Productive Provider Newsletter

September 2006
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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.

It's Just My Opinion

I recently had an interesting conversation with a very good friend of mine. He works for one of the large health insurance companies in our area. We had intended to just spend some time together and visit that evening at my home, but the conversation soon turned to what occupies most of our time, health care and insurance.

He mentioned that just a few days ago, a major national retail store chain had announced that their pharmacies were going to offer generic drug prescriptions to customers at $4.00 each. Currently there are some 300 drugs available on this program and that by the end of 2007 or early 2008, nearly 6000 generic drugs might be available. All at $4.00 each.

My friend voiced his concern that some of the generic drug manufacturing companies may be forced out of business by this practice because it often costs more than $4.00 per prescription to produce the medication, but because of the purchasing power of this retail company, they will be able to demand concessions from the drug manufacturers and wholesalers in order for them to have their products represented in this chain of stores. Eventually, this may lead to a reduction in the number of available generic drugs.

Reportedly, a second national retail store chain has announced their intention to match the same program. I have heard some brief news reports on the radio about this new trend.

I couldn't help but wonder what will happen to my independent neighborhood pharmacies. You know, the pharmacies where the same guy is behind the counter nearly every day and who knows my voice when I call in. The guy that asks how I'm doing and what's new in my life before I give him a prescription for my patient.

Our conversation then migrated to a discussion about the relationship between healthcare

See Opinion on page 2 . . .

Procedure Versus E/M Service

After last month's newsletter, I received an interesting question that I would like to share here today. Here is the question (slightly edited) as posed by the reader;

I would like to present a scenario of a visit I made to a patient in a long term care facility that offers some puzzles in coding. I am a member of SUNA [www.suna.org] *and have attended your workshops there. As such, I am a specialist Nurse Practitioner* [NP] *in urologic nursing, especially bladder function. I see patients in about 5 nursing homes as a consultant in continence programs required by Medicare and as a urologic consultant.*

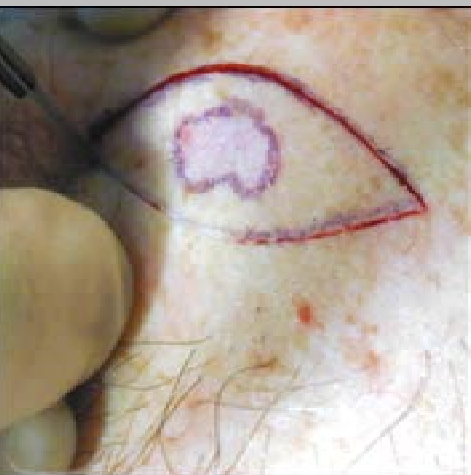
I was called in to see a patient who had a suprapubic [bladder catheter] *insertion procedure one week earlier by a urologist in an outpatient surgery center. The urologist ordered that I see the patient in 6 weeks for first change of the S/P tube.*

On the day in question, the primary care NP called me because the suprapubic tube had stopped draining and [a] *bladder scan showed 900cc urine in the bladder. She had tried all sorts of repositioning and milking the tube with no drainage. I considered this an emergency and went right in to the facility even though I planned on spending the day at home doing paperwork and housework.*

When I arrived, the patient was distended, in discomfort and needless to say, the tube was not draining. I repositioned the tube, removed water from the Foley balloon, advanced the catheter, made sure it had not been pulled out of place, milked the tube getting a couple of clots, and irrigated the bladder with normal saline. I also spent significant time reviewing the chart and educating the charge nurse on proper technique in changing from drainage bag to leg bag to prevent UTIs. All in all, I was there for over 1 hour.

My [concerns] *include: I consider this high decision making because the non specialist was unable to relieve the problem. I consider the patient's problem to be a danger to the patient because without intervention there could have been kidney damage. Changing of the cystostomy tube is a high*

See "Procedure vs. E/M" on page 3 . . .



MARK YOUR CALENDARS

EVALUATION and MANAGEMENT CODING ESSENTIALS WORKSHOPS & LECTURES:

MPECS 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;

Phoenix, Arizona
November 3, 2006
Lehi, Utah
March 10, 2007

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

CONFERENCE LECTURES;

NJAPN November 11, 2006
New Brunswick, NJ

Opinion

providers and the insurance industry. His comment was that the general perception in his company is that relationship is adversarial at best and that providers are the main reason that health costs are so high. We talked about this for a very long time. I pointed out that most physicians and practices are making less now than they ever have, but that the insurance companies are making more than they ever have.

