Productive Provider Newsletter

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AT A GLANCE:

In this month's

Productive Provider Newsletter

FRONT PAGE:

It's Just My Opinion
Are you sick of hearing about "Reimbursement?" I am.

Asset or Liability?
How is your contribution to your practice profitability? Are you an asset or a liability?

PAGE FOUR:

What Makes a Good Medical Record?
The Basics. The medical record should . . .

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Front Page

It's Just My Opinion

I think it is time to talk about *reimbursement* again. The term is used every day as we talk about insurance companies, Medicare, Medicaid and so forth. Whenever we start talking about the business side of medicine, we talk about reimbursement. However, I find the term very puzzling in it's use and confusing in it's application.

I first wrote about reimbursement in December of 2003. At that time, I looked up the word in a dictionary. I looked it up again today, and it hasn't changed much. I suspect any difference may be in the source I used on the two separate occasions.

Today, I used an Internet based dictionary. There were several definitions, all of which define reimbursement as "repayment for an expense or loss incurred." The definition I quoted back in 2003 was a little more specific; "Pay back money to somebody: to pay somebody back money spent for an official or approved reason or taken as a loan, or give somebody money as compensation for loss or damage."

Now, I don't know about you, but when I see patients in my practice, I don't view what I do as a loss or as damage to the patient nor do I view it as a loan. I provide a valuable and essential service. The flip side of providing that service is that I expect value to be associated with the service and a fair fee attached to it. I should be able to expect to be compensated fairly. What good is it if a medical practice can't pay the bills to keep the doors open?

The fact of the matter is that many years ago, when my oldest kids were little, we had to pay our family doctor directly. This was expected at the time of the visit. We were then given a receipt for the fees we had paid. We then sent that receipt to our insurance company. In turn, the insurance company would REIMBURSE us for the expenses we had incurred providing they were covered by our policy and based on their reimbursement rate. Often less than

See "Opinion" on page 2 . . .

Asset or Liability?

I talk to a lot of healthcare providers in many different settings, in many parts of the country. It is one of the most enjoyable aspects of my work experience. Many of these providers express frustration with the complexity of evaluation and management (E/M) coding, maintaining practice profitability and trying to maintain some form of home and social life. I recently was honored to have a physician attend my E/M Coding Essentials workshop for the second time. My first repeat customer, I think. He told me that the first workshop he had attended had made such an improvement in his overall billings and collections, that he wanted to attend again to build upon what he had learned the first time.

He further explained that in his practice (a large multi-specialty group), each provider is paid based on a "draw" against the collections for their own billings. Every quarter, he receives some kind of a balance sheet that shows his salary and shared costs of maintaining the practice (similar to rent) in relation to his billings, and collections. Prior to attending the workshop the first time, his quarterly balance sheet would show as much as $12,000 in the hole. No production bonus with those kinds of numbers.

Since attending the workshop the first time a year ago, his balance sheet has improved and is showing as much as $12,000 on the positive side. Now as I see it, that is about a $24,000 improvement per quarter which comes close to $100,000 a year. He isn't seeing any more patients than he did before the workshop, but he is documenting with more detail and billing appropriately for the work he performs. Amazing!

Can a provider be a liability to a practice? Sure, especially when everyone else in the practice is carrying the load for that provider. This is more likely to happen in a group practice or large clinic setting where expenses gets pooled together. It appears sometimes as though there isn't much attention focused on individual providers, especially if the bills get paid every

See "Asset or Liability" on page 3 . . .

