sheet is invaluable for this information. I like to ask patients to bring all of their medications from **all of their doctors** with them to every office visit. The medical assistant or nurse can take the time to go over all of their drugs and update the information sheet before I see the patient. I can then review the information in a matter of a minute or so in the exam room.*

6. Document the progress, response to changes in treatment, planned follow-up care and instructions to the patient and the family

Documentation of progress and response to treatment is good medical care. Children and elderly patients are often accompanied by family members; when you discuss treatment plans, instructions and follow-up care, document to whom you are giving the instructions, etc. so that when questions arise,



UPDATED CODER

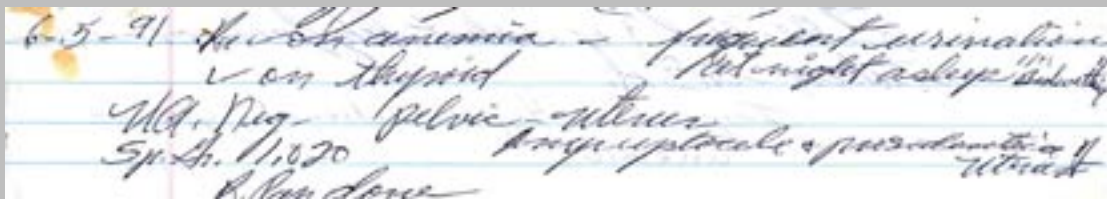
Do you know the specific elements of documentation that determine which E/M code you should use? You are not alone if you are still struggling with this process. Updated with changes for 2006.

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.





Medical Records Should . . .

you'll know to whom you gave the information.

7. Support the CPT and ICD-9 codes reported on medical claim forms

Your documentation for any given patient encounter must support the CPT and ICD-9 codes you are submitting for payment. For example, if you submit a charge for a rapid strep test, somewhere in your note, you should document a complaint of sore throat. If you list other symptoms of an upper respiratory illness but do not include sore throat, someone auditing your claims may wonder if you are simply padding the bill with extra charges.

8. Be maintained with regard to requirements of medical ethics and law concerning confidentiality

What is your office policy on this matter? Is it written? Is it followed? Patient records, charts, lab reports and so forth should not be left where unauthorized people can pick them up, look at them or have access to them in any way. Your office policy should be written and consequences for failure to follow policy should be spelled out.

So take a look at your charting system and look at it with these eight items in mind. Once a month, all of the providers in your practice should meet together with the office manager and billing staff and conduct audits of random charts for each provider. During these audits, all of the items mentioned above should be looked for in each chart. Additionally, charts should be scrutinized for correct billing practices. This process should be part of the compliance plan in every practice.

For additional information on chart audits and compliance plans, please look at the July 2004 Productive Provider Newsletter article "Its Just My Opinion" on chart auditing and compliance plans. You can access that article on the Newsletter page of the MPECS web site, www.mpecs.org/newsletter.

Opinion

significantly higher. It could be lower, but I don't think by much.

With the cost of running the business of medicine today, can any provider afford to not bill appropriately for the E/M services they provide? I think not. If a provider is unsure of how to use E/M codes correctly, that is what MPECS is all about. This newsletter is only one source for information. Please let us help.

Finally, before I am branded as a money grubber and a heartless clod, let me make this point perfectly clear, I am all for providing services to the uninsured/underinsured people in our communities. I have written previously about how to implement discount polices into your practices. I do not advocate that any provider should provide free services to the financial detriment of their overall practice. I have seen it happen. Wisdom is required.

Its just my opinion.

Jim Meeks, P.A.-C.

1. Greg N. Korneluk, *Practice Enhancement: The Physician's Guide to Success in Private Practice*. Macmillan Publishing Company, New York, New York, 1985. pg 263.

May Practice Profitability Workshop

Mark your calenders for May 6th, 2006. The next great Practice Profitability Workshop is scheduled for this day. This will be an exciting experience for all in attendance. The workshop is being held at Cabela's, the "world's foremost outfitter." This is the first Cabela's store in the Western United States. They have a nice classroom that has been reserved for this Saturday morning workshop. If you cannot attend, please tell your associates and any other coding and billing challenged providers about it. Four hours of CME are provided. Register before April 29, 2006 and save \$50.



"This may have been the best 4 hours spent in CME I have ever had. Everyone should attempt to attend if at all possible"

Workshop evaluation form comment.
See the "Feedback Page" on the MPECS Web Site