MPECS PRODUCTIVE PROVIDER Newsletter

By Jim Meeks, PA-C
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MARK YOUR CALENDARS

EVALUATION and MANAGEMENT CODING ESSENTIALS WORKSHOPS & LECTURES:

Jim Meeks, PA-C 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;

Orlando, Florida
March 14, 2008
Lehi, Utah
April 12, 2008

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

CONFERENCE LECTURES;

FAPA Conf. Orlando, Florida
February 8, 2008
NJSNA APN, Atlantic City, NJ
April 2, 2008

Available for 2008 bookings.
Contact me at
PracticeProfitability@mpecs.org

Front Page

A Couple of Random Thoughts

Every so often I observe some things that I think are worth discussing here. Many of them are topics I have covered in previous newsletters, but are worth bringing up again because I see the same problems over and over.

TIME: Time is an often misunderstood and misused entity in relation to Evaluation and Management (E/M) coding. The "rules" clearly state that time is to be considered (or used) only when "counseling and/or coordination of care dominate more than 50%" of the patient/provider face to face time.

As simple as that may seem when we read it, it is often misapplied. I am frequently surprised when I hear a provider come out of an exam room and say that they spent 15 minutes with that patient and then select an E/M code based on the time and not on the components of the exam and complexity of the patient. Or, when doing chart audits, I find a few short notes and a statement of "10 minute visit" at the end of the note.

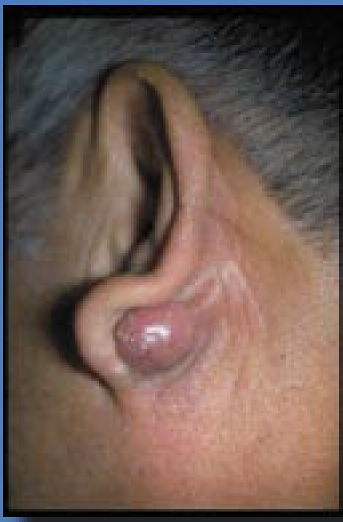
This raises some concerns for me. If a provider has actually spent 7 or more minutes of that 15 minute visit "counseling and/or coordinating" care, then that might be an appropriate application of the time concept. However, I don't believe that we do "counseling" on a routine basis. More typically, we get some history, do an exam, make a diagnosis, write a prescription or two and maybe order some tests. Yes, we spend time explaining things, but that doesn't constitute counseling and/or coordination of care. I believe that using time in this way under estimates the value of the work we actually do.

As we have discussed in previous newsletters, it is entirely possible and appropriate to spend only 10 or 15 minutes with a patient and still achieve a high level of billing. Time isn't the primary area of concern. There are other considerations that we should be focusing on before time. How complex is this patient? Are there a number of co-existing concerns such as hypertension, cardiovascular disease, diabetes and such? Is this a new problem or a follow-up visit? Does today's history and physical give me enough information to make a diagnosis or do I need to do additional studies or testing? What is the "nature of the presenting illness?" These and many other questions must be considered and to some extent answered with every patient encounter.

I recognize that there are times when a normal patient encounter can turn into a session of counseling and coordination of care. I can't even begin to estimate how many times I have spent an unusual amount of time explaining my reasons for a specific therapy, test or referral. We have all encountered those patients that seem to have the need for an unusual amount of reassurance or encouragement. These patients do take more time. When we spend a significant (more than 50%) of that time counseling the patient, it is appropriate to use time as the basis for selecting the appropriate E/M code.

The complexity of the E/M coding process may be leading some to use time as the criteria for E/M coding selection, but I think it is inappropriate. Remember that history, exam and medical decision making are the key elements for determining the level of care. Counseling, coordination of care, nature of presenting problem and time are contributory. They must be considered and given their due, but they should not be the driving element in most encounters.

DOCUMENTATION: I am amazed that some providers still don't get it. Their documentation is really poor and doesn't meet the standard that has been in place for over a decade. This mostly applies to hand written or dictated notes. Electronic medical records (EMR) or electronic health records (EHR) have helped considerably, but not always. It is still up to the person generating a note to be complete and correct. Preprinted forms with check boxes or back slashes are only as good as the person filling them out. If the form isn't filled out, the information is missing. I find this to be a very common problem during chart audits and



Random Thoughts . . .

unfortunately, during medicolegal case reviews.