Newspaper and journal headlines all across the country have reported record profits in a number of large health insurance companies in the past few years. The CEO of United Health Care (reportedly, America's largest health insurance company) personally earned over 90 million dollars in 2003 and over 120 million dollars in 2004 in salary and incentives. Other company executives also received multi-million dollar packages. I haven't seen the 2005 figures for United Health Care executives, but I suspect that there will be similar findings.

This friend of mine in the insurance company admitted that a large focus of their day to day operations is to increase profits and decrease expenses. This, from a company that is nonprofit. All profits they do earn are "reinvested" into programs and services in the company. Profits are also invested in a number of other places to increase income for the company to ensure a good long term profitability plan.

Of course, the executives of this company make pretty good money too.

I find it interesting that health care providers are considered to be the "enemy" by the insurance company, but incomes for physicians and practices have been steadily declining for years. I suspect that some of this "enemy" sentiment extends into the halls of governmental insurance programs too. It is my personal opinion that at least some of this sentiment is being translated into the "performance incentives" we see on the horizon.

Performance incentives are promoted under the guise of improved outcome for patient care. In concept, I don't have any problem with anything that improves patient care. I am troubled that it is to be tied to the financial end of practice and that accountability will be to the insurance company or a government agency.

Instead, I believe that performance standards should be defined and promoted by professional organizations of the respective specialties that providers work in. Accountability should be between the provider, the patient and peers in the profession and specialty.

It is my understanding that soon (if not already), in some areas of the country, patients will be able to log onto an insurance company web site and find information that ranks providers by their charges for the services they provide and by patient satisfaction. What this means is that if you are looking for someone to do a particular procedure, you can look at this web site, see all the providers that perform the given procedure, see how they are ranked by patients and determine who provides the desired service at the cheapest rate.

What this service fails to make clear to patients is that no matter what any provider charges, they are all paid whatever the insurance company stipulates is the acceptable rate. Yet, the financial ranking on the web site will be based on the amount the provider bills. This will give the impression to patients using this service that perhaps one provider is billing significantly more for the same service that another provider may be charging half as much for. The patient will never know that both actually get paid the same from the insurance company. To rank providers based on the charges they submit is ridiculous.

The final thought I have on all of this is that the patients we see every day are not getting the clear picture of what is going on in healthcare in America. We hear all kinds of stories about medical mistakes and malpractice in the day to day media. As yet, I have yet to see much directed at the consumer informing them of the enormous power of insurance companies in determining who they can and cannot see and sometimes when and how often.

As difficult as it may be, healthcare providers everywhere need to educate patients on these developments and trends in medicine and insurance management. It seems to me that some of the information being held out to them isn't as straight forward as it should be. Misconceptions are likely to occur and the healthcare provider will be the one that comes out as the bad guy, unless we all take the time to educate patients. I do.

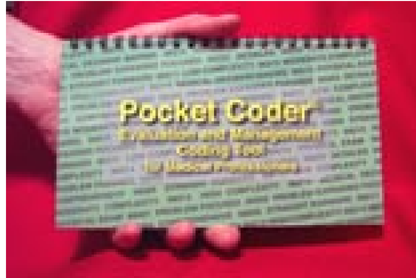
It's just my opinion.

Jim Meeks, PA-C

Comments, questions, objections or observations? I'd like to hear from you. Please submit any comments to me via the MPECS web site at PracticeProfitability@mpecs.org. I'd love to hear about your unique coding experiences.

M.P.E.C.S.

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

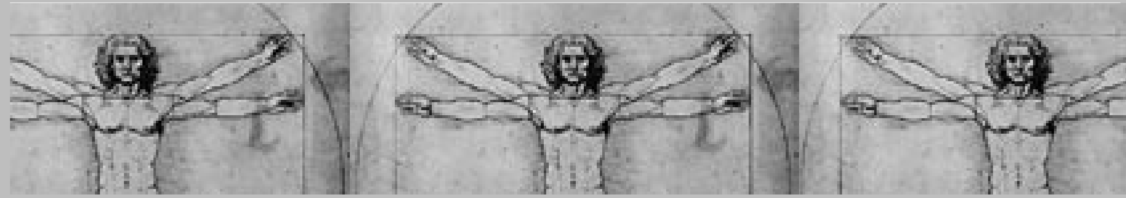


CODING TOOLS

Do you know the specific **elements of documentation** that determine which E/M code you should use? **You are not alone** if you are confused with this process.