MARK YOUR CALENDARS

EVALUATION and MANAGEMENT CODING ESSENTIALS WORKSHOPS & LECTURES:

MPECS is dedicated to making your practice of medicine more productive, more profitable and ultimately more enjoyable. The comprehensive MPECS 4-hour **E/M CODING ESSENTIALS** 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;

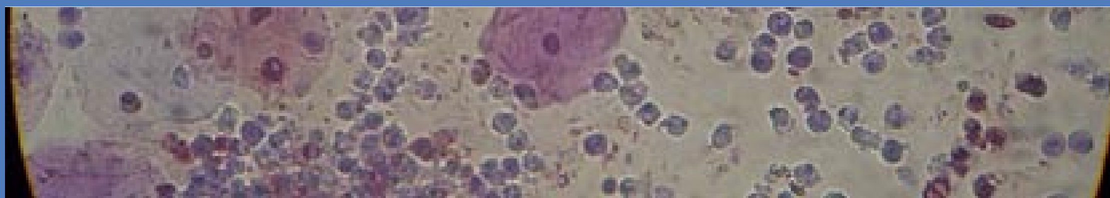
UP-COMING MPECS WORKSHOPS;

Lehi, Utah
September 15, 2007
Monterey/Pacific Grove, CA
Looking for interest

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

CONFERENCE LECTURES;

Available for 2007 - 2008 bookings. Contact me.



Opinion

the amount we had paid. To pay back money that is SPENT for an approved reason, that is reimbursement. The current system we work under isn't reimbursement. Since the patient hasn't paid anything more than a co-pay, how can it be reimbursement?

I am sure that many of you out there are asking where I am going with this. Primarily, I feel the same, as I believe most healthcare providers do; I just want to take care of my patients. That was my primary goal when I decided on a career in medicine. As a result, I have found great personal satisfaction in caring for my patients and I am fortunate enough to have established a good relationship with most of them. Some have even become very dear friends.

The problem is this. Within the current medical system, many patients are steered to healthcare providers by way of their insurance company's "approved provider list." Fees paid for services are essentially dictated by the insurance companies we contract with and are stipulated to the provider in the authorized "fee schedule." A number of practices or providers just don't seem to pay a lot of attention to the insurance company fee schedule or to the patients that come and go in the practice. Patients seem to change providers often because employers change what plans they offer to their employees.

Because practices and providers seem to buy into the current reimbursement concept, I see many that believe seeing more patients means more money. Unfortunately, I also hear patients complain about it. They express frustration with being treated like cattle in busy practices. It takes a couple of days to get a phone call report on lab work or other tests, let alone get an appointment.

One patient recently switched to our practice (found our name in her insurance company provider booklet), because she believed that people at her previous provider's office weren't being honest with her. She had called a number of times trying to get results of some basic lab tests that had been done. On one attempt, she was told that the results were on the doctor's desk, waiting for him to review and that she should hear back later that day. She heard nothing. On the next day, she was told that the results hadn't been received yet, a full week after the tests had been performed. Finally in frustration, she called our office, made a same day appointment, met with me and I was able to pull her lab results off the laboratory computer and review them with her. She was frustrated to learn that the results had been posted on the computer the day after they were drawn. She was angry that the medical staff at the previous provider's office had brushed her off. She was thankful that I was able to serve her needs and manage her health without a big hassle.

I have talked about "customer service" issues before. It is a concept that needs to be considered and practiced every day in a practice if it is to be totally successful. If you are losing patients because of poor customer service, what value do they attach to the service you provide to them?

Dealing with a third party that is largely distant from the patient/provider process injects a sense of disconnection between patient and provider. I believe that at least sometimes, providers become more focused on the expectations of the reimbursement entity and government agencies than on patient satisfaction. Again, seeing more patients to increase the income but actually spending less time caring for the needs of the patient. I hear about this from friends, associates and patients, so I know it exists.

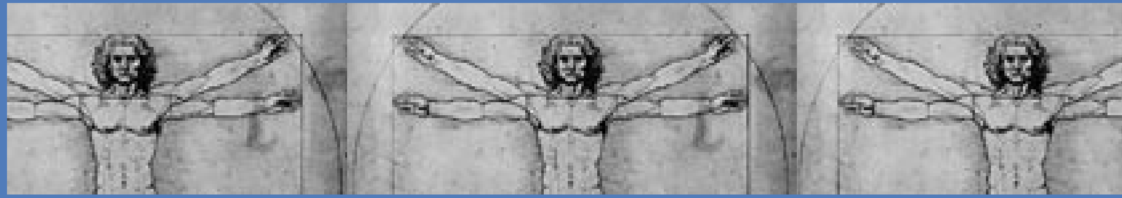
My personal belief is that we should eliminate the term *reimbursement* from our vocabulary in connection with the practice of medicine. We offer a service. We should get paid for our professional skills and the services we provided to our patients. With a different frame of reference, maybe we can begin to focus again on the important issues of patient care. At the same time, if we provide a service, instead of hoping to get "reimbursed" we should expect **payment for services rendered**.

