Productive Provider Newsletter

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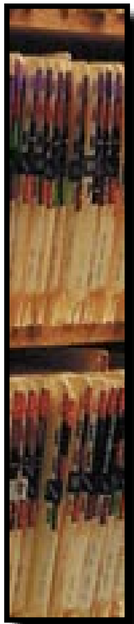

M.P.E.C.S.
Medical Professional Education and Consultation Services

Jim Meeks, P.A.-C.

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

Welcome to the *Productive Provider Newsletter*.

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.

Your questions and comments are essential to the success of this publication. Please make comments and suggestions on the content of this newsletter. I'd like to hear what you have to say about these issues.

Thanks in advance for your support.

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

1. **It's just my opinion**
   He said that most of the time, he just marked the "brief" office visit code.

2. **Two or Three Components?**
   Elements of documentation revolve around seven areas of information.

3. **The Power of a Touch**
   . . . we underestimate the power of a touch . . .

1. Its just my opinion.

I clearly remember my first experience with selecting an Evaluation and Management (E/M) code. I was a student working in a family practice with a wonderful physician in his solo practice. He had many years of experience and I was learning a lot from this caring man.

I had just completed an encounter with a patient and was ready to present it to him. We were standing just outside the exam room door discussing the case when he asked me how I was going code the visit. My first response was "What?" I had no clue what he was talking about. Code the visit, what does that mean? My first three clinical rotations as a student had been in emergency medicine, OB/GYN and orthopedics, none of which had exposed me to any billing issues. He then informed me that I needed to select a billing code.

On the front of the chart was a sheet of paper that he called the "superbill." There were lists of words and numerical codes and he wanted me to pick one of the codes for the office visit. This, he explained, was how he billed the insurance company for the patient encounter. This was how he made his living.

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I felt so stupid.

After a brief discussion, he then simply said that most of the time, he just marked the "brief" office visit code unless he spent a long time with the patient or had done a procedure. From that point on, I generally marked the "brief" office visit code as I had been instructed. I later learned that a "brief" office visit corresponded to a 99212 code.

On his superbill, he had several terms that were used in an attempt to assist us in selecting a billing code. They were, "Nurse, Brief, Limited, Extended and Comprehensive." Each had a corresponding billing code. There were codes for new patients and for established patients and a list of codes for office procedures and such. As I recall, probably 80% of the visit encounters were coded as "Brief" and all of the others were coded as "Limited." I do not recall ever coding anything higher than that.

When I finally completed my training, I took my first job in an emergency department in Phoenix, Arizona. In that position, we dictated lengthy notes which were then sent to a billing service. I had no exposure to the billing end of things there either.

Soon thereafter, I began moonlighting in a North Phoenix family practice. The office manager there took me aside on my first day and informed me that I needed to code my patient encounters at a higher level. Generally, she expected me to be coding at the 99213 level or above. The superbills in this office used terms like "Problem Focused, Expanded Problem Focused, Detailed and Comprehensive." More confusion for me.

When I asked for help in understanding the differences between these various coding levels and terms, I was given some very non-specific guidelines. Basically, I was left to guess which code to use.

From that point on, I began to educate myself on coding issues. I read everything I could find on the subject. I attended workshops and presentations on coding and billing. At most of these, I discovered that there were a lot of office managers and billing clerks in attendance. Rarely was there a physician. I don't ever recall seeing another physician assistant nor did I see a nurse practitioner. All of the events I attended were taught by an office manager, an accountant or other administrative type person, but never by a healthcare provider.

After a couple of years of clinical practice and educating myself on the coding issues, I began to realize what a disadvantage it had been for me as a provider to not have some kind of understanding or at least an introduction to coding and billing issues as a student.

It was in 1995 that I approached the director of my PA program and suggested adding a coding and billing component to the curriculum in that program. He agreed and I began teaching PA students at the University of Utah PA program that year.

