

Productive Provider Newsletter

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Productive Provider Newsletter

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I need your help

I have a message to share. . .
. . . immensely satisfying and enjoyable.

Productive Provider Newsletter

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Front Page

Its Just My Opinion

Thanks to all subscribers of the Productive Provider Newsletter. I appreciate hearing from people about how much they appreciate the information presented every month in this newsletter.

A few weeks ago, I spoke at the national conference of SUNA, the Society of Urology Nurses and Associates. I was asked to present the MPECS Practice Profitability workshop to advanced practice providers and physicians at a special session of the conference held in Las Vegas, Nevada.

There were 53 people in attendance at my workshop. I was given only three hours for the presentation. So, to try to include everything essential in three hours is a challenge especially when the usual 4 hour workshop doesn't always provide enough time to cover everything. But what an exciting experience these conference presentations are. So many good questions.

One thing is for certain, there is still a lot of confusion out there about Evaluation and Management (E/M) coding. Many providers are still undercoding for the work that they do.

It seems that for some providers, there is a real fear of coding anything over a 99213 for office visits. I hear often that providers are told that they should NEVER bill a 99215. I don't understand that thought process. I mean really! Why not? If I see a

See Opinion on page 2 . . .

Speaking of Modifiers

In last month's issue of this newsletter, I began discussing modifiers. Specifically, we looked at modifiers 21, 24 and 25. This month, I will continue with modifiers 32, 52 and 57 because they too are directly related to Evaluation and Management (E/M) coding.

Modifiers are found in Appendix A of the CPT book. Six apply directly to E/M coding. The purpose of a modifier is to clarify or to "modify" the usual circumstance of a given patient encounter, service or procedure. The primary purpose of attaching a modifier to any CPT code is to provide additional information to assist with the processing of a claim.

It is essential that providers understand that patient encounter documentation needs to support the use of modifiers by correctly reflecting the circumstances that require a modifier in the first place. Lack of adequate medical documentation and/or incorrect usage of modifiers may lead to charges of fraud or abuse. A modifier is the method by which a provider or facility identifies a modification or alteration to a service provided to a patient without changing the basic CPT code used.

Modifier 32, Mandated Services;

There may be occasions when an insurance company or some other "third-party payer" sends a patient to a provider for a second opinion, for a specific evaluation or determination of disability. When the provider is aware of one of these circumstances, modifier 32 is used to indicate that this is a "mandated service."

See Modifiers 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;

**San Antonio, Texas
November 12, 2005**

**Salt Lake City, Utah
April 29, 2006**

CONFERENCE LECTURES;

The 2006 schedule is now open. Please call to schedule a conference event in your area.

The MPECS web site lists the specific details for each **workshop** as it becomes available. Check back often. Register EARLY for significant workshop discounts.

Need a conference speaker? Give us a call. We'll talk!



Opinion

patient whose medical condition and subsequent exam warrants billing at that level, then I SHOULD bill a 99215. And when I do, there is no reason to be fearful about it.

I have said over and over that your best defense if someone questions your billing practices is to understand the billing criteria. You cannot rely totally on a computer program to tell you what codes to bill. Sometimes, computer programs just don't get it right. You won't know that if you don't know what the criteria is in the first place.

Let me illustrate. You have a patient come to your office, let us say that he hasn't been to the office for about a year. He needs refills of medications for hypertension, mixed hyperlipidemia and occasional heartburn.

The patient's history, which includes history or present illness, a complete review of systems and past medical, family and social history is reviewed and updated in the patient chart. This constitutes a comprehensive history.

Next comes the exam. Now, I am not going to list all the elements of exam you should perform. Instead, you need to consider your patient and what the appropriate exam for his situation will be. You may want to do an extensive physical exam. By definition, that would require that you document examination of at least 18 elements, 2 or more from 9 organ systems. Based on the criteria for **Multi Organ System Exams**, that qualifies as a comprehensive exam.

If you are working in a specialty practice, say cardiology for example (it could be any specialty), you may do a complete exam of a single organ system. That would also qualify as a comprehensive level exam.