In the current climate of denials for services, reduction of payments, cost cutting initiatives and so many other challenges to health care, we should recognized that we offer a valuable service. It doesn't matter who pays the bill, but it sure isn't reimbursement. It is business. If we fail at the business, we fail our patients.

No other industry in America subjugates itself to a third party payer the way medicine does. Do we need an adjustment the perception of ourselves?

It's just my opinion.
Jim Meeks, PA-C

Comments, questions, objections or observations? I'd like to hear from you. Please submit any comments to me via the MPECS web site at PracticeProfitability@mpecs.org. I'd love to hear about your unique coding experiences.



Asset or Liability?

month. It is much different in a small or solo practice.

I have written about this before but it bears mentioning again here because it illustrates the point so well. A couple of years ago, I received a call from an office manager of a group of surgeons and PAs. This practice was very specialized and surgery was the primary focus of what everyone in the practice does. So naturally, that is were the surgeons tend to make most of their money. But we all know that surgeons also do office visits. Not everyone that comes to the practice is going to need surgery.

As it was explained to me, one of the providers in this group practice never billed for office visits, only the surgeries he performed which by themselves generated a substantial income for the practice. I don't have any statistics on this particular situation, but lets suppose that this provider sees between 20 and 30 patients on clinic days, two and a half days a week (assuming the rest of the time is in surgery or doing hospital care), maybe about 70 patients per week, four weeks a month. That is about 280 office visits per month. Again, not knowing the actual numbers and just thinking out loud, let me speculate that 5 patients per week are new patients that are going to be evaluated to see if they even need surgery, or about 20 per month. It is probably much higher than that, but I have no way of knowing.

Since we are talking about new patients, we need to use new patient office visit codes, 99201 through 99205. Trying to keep things simple, I'll select a middle of the road level E/M code for this example, a 99203. Of course, we have to consider all the criteria for this code, which requires documentation that supports a detailed history, a detailed exam and low complexity medical decision making. I doubt that many patients in this type of surgical specialty practice are really in the "low complexity" category.

If you are unsure of what constitutes a detailed history, a detailed exam and low complexity medical decision making (you are not alone), you should consider getting a POCKET CODER which outlines the specific elements of a patient encounter in an easy to understand matrix format. See information in left column of this page.

In my practice, a 99203 level office visit is billed at $135. So, if I extend this out and apply these numbers to the situation above, at $135 for 20 visits per month, that comes to about $2700. For the year, that is $32,000 that isn't being billed, for work being done. Probably much higher in the specialty office.

What about the other office visits this provider isn't billing for? Are all of his visits surgical follow-ups? I doubt it. I am sure that there are a number of visits that could be billed for. Remember that surgeries have a patient care window that extends from the day before the surgery to any where from 10 to 90 days after the surgery. Any care related to that surgery or procedure performed during that care window is included in the surgical fee. Any unrelated patient encounter is billable but has to be coded with the correct modifier.

I think that you can see the picture I am trying to paint here. One provider in a large group not billing (or under billing) for office visits, can have an enormous impact on the overall practice profitability. Billing incorrectly can be equally detrimental to a practice. If any provider isn't documenting, coding and billing correctly, it can severely impact the overall practice profitability. The bigger the practice or group, the less noticeable it may be. The smaller the practice, the more detrimental it may be. Either way, incorrect coding directly effects the entire practice, not just the single provider.

