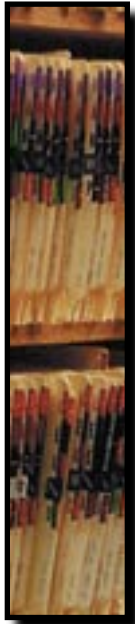


Productive Provider Newsletter

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

Jim Meeks, P.A.-C.

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

Welcome to the *Productive Provider Newsletter*.

A unique publication bringing you timely, thoughtful and valuable information on the confusing topic of Evaluation and Management (E/M) coding. Designed specifically for the busy medical practice and provider seeking no nonsense information on coding E/M services.

Your questions and comments are essential to the success of this publication. Please make comments and suggestions on the content of this newsletter. I'd like to hear what you have to say about these issues.

Thanks in advance for your support.

AT A GLANCE: In this month's *Productive Provider Newsletter*

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- 2. It happened again**
Knowing the codes pays off, again.
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1. Its just my opinion.

I have been asked to explain the reason for performing regular chart audits. This is an excellent question and I will do my best to answer it. I can think of several reasons to do chart audits.

Probably the first and most appropriate reason is to simply make sure that charts are getting completed. I can remember more than one occasion in my career, opening a patient chart just prior to entering an exam room only to discover that the note from the last visit was missing or wasn't completed. How does this happen? Well, on a busy day, I have been known to start a note while in the exam room with the patient, write prescriptions and orders,

Productive Provider Newsletter is published electronically by Jim Meeks, P.A.-C. doing business as MPECS • PO Box 899 • Pleasant Grove, Utah 84062-0899 • www.mpecs.org • PracticeProfitability@mpecs.org

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hand them to the patient and then place the chart on my desk with the anticipation of completing the visit note later. Some dutiful office staff or nursing staff member picks up the chart to check something, document something or whatever, and it doesn't get placed back on my desk. Then, when the patient returns for follow-up, the note is not complete. Or, when dictating, the tape is lost, or the dictation ended abruptly, or the dictation was placed in the wrong chart. I could go on and on, but I think that you get the picture.

Another reason to do chart audits, is to determine if services provided were billed for. If a urinalysis was performed, was it billed for? How about that rapid strep or pregnancy test? If I did some other procedure, was it billed out, or just the office visit?

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What about evaluation and management codes? Are they correct? Are they consistent within the practice? Do you have multiple providers in your practice? If so, you should make sure that they code consistently. If one provider bills most of his or her established patients at 99213, but another provider doing the same type of visits is billing a lot of 99214s, it won't be long before the patients figure out that seeing Dr. "A" costs more than seeing Dr. "Q," especially if you deal with private paying patients.

Don't forget to consider the medical/legal aspects of charting. Are chart entries legible, logical and complete? Is the provider of the service clearly identified? Is the location of the service (office, hospital, nursing home, etc.) identifiable if not obvious? Are all chart entries dated?

If you are seeing Medicare patients, you are required to have a compliance plan in place. Part of that compliance plan should include chart audits and a way to correct errors in billing when they are discovered. If you are under billing or missing charges, this is the time to discover them and fix the problems. If you are overbilling for some services, this is the best time to fix the problem. Discovering that you are having problems with billing during or after an audit by Medicare or some insurance carrier isn't a good plan.

Having a good audit program in place with documentation of the proceedings of the audits may go a long way in helping a practice defend themselves against claims of fraudulent billing.

I routinely recommend that practices, no matter how small or how big, have a monthly meeting where providers, nursing staff, billing staff and office manager(s) meet for this very purpose. This should be a formal process. For each provider, somewhere between 10 and 20 charts should be pulled from patients seen within the past month for audit. The most productive way to do audits is to have a standardized form that can be used for each chart (see MPECS web site for Chart Audit Forms). Having providers audit their own charts is one of the best ways I have ever seen to help them improve their own charting. We audit some examples of patient notes in my Practice Profitability Workshops and it is always an excellent learning experience for all participants.

Chart auditing is an extremely valuable tool. I recommend it to everyone. If you can't get your practice to commit to a consistent program, set one up for yourself. You'll be amazed at what it does for you.