See all of the MPECS **coding tools** on the MPECS web site. The **POCKET CODER**, the MPECS **Workshop Workbook**, several **Single Organ System Exam** tools and **Chart Auditing** forms are all available on the web site. Other tools are in the wings. Check back often. Refer a friend!

Order your Productive Provider coding tools today online at **www.mpecs.org/tools**. It is a must for every provider.



Procedure vs. E/M . . .

value procedure but I was able to fix the problem without changing the tube. It seems to me that the techniques involved in the managing of the problem are as complex as if the tube were changed. The problem could have been handled by sending the patient to the ER but we were committed to handling the problem in the long term care facility if possible.

What do you think? Instead of a high E/M code, should I have used a moderate one with procedure codes. What code would be appropriate for a problem solving intervention using multiple techniques and technical knowledge.

To answer these questions, we need to decide if this is an evaluation and management (E/M) encounter (and if so, what kind) or strictly a procedural encounter.

I can find only one CPT code listed that really applies to the described procedure "51701" which is for "bladder irrigation, simple, lavage and/or instillation." There is no code for a complicated bladder irrigation. Changing a cystostomy tube can be either simple (51705) or complicated (51710). However, since the catheter was not changed, neither of these codes can be used, so that leaves us with the bladder irrigation code. From the effort described above, I don't think that really encompasses everything in this patient encounter involved.

The information in the question states that the "primary care NP called . . ." This implies a request for consultation. The patient was evaluated and found to be in need of intervention. That intervention involved catheter manipulation and ultimately, bladder irrigation. Also involved was some patient evaluation. Although not specified in the information I received, it would be appropriate to do additional examination of cardiopulmonary, gastrointestinal and integumentary systems as well as psychological. The extent to which each is done is up to the provider performing the service.

Also mentioned is what sounds like an extensive review of the medical record and teaching of the staff (coordination of care). Depending on what is done and documented, this could be a fairly extensive E/M service (consultation).

A look at the consultation criteria shows that there are five possible levels (99241 through 99245) of acuity, each depending on the history, exam and medical decision making. All three must be included. Do not forget to consider the nature of the presenting problem (see last month's newsletter). If there are a number of comorbidities, the level of acuity increases. Based on the information provided, it is hard to be sure, but I suspect a "high severity" problem in this case.

As always, the documentation will determine the level that can be billed. It doesn't really matter what was done. If not documented, it doesn't count.

Considering the probability of a "high severity" presenting problem, appropriate care would dictate obtaining a comprehensive history. That means a history of present illness with four or more elements, a review of systems with at least ten elements and a complete personal, family and social history all need to be documented, reviewed or updated, either on an information sheet or in the encounter note.

A comprehensive physical exam requires either a multi-system exam that includes documentation of 2 bullets in nine areas or a complete exam of a single organ system. Since this is a urology problem, a male genitourinary single organ system exam (SOSE) is certainly appropriate and the most efficient use of a provider's time. If you are not sure what a SOSE is, see the August 2004, January and February 2005 newsletters at www.mpecs.org.

Finally, the medical decision making (MDM) process has to be considered before we can select the correct billing code. This is where understanding the nature of the presenting problem and obtaining a complete medical history pay off. In our case, the patient has a urological dysfunction that required placement of a suprapubic tube. A problem that was inadequately controlled, worsening (without intervention) and not improving as expected. The patients other conditions (unknown in our situation) would also be considered if reviewed during the encounter.

The amount and/or complexity of data to review may be significant depending on the completeness of the medical record. The reader mentioned doing an extensive chart review.

The risk of complications and/or morbidity or mortality is high due to the chronic illness with severe exacerbation which required intervention. Comorbidities also contribute to the risk and would be determined during the extensive chart review too.

