

Productive Provider Newsletter

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AT A GLANCE:

In this month's

Productive Provider Newsletter

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It's Just My Opinion

I believe it to be a big mistake to neglect this part of medical practice.

It's Not Just Bullets!

Most providers are pretty good at documenting all of the bullets.

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Alexander Graham Bell and
Will Rogers

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Front Page

It's Just My Opinion

"Well, they just couldn't care less." Wow, what a response. I was totally amazed as I stood at the front counter of a multi-provider clinic. I had been next door speaking with a family practice physician that is trying to improve evaluation and management (E/M) coding in his practice. On my way out, I thought I would drop off a flier about an upcoming MPECS Practice Profitability Workshop and see if the providers in that office might be interested in attending.

I was greeted by a very nice woman who just happened to be the office billing supervisor. We talked for a minute and then I explained what I was offering at the workshop. She asked me if the workshop was for her billing staff. I assured her that it certainly was and that it was also for all of the providers in the practice. I explained that I had found that the best results for improving E/M coding was to have both providers and billing personnel in the same workshop. This allows each to understand the perspective of the other and opens dialogues that don't happen otherwise.

You might think that this kind of a response is uncommon. I assure you that it is not. I have heard it many times in different formats, just not quite so bluntly.

Still, every time I get a group of people together (providers, office managers and billing staff) to talk about billing and coding, there seems to be this window of fresh air that opens up and brightens everyone up.

See Opinion on page 2 . . .

It's Not Just Bullets!

"If I document 12 or more bullets for my physical exam, can I bill that as a level four visit?"

A common question, a simple answer, "No."

Some providers focus too much on the number of bullets they mark on a form, or dictate, or write in a chart and forget the real purpose of documentation. The medical record is a tool of clinical care. It should reflect the overall care plan for the given patient. Counting bullets is only ONE aspect of that effort.

For any given encounter, there are three areas of the encounter that are considered key components for documentation. They are; 1. **history**, 2. **physical exam** findings, and 3. **medical decision making**. Other areas to consider as contributing elements are counseling, coordination of care, nature of the presenting problem and time spent with the patient and or family (see "Two Or Three Components" in the July/August 2005 Productive Provider Newsletter).

When we talk about these contributing elements, we have to consider the nature of the visit. If we are doing a lot of counseling and coordinating of care, then time becomes the primary factor if more than 50% of the encounter time is spent in this effort. If the nature of the presenting problem is minor and self limited, meaning that the problem probably would resolve without our intervention, it is a minor problem. If however the problem could pose some threat to bodily function or life, then we have to consider the encounter in that frame of reference.

See "Bullets" 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
September 16, 2006
St. George, Utah
July 15, 2006
Phoenix, Arizona
November 3, 2006

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

CONFERENCE LECTURES;

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



Opinion

Last month, I talked about giving yourself a raise. A raise of about \$25,000 would be nice, wouldn't it?

I have read some articles that project that perhaps as much as one hundred thousand dollars in charges may be missed by some providers, especially those in specialty practices. Now, I don't have any studies to support that, but I do have some personal experiences to draw upon for my own reference.

I recently spoke with the manager of a specialty surgical practice with a number of very specialized physicians as well as some nurse practitioners and physician assistants. One of the physicians refuses to bill any of his patients for office visits relying instead on his surgical procedures for his income and practice contribution. No reason was given, but this office manager expressed some frustration, knowing that a significant amount of fees that should be coming into the practice and to that physician were being missed.

I admit that the current set of rules we work under are very difficult and very confusing. With global periods, bundled charges and a host of other issues, the entire process becomes not only frustrating, but sometimes downright intimidating. Considering all of that, I do not believe that a provider refusing to bill for office visits is doing anyone a favor. It isn't fair to partners that expect a certain level of performance and contribution and it isn't fair to patients either. It promotes unfounded expectations when they see other providers in that practice or in any other practice.

In another instance, I spoke with a provider working in another specialty surgical practice where the office policy dictates that all in office patient encounters be coded as either a 99203 for new patients or 99213 for established patients irregardless of their presenting complaints, diagnosis or exam. The reason given was to never over bill and to "avoid audits." Be assured that undercoding or down coding does NOT protect providers from audits. In fact, it may increase the likelihood of an audit.

Undercoding or down coding is costly. In my current practice location, there is a difference of \$36 between a 99213 and a 99214 visit. If I were to undercode just 4 of the patients I saw in a given day by just one level (99213 instead of a 99214 for example) that would be \$144 in charges that I might be missing daily. If I did that daily for the approximately 20 days per month that I work, I'd be undercoding at a cost of \$2,880 per month or worse yet, nearly \$35,000 per year. That's just from undercoding four visits a day. Imagine, not billing for any office visits at all.

Granted, in a surgical practice, not all visits are billable due to the global periods associated with the surgical services provided, but not all office visits result in surgery or are related to surgery. Why not bill for the professional services being provided?

I personally believe that every provider should be actively involved in the selection of E/M codes for office visits. After all, who knows better about what was done during that encounter?

Furthermore, every provider (especially in specialty practices) should be actively involved in the supervision of billing personnel that are coding their surgical services and procedure codes. This allows for interaction and teaching that will improve billings and the success of the practice. I believe that turning billing over to the billing staff or service without any review of the billings and payments is a drastic mistake. Yet, I encounter comments such as the opening comment of this article, often.

I anticipate that I will continue to encounter providers that don't give a hang about coding and prefer to defer that to their billing staff or service. I understand the desire to just care for my patients. After all, that is why I wanted to practice medicine in the first place. However, I believe it to be a big mistake to neglect this part of medical practice. Insurance companies invest enormous resources and assets to assure that they don't over pay you. You should invest something to insure that you get paid what you are entitled to. If you don't, no one else will.