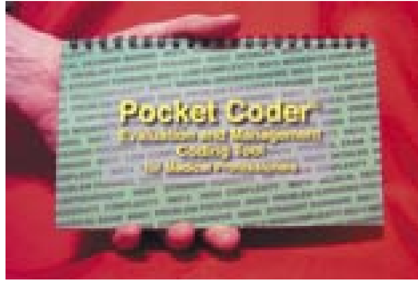
So, are you an asset to your practice or a liability? Is your performance subsidized by other providers? Is more than one provider struggling with coding and billing?

Someone once objected to my take on this at a speaking engagement stating that all of his patients were very complicated and required extended visits to collect history and manage medications. He said that because of the complexity of his patients, he could never see as many patients as the other providers in his practice. He obviously was missing the point of the entire presentation.

If your patients are that complicated and require that much time, you should be billing at a level appropriate for the complexity of the patient. Billing all of those patients at a level 3 all the time is incorrect. I have known practices that do that; every office visit is coded as is either a 99213 or a 99203, no matter what goes on during the visit or how complex the care of the patient is. That kind of billing reflects a total misunderstanding of E/M coding. Billing should be consistent among all providers in your practice.

In the first place, 99213 and 99203 are NOT interchangeable for established patients versus new patients. The E/M criteria is very different. Secondly, this type of billing will raise

See "Asset or Liability" on page 4 . . .



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 MPECS **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.

What makes a good medical record?

The Basics

Standards of documentation apply to all types of medical and surgical care and services. Essentially, on any patient encounter, record everything you did or did not do and why. The following are the basic principles of documentation. They apply to all types of medical and surgical services in all settings.

The medical record should:

1. Be first and foremost a tool of clinical care and communication.
2. Be complete, logical and legible.
3. For each patient encounter, include or provide reference to:
   - date of visit and legible identity of the health care provider
   - the chief complaint and/or reason for the encounter and as appropriate, HPI and past history (relevant PMFSHx)
   - physical examination findings
   - prior diagnostic test results and reasoning for new or additional tests, procedures, referrals etc.
   - assessment, clinical impressions or diagnosis
   - plan for care; and follow up
4. Identify past and present diagnoses and conditions, health risk factors, allergies to medications and immunization status.
5. Identify current medications.
6. Document progress, response to changes in treatment, planned follow-up care and instructions to the patient and the family.
7. Support the CPT and ICD-9 codes reported on medical claim forms.
8. Be maintained with regard to requirements of medical ethics and law concerning confidentiality.

Asset or Liability?

red flags and may trigger audits. It may lead to loss of insurance company panel status.

Personally, I believe that it isn't the number of patients we see, but the care we provide. If a patient is complicated and takes a lot of time and effort to care for, we had better understand E/M coding to the point that we don't feel uncomfortable billing at the correct level. If you are uncomfortable with the billing you are doing, you need to invest some time and learn to code correctly. Understanding what qualifies for a specific level of coding can go a very long way to helping you achieve confidence and success in your day to day patient encounters.

I once helped a physician nearly double his annual income (not billings, but actual take home income) when he learned to code and bill correctly. He had been coding EVERY office visit as a 99212, but charging $60 for the visit. He couldn't understand why he was getting less than half that amount from the insurance companies. Once he learned how to document, code and bill correctly, it all changed. He was much happier and he was able to work a lot less hours and enjoy a greater return for his effort. "Work smart, not hard," took on an entirely new meaning for him. Imagine.

Ultimately, history, exam and medical decision making with consideration of the nature of the presenting problem will determine the level of coding and billing any patient encounter qualifies for. If you are unsure of how that all works, isn't it time to do something about it?

Check the archives of this newsletter. There is a wealth of information there detailing all of the essentials for coding and billing. Of course, if you haven't attended one of my *Evaluation and Management Coding Essentials* Workshops, maybe it is time you gave that some consideration. I'd love to help. Become an asset, not a liability.

Have a comment you would like to share? Please visit our NEW testimonial page. Help me get the word out to others searching for help. Please visit:

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