For an established patient, a comprehensive history and a comprehensive exam qualify for a 99215 billing. There should be no hesitation in billing that kind of an encounter at the level that is justified. Guidelines specifically state that you only have to meet the criteria in two of the three areas (history, exam, decision making) for established patients. It doesn't matter how many diagnosis the patient has or anything else related to medical decision making because you met the requirements in the history and exam areas.

The number of diagnosis is another question that comes up often. It isn't always the right area to focus on. More often, providers do sufficient work (comprehensive history and physical exams) but fail to recognize that it qualifies for a higher billing level than they are using because they are worried about the number of diagnosis the patient has. That is the wrong thought process. Sometimes, some computer programs make the same mistake.

If you do the work, bill for it. You are entitled to be paid for the work that you do.

I sometimes feel that there is some unseen element out there that wants to keep everyone fearful of billing at this level. Of course it has to be appropriate and exams shouldn't be fluffed just to meet the comprehensive criteria.

If providers would take the time to learn the requirements for the different billing levels, they would be more comfortable using them appropriately. When questioned about their billing levels, they would feel more comfortable in explaining how they arrived at those levels.

It is interesting to me to hear that insurance companies reduce payments for billed services with some arbitrary statement about the diagnosis not qualifying for the level of service billed. Again, that may be the WRONG focus. That is when providers need to file an appeal explaining the level of work done (comprehensive history and exam) and identifying in detail how it meets the criteria for the level billed. You cannot afford to allow reductions in payments without an appeal.

Take care of your patients, document the work that you do, bill correctly and defend your billing by knowing the criteria.

It's just my opinion.

Jim Meeks, P.A.-C.



Modifiers continued . . .

It is not appropriate to use it when the patient, family members or other parties request second opinions or other services.

A common circumstance where this modifier might be appropriately used would be when a patient is sent to a provider by a workers' compensation carrier asking for a second opinion. Another might be when children in state custody are sent to your office for health examinations when placed in temporary custody or foster care.

Generally speaking, when an encounter was requested by a third-party (insurance company, state agency, law enforcement, etc.), consider it to be a mandated service.

Modifier 52, Reduced Services;

There may be times when a service or procedure is reduced or even stopped for various reasons. When this occurs, the usual CPT code is reported with the attached 52 modifier to indicate that the usual work (See "What is YOUR Time Worth" March 2004 MPECS Newsletter - www.mpecs.org/newsletter) of the service or procedure was reduced in some way and should not be paid at the full rate.

Surgical procedures billed with this modifier require detailed documentation about how this particular event differs from the usual service or procedure as described in the CPT book. Submitting the operative report is beneficial and should contain this descriptive information.

This modifier is not to be used to reduce charges when a patient is unable to pay due to financial hardship. That is an incorrect application of this modifier. (For recommendations on how to handle discounting patient visits, see "It's Just My Opinion" in the June 2005 MPECS newsletter - www.mpecs.org/newsletter).

If a service or procedure is terminated due to some situation that may threaten the well-being of the patient, it may be more appropriate to use modifier 73 or 74. These are specific to surgical situations where sedation or anesthesia was administered to the patient before termination of the service or procedure.

Use of modifier 52 may not always be recognized by insurance carriers. It is important to check with them to determine what their respective policies may be.

One example of using modifier 52 might be during a preventive medicine visit which requires a comprehensive history, a comprehensive physical exam and that anticipatory guidance be provided to the patient at the time of the encounter. If any one of these requirements is not met for whatever reason, a preventive medicine code could still be used, but with the 52 modifier to indicate that the expected level of service was reduced. Documentation notes should indicate what part of the encounter was not performed and why.

When a procedure that normally includes bilateral structures, (a vasectomy for example), is initiated and is then terminated after only one side is done, the correct CPT codes is reported with the attached 52 modifier. Operative notes should then include details about why that procedure was reduced.

Using modifier 52 with E/M codes is something that isn't very common, but may be appropriate depending on the circumstances of the encounter.

Modifier 57, Decision for Surgery;

This modifier is usually attached to an E/M code when a decision for surgery is made and then that surgery is scheduled on the day of or the day after the E/M encounter. That encounter may be in the office, hospital, care facility, etc.

Medicare has established postoperative periods for surgical procedures. Those with a 90 day postoperative period are considered to be "major" surgery. Procedures with zero to 10 day postoperative periods are considered to be "minor" surgery.