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



Bullets . . .

Bullet counting is only one aspect of a very complicated and sometimes frustrating process. A number of studies have demonstrated that when several expert coders are presented with a specific case documentation, they often come up with different levels of coding for that same situation. If there is such a degree of variance in the opinions of expert coders, how are regular providers or billers supposed to understand the process and do it correctly? That is the challenge.

The simple answer for this problem is to understand the essentials of medical record documentation and the areas that are necessary for correct coding to be assured. Although the current Evaluation and Management (E/M) coding system is not perfect, it is what we are required to use for the time being.

Your medical record should make it easy to document the three key components of the medical encounter. Here are some suggestions.

History. It is not necessary in most clinical practices to do a complete medical, family and social history on every visit. If a complete history is obtained on the first visit, it can be updated from time to time in the chart. The most important factor here is to keep the information current. I suspect that this is often neglected. I base that suspicion on medical records that I have reviewed during practice consultations and in reviewing medical records for malpractice cases.

The easiest way to deal with this is to have an information sheet somewhere in the front of the chart that can be reviewed and updated as needed. My favorite arrangement for that in a paper chart was in a clinic where upon opening the chart, I found the medical history sheet on the left and the most recent progress note on the right. Underneath the history sheet were several tabs identifying locations for insurance information and other administrative stuff and on the right side, below the progress notes were tabs for labs, radiology, consultations and other medically related items.

In this format, it is easy for medial staff to review the medical, family, social history information sheet and update it as needed. Also included on this sheet are current medications, recent screening test dates for colonoscopy, lipids and such.

A common problem I see is that a similar type of sheet is often in the chart, but seldom updated and sometimes, it is just blank. It seems that we are good at getting this information when the patient is new and we hand them a stack of papers to fill out when they first register. After that, it is a real challenge for most of us to take the appropriate time to update the information and keep it current.

Electronic medical records sometimes make this process a little easier, but the same problems are evident when the information is not updated frequently.

I think it is really easy to train the ancillary staff of medical practices how to collect and update this information and is an appropriate use of that resource. This frees up the medical provider's time and allows for simple review of the information and making a note in the chart on the date of the visit that the information was reviewed and/or updated.

My experience leads me to believe that most providers are pretty good at documenting all of the bullets of the physical exam they perform. I have seen some really great forms created for various types of medical practices that are quite impressive. It still amazes me that providers are unaware of single organ system exams ([see Single Organ System Exams articles in August 2004, January 2005 and February 2005 Productive Provider Newsletters](#)) that focus more attention on specific body systems rather than the general multi-system exams that many of us tend to devote so much attention to.

The downfall that I most often encounter is the incomplete documentation of the history of present illness and the review of systems. This can be detrimental to a medical case being reviewed for malpractice. It really needs our attention in today's practice of medicine.



UPDATED CODER

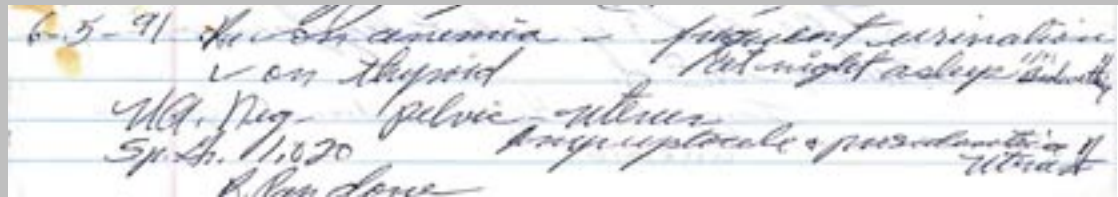
Do you know the specific elements of documentation that determine which E/M code you should use? You are not alone if you are still struggling with this process. Updated with changes for 2006.

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.





Bullets . . .

Finally, medical decision making (MDM). Providers seem to understand that the more diagnosis the patient has, the higher the complexity of the visit. That however is not the only factor to consider in medical decision making. This area of the medical encounter (MDM) comprises three areas; 1. The number of diagnosis and/or management options, 2. The amount and/or complexity of data to review, and 3. The risk of complications and/or morbidity and mortality.

The MDM alone is often so confusing that providers tend to focus on the number of diagnosis without considering the other two factors, especially the third area. More attention should be paid to these elements when considering the level of care and billing for any given encounter.

Please see ["Medical Decision Making" in the October 2003 Productive Provider Newsletter](#). There is an excellent MDM matrix that may be very helpful.

The key here is that it isn't just the bullets and it isn't just the number of diagnosis the patient has. There are many factors that have to be considered and your documentation should reflect that.

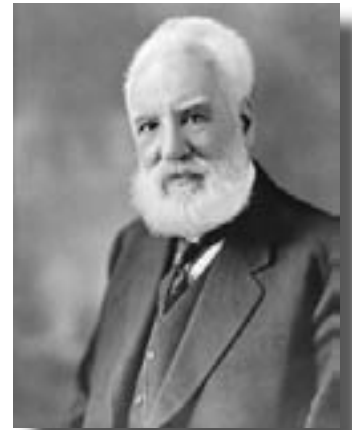
If you are doing the work, you should get credit for it. The only way to assure that, is to document it correctly. Not doing so only short changes the provider and the practice. It is worth the effort. Document correctly, get paid accordingly.



Food For Thought

"When one door closes another door opens; but we so often look so long and so regretfully upon the closed door, that we do not see the ones which open for us."

Alexander Graham Bell



"It's not what you pay a man, but what he costs you that counts."

Will Rogers



"The material with the examples & audits were tremendous, especially for doctors to understand coding."

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

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 about your unique coding experiences.