A “SOAP” note or some other format of written or dictated note is fine as long as it meets the current standard. Not only for medicolegal reasons, but for billing and coding expectations as well. The standard requires specific elements. The higher the level of billing you submit, the more elements of documentation are required. Those elements have been spelled out in some detail since 1994 with a few modifications along the way.

When you generate a note for a patient encounter, you need to include some key points. These would include some description of the reason for the visit, or the history of the present illness (HPI), a review of systems (ROS) and the past medical, family and social histories (PMFSHx) of the patient. The detail you include is often dependent on the nature of the presenting problem. Sometimes, the nature of the presenting problem is only manifest by a complete ROS and PMFSHx. That is where your clinical judgement comes in.

The exam. My observations lead me to believe that many providers are fair at documenting the elements of exam they perform, but sometimes, they forget to document some of the things we do without thinking about it. For example, every time I meet with a patient, I am evaluating their mental health. Most providers neglect to document these simple observations; mood and affect, mental status, etc. Lets face it. Most of us subconsciously think about that with most patients we see. We just don’t tend to document it, but we do it.

Medical decision making (MDM) is very complex and difficult. It is a challenge for me every day and I have been teaching this stuff for over 10 years. You can’t do a good job with the MDM process without the correct information. All of the history information gathered can give you a preliminary impression of the complexity of the patient and their current complaint yet this is an area often neglected, especially on follow-up visits.

I believe that the best way to gather and/or update that information is to do it before the provider sees the patient. The history (HPI, ROS and PMFSHx) can all be collected or updated while the patient is waiting in the waiting room or in the exam room. I use a pre-printed form that the patients fill out at EVERY visit. The receptionist hands it to them when they check in and asks them to please fill it out. Yes, some of them fuss about it, but when the receptionist explains that we need the information to ensure that we give them the very best care, they usually comply willingly. If they have difficulty with the form (elderly patients for example) your medical staff can assist them.

Once that is done, it is attached to the front of the chart and I look it over quickly before I enter the exam room. I then already have an idea of what has happened since I last saw the patient or if they are a new patient, why they are there in the first place. In the case of EHRs, this can still be done with a form filled out by the patient and then the person getting their vitals and placing them in the exam room can simply use the form to update their information on the EHR. It is a simple process once everyone understands how vital it is.

Having current history information is essential to good health care. There is no reason that it can’t be collected or updated before I see the patient. It doesn’t have to take a long time during the patient encounter to review it.

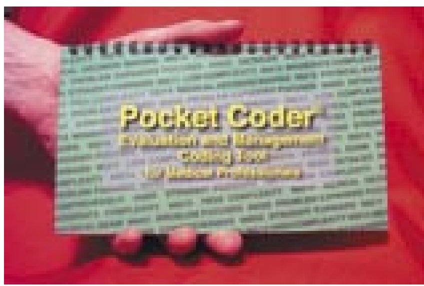
With the demand on our time, we need to be as efficient as possible. If you are not using an EHR/EMR, then you need to do everything you can to make what system you are using more efficient. Use of ancillary staff to collect and record this information is a very efficient way to do so.

2008: It’s that time of year again. Coding books for 2008 are available. I just got my new CPT book for the year and once again notice numerous changes and additions. By my count, there are 126 new codes and 291 revised or modified codes.

I was recently in an office and noticed that on the desk prominently sat their copies of the CPT and ICD-9 books, both from 2005. When I asked about these books, the response I got surprised me a little. “The codes don’t change much, so we don’t buy new books very often” I was told.

As always, I struggle to understand why a practice will try to save a couple of hundred bucks by not having current coding references in the face of a potential loss of thousands of dollars if the most current codes aren’t used. Do you think some insurance company is going to tell you that there is a better code to use for a given service, especially if it has a higher payment attached to it? I think not.

Make an investment in your practice and yourself. Get the current books and make sure you take the time to update the codes you use most often. What can that hurt? For years, I have purchased my own copies despite what my employer may do. Maybe you should too.



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.

Pre-printed chart **auditing forms** are available. And now, you can download an audit form in PDF format for your perpetual use.

See information on the PRODUCTS page of this web site.

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