Based on my experiences with events I have attended, my perspective as a practicing provider gives me a unique perspective on the topic of E/M coding. It certainly makes it easier to teach. Over the years, my teaching at the U. of U. has allowed me to develop the Practice Profitability, Strengthening Your Bottom Line workshop. My intention was to help students be a little more prepared when they enter the healthcare world. That original intention has grown beyond the teaching of students to wonderful experiences with physicians, PAs, NPs, Nurses and other healthcare professionals as well as office managers and billing staffs. It has been an amazing journey. Almost universally, I discover that providers in all disciplines struggle with the complexity of the E/M coding process. Based on the feedback I get from my workshops I believe that I am helping in that struggle.

Evaluation and Management coding class, First Year PA students,
A.T. Still University, Arizona School of Health Sciences, Mesa, Arizona

This past week, I had the extreme privilege of teaching some 50+ PA students at the Arizona School of Health Sciences in Mesa, Arizona. What a wonderful experience and what great students. It is gratifying to see a top notch program incorporate coding and billing concepts into their student training. These students are just getting ready to start their clinical rotations, the second year of their training. What a marvelous advantage they will have as they begin their clinical experience. An advantage I didn't have.

My experiences teaching various groups of healthcare professionals demonstrate to me that there is widespread frustration on the topic of E/M coding. The positive feedback I continue to receive after my presentations and workshops convinces me that there is a lot of work yet to do. I look forward to it.

It's just my opinion.

Jim Meeks, PA-C

2. Two or Three Components?

Lets face it, Evaluation and Management (E/M) coding is confusing. The challenge I have in teaching useful coding concepts to healthcare providers is ongoing and never easy. The purpose of the Practice Profitability Workshop is to alleviate some of that confusion. It is my mission. I enjoy it.

With that in mind, I'd like to review some basic concepts today.

Elements of documentation revolve around seven areas of information. These are; 1- Patient history, 2-

Physical exam of the patient, 3- The medical decision making process, 4- Counseling, 5- Coordination of care, 6- The nature of the presenting problem, and 7- Time.

The first three of these elements (**History, Exam and Medical Decision Making**) are considered the **KEY** or primary components in documentation. The other four are considered to be contributory elements and are generally used to assist in the medical decision making process. The exception to this is in the consideration of time when counseling and coordination of care dominate more that fifty percent (50%) of the patient encounter (Please see the December 2003 and the April 2004 MPECS Productive Provider Newsletter for information on the subject of TIME; www.mpecs.org/newsletters).

Much of the confusion, and therefore challenge to me as I teach workshops, centers around the use of these elements and the correct selection of a billing code. Lets remember that patient encounters occur in a number of settings and that these encounters are significantly different for a new patient than they are for an established patient.

To correctly select a billing code (E/M CPT© code), established coding guidelines require that we consider **three out of three** components (referring to the **KEY** components listed above) when we see a new patient in the office. Additionally, three out of three components are required for initial hospital admissions (both observation and regular admissions), in the emergency department, for initial and confirmatory consultations (inpatient and outpatient) and for new patients in nursing homes, rest homes, custodial care situations and for home visits.

When we have an established relationship with a patient, coding guidelines state that we only need to consider **two out of the three** **KEY** components. Remember however that if you have an established office patient that you admit to the hospital, that is considered an initial admission visit and that requires three out of three components be documented on that visit.

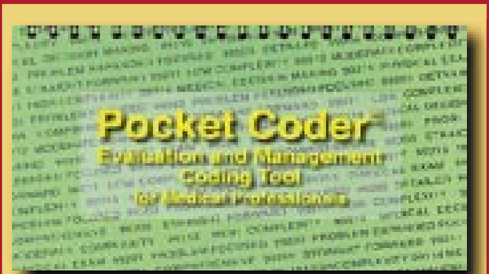
What this all means is that in any new patient encounter (or initial hospital admission) situation, your documentation must include information on history (history of present illness, review of systems and past medical, family and social history), physical exam findings and Medical Decision Making (MDM) to allow selection of the correct billing code. Yes, this requires more work, but that is why payment for these services is at a higher level.

So, now that I have explained the requirements for new patients, let me explore some of the confusion I encounter around established patient encounters, in any setting. Remember that the documentation required for these visits focuses on any **two out of the three** **KEY** components of documentation. This literally means that you can select an E/M billing code based on history and MDM, without ever touching the patient. You can consider physical exam findings and MDM without reviewing the patient's medical history, family medical or social history. You can get a good history and do a patient exam and select an appropriate E/M code no matter how many diagnosis are listed.