I suspect that at a minimum, the patient has a moderate complexity MDM but may very

See "Procedure vs. E/M" on page 4 . . .

Procedure vs. E/M coding . . .

well have qualified for a high complexity MDM level. Without more information here, it is hard to say for sure.

Additionally, we could look at time. The reader states that she was there "for over 1 hour." If the actual time was 80 minutes and that was documented, the selection of the correct CPT code can be based on that element and would be a Level 5 visit or a 99245. It the visit was less than 80 minutes, but meets the requirements for a Level 5 visit based on history, exam and medical decision making, that would be the correct choice too.

The bladder irrigation code should also be used and a -25 modifier applied to the 99245 code to indicate that not only was a procedure performed, but a significant and separate E/M service was provided as well.

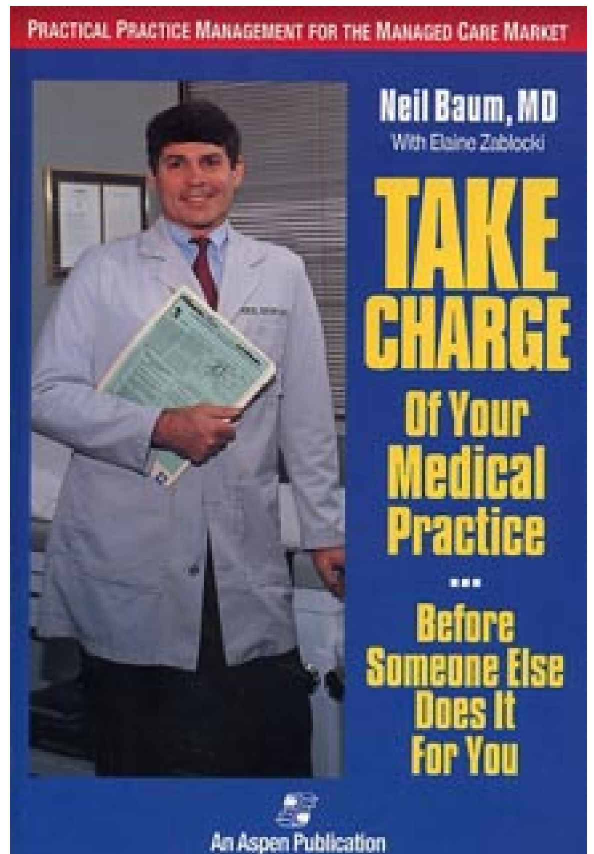
If however, the primary event of the encounter was irrigation of the catheter, that would be the only charge that could be ethically used if no other services were provided.

The standard of care would dictate that if the provider had no relationship with this patient previously, collection of history either from the patient or the medical record and a physical exam would be expected and appropriate. The medical decision making process is ongoing and is determined by the overall picture of the patient's health and comorbid conditions.

The answer to the question posed by the reader is that deciding whether to use E/M codes, procedure codes or a combination of both is determined not just by what was done for the patient, but what was documented in the patient encounter.

Food For Thought

A couple of thoughts from an excellent book by Niel Baum, MD. The book is "TAKE CHARGE Of Your Medical Pracitce - Before Someone Else Does It For You." Published in 1996 by Aspen Publishers, Inc. Gaithersberg, MD 20878.



"Many of us are wondering how the current health care crisis developed and how we can extricate ourselves from it. Of course, there are no easy answers and certainly no painless solutions, but those who are willing to accept that changes are occurring in the health care system and are willing to modify the way they practice medicine will have successful and profitable practices. The Chinese symbol for crisis is also the symbol for opportunity. The reality is that the health care crisis affecting all Americans also offers great opportunities for service providers.

A major concern for everyone is the rapidly rising price of care. Costs have risen rapidly in part because consumers have not been sensitive to costs. In the old days, a patient would contact a physician, who would provide a service in return for a reasonable payment from the patient. Next came insurance companies and other third-party payers. For most people, insurance companies pay for a large portion of health care expenses and "somone else" (employers, Midicare, or Mediciad) pays for the insurance. Consequently, people who receive services in our helath care system usually do not directly pay for them."

I really do not like the current term "Reimbursement" used by so many. It is so inaccurate. If you have any thoughts on this or any other subject, please contact me via the MPECS web site at www.mpecs.org.

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