Productive Provider Newsletter

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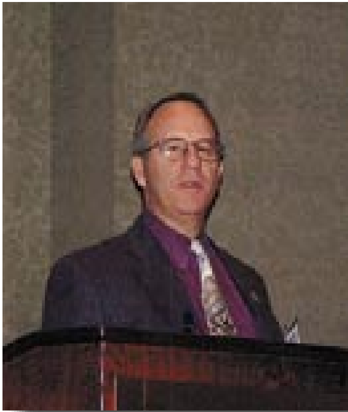

M.P.E.C.S.
Medical Professional Education and Consultation Services

Jim Meeks, P.A.-C.

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

This is the *Productive Provider Newsletter*. Thanks to our readers, we continue to grow. Welcome to all of our new subscribers. Judging by the E-mail questions and inquiries, the word is getting out *slowly* that it is OK to be profit minded and take care of your patients at the same time. Right on!

This newsletter is 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.

Please respond, comment and suggest on the content of this newsletter. Your questions and comments are essential to the success of this publication.

Thanks, enjoy this newsletter and have an absolutely great day.

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

1. **It's just my opinion**
   How could the provider defend his care or instructions to the patient when they hadn't been documented?

2. **Not Just Office Exams**
   Do you feel like you get lost some times? So do I.

3. **Learn From Your Failures**
   "If you're not experiencing failure, you're not working hard enough."

Productive Provider Newsletter
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All material contained in this publication is the original work of Jim Meeks, P.A.-C. unless otherwise noted. Quotations from and references to this material are encouraged and authorized as long as credit is given to the author, this newsletter by name and reference to the MPECS web site is included.

1. Its just my opinion.

As we begin to see the leaves changing color and cooler temperatures, we can all look forward to the onslaught of cold and flu season. Typically, we extend our office hours to accommodate the increased demand for our care during the flu season. We tend to try to fit in one or two more patients each hour to try to help and to keep our patients out of the ER. If you're not in primary care, I am sure you have your days when there just doesn't seem to be enough time to see everyone that wants to be seen. You pick the situation.

Unfortunately, more often than not, the result is that our documentation suffers as well. In an effort to keep up, we keep moving from patient to patient. The stack of charts we need to dictate or write in gets deeper and deeper. Then, there are all the call backs we need to take care of before we can go home too. Suddenly, at the end of the day, the documentation becomes a burden. It most definitely becomes much less of a priority.

Lets face it. When we are busy, we tend to document with a little less detail than we normally would. It is the logical outcome and occupational hazard of what we do every day. We all just hope that this isn't the chart that will come up someday in a medical review or worse yet, in an allegation of malpractice.

Occasionally, I review medical records for several law firms in my local area. So far, these have been on the defense side of the medical professional. It has been a very educational experience.

Having taught coding and documentation issues in one form or another for about nine years now, it has always been my intention to do a good job in my own charting. Sometimes, when we are really busy or I just need to get out of the office on time, I don't put as much effort into a chart note as I should. Just the minimum, enough to get the job done and get out. I am sure that I am not the only one to do so.

What I have learned from nearly every medical record I have reviewed both for legal counsel and during chart audits in offices, is that the overwhelming deficit isn't in the care. It is in the documentation. Rarely does a chart note fully describe everything that went on during the provider's encounter with the patient. Unfortunately, that is what often comes back to haunt us.

There are several ways that providers document patient encounters. Probably the most problematic is the hand written note. Lets face it, it takes a long time to write a good note. To get it done, we take short cuts or leave out details of the exam, teaching, etc. Legibility becomes a big issue as our hand gets tired at the end of the day. For some of us, it is an issue right at the start of the day!

Dictation is probably the best for detail and time efficiency, but it is so very expensive. To save costs, we again tend to leave out detail and go for the basics. For comparison, look at a hospital dictation of an admission history and physical, then compare that to a dictation in the office for the same patient. They are often vastly different.

Electronic medical records (EMR) are wonderful tools. However, the software and support are expensive. There is a learning curve associated with learning a system and that can really bog down an office the first few days or weeks of use. I tend to be uncomfortable with some EMRs I have looked at. They aren't very flexible and rely too much on templates. Don't get me wrong, I like templates when they are used correctly, but a template only system is too restrictive for my taste. There are systems that have a combination of templates and free text writing that are more to my liking. Again, cost is a big issue. The biggest advantage to EMRs is that you never have to look for a lost chart.