I hear this all the time, "I can't bill a Level Four (99214) visit because I only have one diagnosis." That is so wrong. If a provider has reviewed and/or updated a medically appropriate history (HPI, ROS, PMFSHx) on an established patient and performed a medically appropriate exam that qualifies for a Level Four visit, it doesn't matter how many diagnosis are listed. It is still considered a Level Four exam based on the history and the exam (two out of the three **KEY** components).

Let me illustrate with this example, an encounter that is fairly common. You have a young patient brought into your office by Mom. The patient has had an off and on low grade fever and some mild upper respiratory symptoms for a couple of days. Yesterday, the patient complained of an earache, sore throat and nasal congestion and a dry cough. This morning, the patient wouldn't eat breakfast. You haven't seen this patient in your office for several months (length of time isn't really important here unless it is more than three years at which time this patient then becomes a new patient again).

The documented elements of history necessary for a Level Four visit include an extended HPI (at least 4 out of 8 possible items documented), an extended ROS (2 to 9 areas reviewed out of a possible 14) and a problem pertinent medical history (one item from the patient's past medical history, family history or social history) all of which would be medically appropriate in the given situation. It is acceptable to state that the PMFSHx was reviewed and updated or that no changes were necessary, but it must be stated in the note and or on the history sheet in the chart.



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.

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PLEASE SEND THIS ON . .

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The physical exam for this patient should also be medically appropriate. Since we are all familiar with the "General Multi-System Exam" bullet list we have all been using since 1997, I will not attempt to recreate it here. In this example, there are a number of organ systems involved. Based on my typical exam of the patient I described above, I would have performed an exam that would have included between 15 and 18 of the recognized bullets in the "Multi-System Exam." In this example, I'll say that no signs of any bacterial infection were found.

Now, some of us might have simply written "URI" for the diagnosis. No matter what the diagnosis is or how many are listed, the history and physical exam components alone qualify for a Level Four (99214) billing code. I met the criteria for history and exam. Medical Decision Making does not need to be considered to make that selection. I have spoken with a number of healthcare providers and a number of office managers that are very concerned about the number of diagnosis on the superbill. While it may be a consideration, it is not the only one that we need to be thinking of.

The same concept (two out of three **KEY** components) can be used when a minimal physical exam is performed. For example, lets say that you suspect a patient has hypertension, you ask them to monitor their blood pressure readings at home and return in a month to re-evaluate. Upon return to your office, you again update the history of the patient. Certainly you would briefly document why the patient is being seen either by stating so or referring to the previous note (HPI information). If the patient happens to have other chronic illnesses, say hyperlipidemia and eczema (or anything else), you would appropriately review the medications and treatment plans for those as well (that is just good medical practice). This is all part of the MDM process that we do all the time. Some providers forget to think if this thought process in these terms and fail to give themselves credit for doing the work.

The point to remember here is that if we are diligent in our work, that is, documenting appropriate history information (that includes the HPI, ROS and PMFSHx information just like in the first example) on this follow up visit coupled with the fact that the patient has two or more stable chronic illnesses in addition to the new problem of hypertension (or whatever else it may be), that information alone qualifies the visit for a Level Four billing, without doing any physical exam. That is because this patient meets Level 4 criteria based on the history and MDM, two of the three required elements of documentation without having to consider the physical exam.

I am not going to take the time to explain the MDM process here today, I unfortunately do not have the space. If you are confused about how MDM works, please refer to the October 2003 (Parts 1 and 2) Productive Provider Newsletter (www.mpecs.org/newsletters) for more information on the Medical Decision Making process.

3. The Power of a Touch.

"The majority of us lead quiet, unheralded lives as we pass through this world. There will most likely be no ticker-tape parades for us, no monuments created in our honor.

But that does not lessen our possible impact, for there are scores of people waiting for someone just like us to come along; people who will appreciate our compassion, our unique talents. Someone who will live a happier life merely because we took the time to share what we had to give.

Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have a potential to turn a life around. Its overwhelming to consider the continuous opportunities there are to make our love felt." *Leo Buscaglia*

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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!

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(www.suna.org)

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