

MPECS September 2007 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;

Las Vegas, Nevada
November 3, 2007
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;

AFPPA Conf. Las Vegas, NV
October 31, 2007

Available for 2007 - 2008
bookings. Contact me at
PracticeProfitability@mpecs.org

Is this a 99212 or a 99213 visit?

I recently had the following question forwarded to me: "OK, I need a down and dirty on coding. I saw an established patient today in clinic for 'fever's' over the weekend. I did a history on lungs, heart, abdomen and bladder. I did a review of systems on these as well. My exam was EENT, chest, heart, abdomen and feet (edema). Do I code this as a 99212 or a 99213?" And here is my response.

You are not alone! Many providers struggle with the same types of questions every day. The Evaluation and Management (E/M) coding system as it now stands, is very confusing and difficult for everybody. Let me help a little. I will have to make some assumptions, but I believe I can offer some direction.

Right up front, this would never be a 99212. You far exceeded the necessary elements for a 99212. It may be a 99214, but easily, it is a 99213 type visit. Without your actual documentation, it is hard to say for sure, but here's why it is what it is.

Remember first that there are 3 KEY areas of consideration;

- 1- **History** (which includes the history of present illness [HPI], the review of systems [ROS] and past medical, family and social history [PMFSHx]),
- 2- **Physical Exam** and
- 3- **Medical Decision Making.**

Lets look at **history**. The history portion of a 99213 visit requires an HPI of only 1 to 3 elements (8 specific elements are recognized) and a problem pertinent ROS. You state that you did an ROS on 4 organ systems. Two to nine areas are required for a 99214 - you got that. Documentation of PMFSHx is not necessary for a 99213 visit. Only 1 element of PMFSHx documentation is necessary for a 99214 - if you have a current history information sheet in the patient chart and it was reviewed and/or updated during this visit, you got that. So the history section is easily a 99213 and may be a 99214.

Your **exam**. Based on your statement, you did an EENT, chest, heart, abdomen and foot exam. A 99213 level exam requires that you document examination of 6 to eleven elements of exam based on a number of pre-determined "bullets" (based on the 1997 guidelines for "Multi-system exams"). Without your documentation, it is hard to say, but I suspect that you probably got at least 6 elements of exam documentation. So, once again, you most likely have a 99213 level here. See the established patient coding matrix at the end of this newsletter, one page from the POCKET CODER.

A 99214 requires twelve or more bullets. You didn't mention skin which I am sure you looked at. I am also sure that unconsciously, you considered the psychiatric health of this patient; Is this patient on the level? You probably didn't document either one of these but most likely did them, a common problem with all of us.

Medical decision making (MDM) must also be considered. Established patients only require consideration of two of the three key components (history, exam, MDM), but it always pays to look at the MDM. Sometimes that is at a higher level than you might think. Unfortunately, MDM is the most complicated (and therefore the most misunderstood) part of the E/M coding process.

Your patient has at least one new problem, fever. I don't know if the edema is new or ongoing, but if it is new, then that increases the complexity of MDM. The question is; Did you perform or order any testing to assist you with arriving at a diagnosis and the management of the patient? If so, that also increases the complexity. Additionally, did you write any prescriptions? How about co-morbid conditions (hypertension, diabetes, etc.) All of these elements increase the complexity of the patient.

So, to boil down your question to a simple answer, at the very least you have a 99213 level of office visit but most likely, you have a 99214 and didn't even know it.

DISCUSSION. Why would this never be a 99212 visit? The answer is because the nature of the presenting problem is too high. With fever and edema identified, that would



Which is it?

be a moderate level of concern. See the "E/M Service Guidelines" section of the 2007 CPT book under the section of "Nature of Presenting Illness" I quote, "**Moderate severity: a problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.**"

The history and exam described are too detailed to be a 99212 exam. A 99212 only requires one element of HPI, no ROS and no PMFSHx information in the documentation. Only one to five elements of exam need to be documented. Taking vital signs (at least 3) counts as one element of exam. MDM only requires one diagnosis and minimal risk to the patient.