For offices that still have actual charts and are using either dictation or hand written notes, I really like paper based templates. Check boxes save a lot of time, as long as they are used. I shudder when I see templates or flow sheet (like used in an ER) and large areas of the sheet don't have a single mark or note. That isn't good.

My impression as I meet with and get to know providers everywhere is that they all just want to do a good job and take care of their patients. It would be so nice if we could just take care of the patient and not worry about all of the legal issues, HIPAA, billing and coding. Here, take two of these and call me in the morning. Oh, wouldn't

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!

The next ***MPECS workshop*** is scheduled in Salt Lake City on **April 30, 2005**. The MPECS web site has the current details. Mark your calendars and register early! Please visit www.mpecs.org for more information.

Jim will be speaking at the SUNA (www.suna.org) Conference in Orlando, Florida, October 25, 2004 on ***Documentation As A Legal Defense***, and on ***Practice Profitability***.

In November, Jim will be speaking at the AFPPA (www.afppa.org) National Conference in San Antonio, Texas on ***UTIs and Hematuria***. Come join us, November 3-7, 2004.

Looking for something unique or different for your next local, state or national conference? Jim is an excellent speaker and the MPECS workshop is an equally excellent topic that is appreciated by all providers.

that be nice.

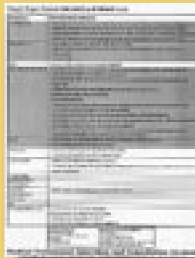
The reality of it is that we do have to consider all of the above mentioned issues. They are vital to our success.

So, how do we deal with the problem? Honestly, there is no perfect answer. Every practice situation has to evaluate their own needs. Unfortunately, when we receive notice of intent to file suit with a request for the complete medical record of the patient, it is a little late to worry about how well we have been documenting. Here are a few suggestions that might be helpful.

Chart audits. These are a great place to start. The investment of a couple hours per month reviewing selected charts is invaluable. I have found nothing better as a tool for educating providers, office staff and nursing staff on the importance of every element of documentation. I prefer to do this in a group setting where everyone meets and looks at chart notes together. It can be done on an individual basis just as easily.

The charts should be selected prior to the meeting and should have been reviewed by a provider or someone that is experienced enough with the type of practice you work in to be able to understand what is going on. A copy of the notes being reviewed should be available to everyone in the meeting or they could be projected on a screen electronically. You can be as open as you want or you can make it as sterile as you want by obliterating patient names, providers names, etc. HIPAA does not preclude anyone that would normally have access to patient charts from reviewing the information in those records. As long as patient information isn't discussed outside the office setting, there is not a concern.

MPECS Chart Audit Forms



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As charts are reviewed, the idea is to see how complete the documentation is. Does it support the CPT code(s) that were used for billing. Is the ICD-9 code correct? What if anything could have been done better? As everyone looks at the chart note, they have differing opinions and observations that when shared, are excellent tools for learning, for everyone. It's a great experience, try it.

Flow sheets or templates. Any practice can develop flow sheets for common and frequently seen problems like upper respiratory illnesses, or whatever. Specialty practices can too. I like them if they are well designed and complete. The advantage to flow sheets or templates is that they are uniform and quick to use. As long as they are used correctly, they are an asset. No matter how good the form, it is useless if it isn't used.

A recent case I reviewed for a law firm involved the death of a patient after leaving a provider's office. The office note was a template type form. Nothing indicated that the care provided wasn't adequate, but the form hadn't been completed by the provider. The dispute was over what the patient's condition was during the exam and what instructions were given by the provider. How could the provider defend his care or instructions to the patient when they hadn't been documented? What good is a flow sheet or template if it isn't used correctly?

Chart organization. If you are still using standard paper charts, take a look at the organization of the chart and your overall charting system. How much time is wasted in your practice looking for that lost chart? If you pay someone in your practice $10.00 per hour to look for that chart, that gets very expensive.

Charts should have a logical and consistent format. Dividers help, but they add a lot of bulk to the chart. In a large practice, space becomes a valuable commodity.