In the case of major surgeries (90 day postoperative periods), a preoperative period is included as part of the 90 days and is defined as the day before or the day of surgery. E/M services provided within this preoperative period (such as hospital admission H&P) fall under the global fees of the surgical procedure unless the 57 modifier is used to indicate that the decision for surgery was made at that time.



DO YOU KNOW?

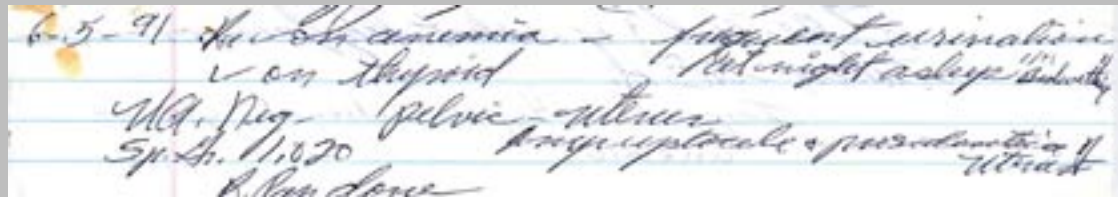
Do you know the specific elements of documentation that determine which E/M code you should use? You are not alone if you are still struggling with this process. Never guess again.

Get the **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. It is a must for every provider.





Modifiers

Using modifier 57 implies that an E/M service was performed and during the course of the E/M service (consultation, office visit, nursing home visit, etc.) a decision was made to perform a surgical procedure on that day or the day following. This allows for payment of the E/M service provided during the preoperative/postoperative care period of 90 days as defined by Medicare.

It is inappropriate to use modifier 57 with a hospital visit code on the day before or day of a surgical procedure when the decision for surgery was made before that period of time.

Generally speaking, it is also inappropriate to use modifier 57 with an E/M code on the same day as a minor procedure. When a decision to perform a minor procedure is done on the same day as the procedure, it is considered to be part of the preoperative care and is included in the global fee for the procedure. An E/M code should not be billed at the same time. You should however check with third-party carriers in your area for their definition of a minor procedure and determine if they recognize this code.

Modifier 57 should only be attached to E/M codes and to ophthalmological codes 92002, 92004, 92012 and 92014. It should not be applied to procedure codes.

Recommendation;

Once again, I recommend the book "Understanding Modifiers" published by Ingenix. It has a lot of detail and some excellent examples of how to use these modifiers correctly. It also points out the incorrect application of modifiers. The Ingenix web site is: www.ingenixonline.com.

Please visit MPECS on our web site. Go to the **Guest Page** (click on the link at the bottom of any page) and leave your comments or thoughts on this topic or any other you may be interested in seeing discussed here.

MPECS is dedicated to improving your ability to code correctly and with confidence. Let us know how we can help. Visit us at www.mpecs.org.



Huge waves pummel a Cuban lighthouse as hurricane Wilma passes close by.

I need your help

As I communicate with providers and office managers in various settings, it is clear to me that there are a fair number of us out there that are frustrated with coding and billing issues. Almost universally, those who attend the MPECS Practice Profitability Workshop express appreciation for the clarity of information presented and simplicity of the POCKET CODER and other products I have created.

In the past, I have spent literally thousands of dollars in direct mailings to physicians, PAs, NPs, clinics, billing services and so forth attempting to let them know about workshops and lectures that I am providing. Often with very little response.

I feel like I have a message to share that sometimes isn't getting out there. Sharing the information I have is immensely satisfying and enjoyable.

If you, subscribers to this newsletter, happen to be in a situation where you are talking about coding and billing, please remember to mention MPECS. As 2006 approaches, I am looking for opportunities to present this information at conferences anywhere providers are interested in "strengthening their bottom line."

Please think of me when your national, state or local organizations start planning for 2006. If you believe your local area can support an MPECS Practice Profitability Workshop, I am very interested in bringing it to your area. It is a valuable workshop that I would be thrilled to bring to your area.

As MPECS slowly grows, I am thrilled with the successes I hear about from you. If I can be part of helping you or your practice, I am honored to do so.

Thank you for your support, I appreciate every opportunity to serve you.
Jim Meeks, P.A.-C.