Sure, you can assign this kind of visit any code you want. However, using a 99212 would be catastrophically undervaluing your skills and service to the patient. Why catastrophically? If you don't place correct value on the service you provide, you can never expect to be compensated adequately. Many of us struggle to balance the needs of the patient with the financial concerns of the practice. I know many practices that have closed their doors because they couldn't cover the costs of operating a practice. Where do the physicians, NPs or PAs from these closed practices go? Many end up joining group practices where they are constrained to conform to policies of management that they don't necessarily always agree with. This leads to dissatisfaction in our careers.

How do health care professionals end up in this position? Is it a 99212 or a 99213? I think that most likely, it IS a 99214. If it is and you bill for something less, you have just shortchanged yourself and your practice payment for services rendered (I hate the word "reimbursement") you are entitled to. It should be easier than that to make an E/M coding decision, for everybody. Unfortunately, there is still too much confusion about how to select a proper E/M code.

The basic fundamentals of E/M code selection center around the three KEY elements I already mentioned, history, exam and medical decision making. Contributing elements to the decision making process include counseling, coordination of care, nature or the presenting problem and time. If you have poor documentation, it will be next to impossible to defend any coding decisions you make and that leads to problems of significant magnitude when an insurance company or government entity asks to audit your charts.

Every physician, physician assistant, nurse practitioner, billing clerk and office manager MUST understand E/M coding. Without a sound foundation of E/M coding, decisions like the one posed at the beginning of this newsletter will continue to trouble us as we see our patients in any setting. We cannot afford to guess about which code to use.

I understand the complexity of the process. I also understand the sometimes very subjective nature of the patient encounter that has to be converted into a measurable entity from which a coding decision has to be made. It is complex and often frustrating. It doesn't have to be.



If you are unsure of what constitutes history, exam and medical decision making (you are not alone), you should consider getting a **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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Back Page

ESTABLISHED PATIENT OFFICE VISIT					
COMPONENTS (History, Exam, Decision Making) Must meet or exceed 2 out of 3 components	LEVEL 1 99211	LEVEL 2 99212	LEVEL 3 99213	LEVEL 4 99214	LEVEL 5 99215
HISTORY		Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Chief Complaint/History of Present Illness (8)		Brief (1 to 3)	Brief (1 to 3)	Extended (4 or more)	Extended (4 or more)
Review of Systems (14)		N/A	Problem Pertinent	Extended (2 to 9)	Complete (10 or more)
1) Past Medical, 2) Family, 3) Social Hx's		N/A	N/A	Pertinent (1 out of 3)	Complete (3 out of 3)
EXAM	Supervision Only Health Care Provider presence not required for Level 1 visits	Problem focused Limited exam of affected body area or organ	Expanded Problem Focused Limited exam of affected body area or organ system and other symptomatic or related organ systems	Detailed Extended exam of affected body area(s) and other symptomatic or related organ systems	Comprehensive General multi-system exam or complete exam of single organ system
1995 Organ Systems (12) / Body Areas (10) 1997 Multi-system Exam Doc. Requirements		(1) / (1) 1-5 *	(2-7) / (2-7) 6-11 *	(2-7) / (2-7) 2 • in 6 areas or 12 •	(8-12) / (8-10) 9 areas, 2 • each
DECISION MAKING		Straight Forward	Low Complexity	Moderate Complexity	High Complexity
Number of Diagnosis		Minimal (1)	Limited (2)	Multiple (3)	Extensive (4)
Amount and / or complexity of data to be reviewed		Minimal or none	Limited	Moderate	Extensive
Risk of complications and / or morbidity or mortality (see table of risk)		Minimal	Low	Moderate	High
TIME (Face-to-Face) in minutes	5	10	15	25	40
Time is the controlling factor only when counseling and/or coordination of care dominate (>50%) the provider/patient and/or family encounter.					
PRESENTING PROBLEM	Minimal	Self limiting/minor	Low to Moderate	Moderate to High	Moderate to High
SEVERITY of reason for patient encounter with regard to disease, condition, illness, injury, symptom, sign, findings or complaint					