What provision do you have for adding labs, x-ray reports, consultation reports and other documents to the chart? Most recent on top or on the bottom? Left side or right side of the chart?

Are your charts falling apart? How much does your practice spend on replacement of worn folders, labels, stickers and so forth?

Someone needs to be responsible and procedures need to be in place to deal with all of these issues. Believe me, it may come up as a point of discussion in a malpractice case. I reviewed one where a provider saw a patient, treated the patient and sent the patient home with a new prescription, all before the chart was found. When it was found, later in the day, a very brief note was written and the chart wasn't reviewed. It had history dating back over 20 years for this given patient. Needless to say, there was a bad outcome and the provider was sued. Having that chart became a lot more important the day the provider learned about the allegation of malpractice.

The bottom line is that you need to do whatever is necessary for your practice to maximize documentation and reduce risk. Their can be excess in either direction. Common sense is essential.

Are you struggling with any of these or other issues in your practice? Feeling overwhelmed? Get some help.

It's just my opinion.

Jim Meeks, PA-C

2. Not Just Office Visits

We've talked a lot about E&M coding for office visits in this newsletter. New patients (99201-99205) and established patients (99211-99215) each have their own CPT codes for the given levels of service provided. The particulars of each level are based on history, physical exam and medical decision making.

In addition to office visits, other encounters with patients have unique CPT codes as well. Each level in a given setting has it's own set of criteria for code selection. These too are based on the amount of work performed and documented for each encounter related to history, physical exam and medical decision making.

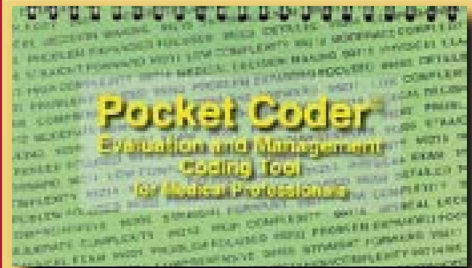
Emergency department visits have five levels of CPT codes (99281-99285). Initial (99221-99223) and subsequent (99231-99233) hospital care visits have only three levels each. There are two codes for patient discharge services related to hospital care (99238 & 99239). Patients in observation status and discharged the same day have three levels of codes (99243-99236) whereas observation patients on observation status for more than one day have three codes (99218-99220) and a discharge code (99217).

Initial inpatient consultations have five codes (99251-99255) and follow-up inpatient consults have three (99261-99263). There is one code (99217) for discharge from "observation status." Consultations in the office, other outpatient settings and in the ER have five codes. Confirmatory consultations have five codes. There are codes for nursing facility services, rest homes and home visits, each with a unique set of CPT codes, all based on history, physical exam and medical decision making.

It is a very complicated system. Do you remember which codes require three out of three areas (history, exam, medical decision making) be documented as opposed to those that only require two areas be documented for a given level? Do you feel like you get lost some times? So do I.

Short of carrying my CPT book with me everywhere I go, it is hard to keep track of all of the codes and the required elements for each one. Failure to do so leads to incorrect coding. Incorrect coding isn't very profitable and can be a problem if you see Medicare/ Medicaid patients. It isn't tolerated very well.

My simple solution is the Pocket Coder©. A concise reference for each of the codes that you will use every day in your practice. It's invaluable, practical. A must for today's busy healthcare providers.



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.

PLEASE SEND THIS ON . .

If you like what you see here in the *Productive Provider Newsletter*, please recommend and forward this newsletter to anyone that is interested in becoming more productive in his or her medical practice. Providers, billers and office managers alike are enjoying this publication.

If you are receiving this as a forwarded message, and you want your own FREE subscription, visit our web site and sign up on the "Site Mailing List" at *www.mpecs.org*.

3: *Learn from your failures . . .*

"If you're not experiencing failure, you're not working hard enough."

Learn From Your Failures. When you experience failure, take some time to reflect upon what happened. Pull out a pad of paper and start writing down the answers to these questions:

* Why did this happen?
* What could I have done differently?
* How can I do it better next time?
* What changes should I make in my strategies?
* What can I do to improve my planning and preparation?

Study these answers. Analyze them. Then go out and do it better the next time.

(Excerpts from SUCCESSFUL PEOPLE AREN'T AFRAID OF FAILURE by Jeffrey J. Mayer; www.succeedinginbusiness.com)