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

2. It happened again.

I saw a new patient earlier this month. A wonderful lady, only 32 years old, with a family history of breast cancer. She noticed some subtle changes in her right breast over the previous week or so. She was concerned about cancer and scheduled an appointment for exam.

Here is what is interesting. In our practice, we use an electronic medical record (EMR) that for the most part is pretty comprehensive and as far as I have been able to determine, one of the better products on the market. Over the years, I have reviewed quite a few EMR products, tried demos and viewed a number of presentations at conferences on various EMR products, so I feel very comfortable making that statement. Our EMR includes a CPT® recommendation component that recommends an evaluation and management code based on the information input into the visit note. My visit with this female patient resulted in a code recommendation that I believe was

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wrong. Lets look at the visit.

As stated above, the patient was a 32 year old female, **new to our practice**. A complete past medical, family and social history (PMFSHx) was obtained from the patient via a form filled out by the patient, then entered into the computer database by ancillary staff. Full vital signs are also obtained and documented in the record.

I **reviewed** the history information and the vital signs then began to ask questions to obtain a history of present illness (HPI). I then reviewed the review of systems (ROS) information provided, again, obtained by the patient answering questions on the form filled out by the patient.

After the physical exam, I **documented** elements of the exam in areas of 1) general appearance/vital signs, 2) respiratory, 3) cardiovascular, 4) breasts, 5) lymphatics and 6) psychiatric findings.

I discussed the patient's concerns, offered reassurances and ordered additional testing as I felt appropriate in the given situation.

Now, I'm not presenting this case as a review of medical care, but I do want to emphasize the components of the encounter that were documented. That is the critical issue when it comes to coding for the visit.

When all of the appropriate information is entered into this EMR, a provider has the option of selecting a CPT code or of asking the computer to make a recommendation. In this case, the recommendation was 99201. I disagreed with that recommendation and instead, designated the visit as a 99203. Let me explain why.

There are **three key areas** that determine the level of care provided during any patient/provider encounter. In this case, this patient encounter was in our family practice office. The same concepts for selecting codes are applied in every patient encounter, be it in the ER or any other setting, but actual codes are different based on the location of the encounter.

These key areas are; **history, exam and medical decision making**. For new patients, all three of these areas must be considered to make a correct coding selection. If this were an established patient, only two (any two) of the three need to be considered, usually the two with the highest acuity.

Under the requirements for **history**, documentation must include HPI, ROS, and PMFSHx. In this case, the HPI included at least four elements, the ROS covered all 14 designated areas and the PMFSHx was complete in each area (personal, family and social). That qualifies as a **comprehensive history**.

For the **exam** component of this patient encounter, I performed an examination that included six specific areas of the body—already mentioned above. Within each of these areas, I examined two or more elements. Based on the multi-system exam bullets we are now all so familiar with, I was able to document at least twelve bullets or two bullets in each of the six areas examined. This level of exam and documentation qualifies as a **detailed exam**.

The last area to consider is medical decision making. Frankly, this is the most difficult area to understand in the code selection process. This also seems to be the area that EMR coding programs have the most difficulty with as well.

Medical decision making (MDM) contains **three areas** of consideration, two of which must be used to determine the level of medical decision making performed. These three areas are;

1. The number of diagnosis or management options (type of problem)
2. The amount and/or complexity of data to review (data information)
3. The risk of complications and/or morbidity or mortality (level of risk)

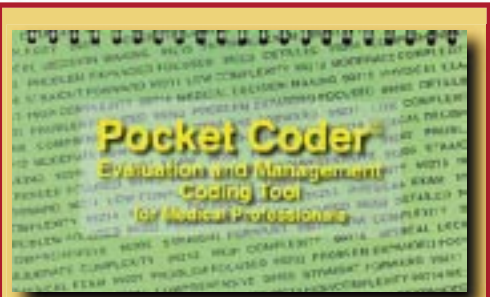
Within each of these three areas are specific criteria used to determine the level of medical decision making, the third key component needed to select the correct code for a patient encounter, especially for a new patient.

In the first area (number of diagnosis or management options), I considered the fact that this was a new problem, previously unidentified or undiagnosed. My physical exam didn't provide me with enough information to make a definite diagnosis and further diagnostic studies were indicated. This component, by itself, constitutes a high complexity type of problem.

Next, I looked at the level of risk and determined that this was an undiagnosed new problem with uncertain prognosis. This element of criteria falls under the moderate risk area.

When I combine these two elements together, my medical decision making is considered to be of moderate complexity. A high complexity problem with a moderate level of risk is considered to be moderate medical decision making because we are required to meet or exceed the criteria in two of the three components. See what I mean about confusing?

So, when we look at all three areas of the encounter (history, exam and MDM), a comprehensive medical



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history, detailed physical exam and moderate complexity medical decision making; we can then determine that this patient encounter qualifies as a 99203, not a 99201 as was recommended.

In my office, there is a difference of \$46.00 between these two levels of billing (99201 and 99203). If this (incorrect coding) only happened once a week, that would come to about \$2,400.00 a year. If this were to happen on a daily basis, even only once per day, that would be well over \$10,000 per year. It could be a loss or a gain, depending on how well you understand the E/M coding process.

The point of all this is that so far and by my experience, coding software programs are not perfect (yet). There is always that human element, either data entry or some other factor that may give you an incorrect code recommendation. The bottom line is this. If you as a provider do not understand the E/M coding system, you will never know if you (or the computer program) are coding correctly. I continue to make two universal recommendations to all providers and practices. You could call them Jim's Rules. First, know how the coding system works. Second, do regular chart audits on every provider in the practice.

3. Heritage and tradition.

Yesterday was Memorial Day. I could not help but reflect on two important areas of my life, heritage and tradition. My heritage as a healthcare provider and the tradition of my profession as a physician assistant.

My great-great-grandfather was the first physician in my family. In the mid-eighteen hundreds, he practiced Thompsonian medicine, a practice methodology based on herbal preparations, the most prominent of which was cayenne pepper. I believe it was referred to as "purge and puke" therapy by some. Based on his journal entries, his practice was quite successful.

His grandson, my grandfather, was a Chiropractic physician, graduating from the Palmer School of Chiropractic in 1922, long before it was a popular practiced art. I remember as a young boy, going to work with my grandfather from time to time at his office in Salt Lake City. I also remember that he had an office for seeing patients right in his home.

I began my medical career when I was still in high school, taking a job as an orderly in the radiology department of a local hospital. At age 17, it was one of the best jobs I can remember having.

My next medical career was as a professional fire fighter/paramedic with the Salt Lake County Fire Department. As a paramedic, I also worked in the emergency department of the same hospital where I had had my first job as an orderly some ten years before. It was there that I discovered the great joy I had in working with people in need. I felt then that there was something more I could do for people. A friend of mine suggested that I consider going to PA school, and I did.

As I reflected on these ancestors and their contributions to the health and well being of their patients, I felt a great sense of pride in what I do. I reflected further on the focus of Memorial Day, honoring veterans. I know that my great-great-grandfather fought a few Indians in his day. My grandfather served in WWI. My father, although not a medical person, served in WWII. I am proud to have served for a time in the Army National Guard.

That brings me to the tradition aspect of this retrospective thought process. My profession as a physician assistant is deeply rooted in the work of those that came before me. Military medics with great skills and foresight, pioneering the way for me and so many others like me. I am truly thankful for what they went through to get us to where we are today. I really love what I do.

On July 11, 2003, a monument was dedicated at Fort Douglas, Utah as part of the University of Utah Physician Assistant Program's recognition of the "Combat Medic." This is a bronze sculpture depicting a combat medic caring for a wounded soldier. The tribute "Lifesavers Then—Caregivers Now" rings true (please see <http://www.utah.edu/upap>) to me. Although I didn't serve as a combat medic, as a fire fighter/paramedic, I did have some very interesting experiences.

Reflections are a wonderful thing. I appreciate having the opportunity to reflect on both my heritage and the traditions of my profession. It is my hope that I may honor both in my career.

Jim Meeks, PA-C

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