

# Productive Provider Newsletter

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

**FRONT PAGE:**  
**It's Just My Opinion**  
Office efficiency and functionality. Hows yours?

**Nature of Presenting Problem**  
Another part of the Evaluation and Management Coding process.



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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.

## Front Page

### It's Just My Opinion

There are few things I can think of that are more challenging than managing a medical practice. The nature of the practice usually has some influence on the overall functionality of the day to day operations, but the end goal is usually the same, providing quality healthcare to every patient.

There are a number of obstacles that often confront us in our quest for efficiency and functionality. No one can control the unexpected circumstances that occur from time to time. Obviously, when a provider is called away from the office to deal with some situation requiring his or her presence, the office schedule gets interrupted. There are those patients that schedule a short visit only to present a list of multiple problems.

I love the patients that say something like, "Oh, by the way" or "One more thing" just as you are opening the exam room door after dealing with the issues they came for in the first place. This seems to happen more often than I care to think about, even when the medical assistants have asked them what they are being seen for when they are placed in the exam room. And don't forget the patients that ask us to refill their husband's antihypertensive (or whatever) medication because he is too busy to get in for a visit. Never mind that he hasn't been seen for over a year.

A well trained staff can do a lot to make office functionality more efficient and to alleviate the concerns of patients when schedules get interrupted by emergencies or other problems. Over the years as I have been a patient, been in practice and been involved in practice consultations, I have made some observations about office functionality and efficiency that I'd like to share with you today.

*See Opinion on page 2 . . .*

### The Nature of Presenting Problem

Within the Evaluation and Management (E/M) coding system, there are a complex set of elements that are used to determine the level of care and ultimately, the correct CPT code for billing. We have talked about these in the past. The "**KEY**" elements are History, Physical Exam and Medical Decision Making. **Contributing elements** are Counseling, Coordination of care, Nature of the Presenting Problem and Time.

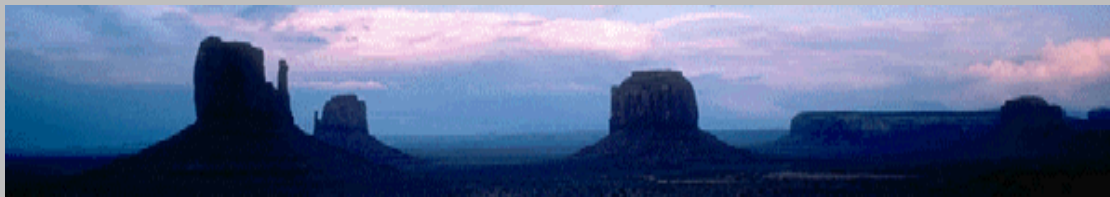
The Nature of Presenting Problem is clearly explained in the current CPT book. In the front of the section that deals with E/M codes, you will find a number of light green tinted pages titled *Evaluation and Management (E/M) Guidelines*. At the bottom of the right hand column of page two, you will find a section on **Nature of Presenting Problem**. It lists five types of presenting problems and offers a brief description of each.

Interestingly, there are no specific instructions on how these definitions are to be applied when considering E/M coding. They are however, an important part of the process. I have seen recent news reports where the nature of presenting problem was the focus of prosecution of healthcare providers for abusive billing practices or over billing.

Just because a provider documents a patient encounter at the maximum level, the encounter doesn't qualify for a level five visit if the reason for the visit was a minor problem. You can document all day long and generate pages of medical records, but documentation doesn't determine the level of care, the nature of presenting problem does. I like to think of it as an umbrella that over shadows all of the other elements.

For example, if you obtain and document an extended (4 or more elements) history of present illness (HPI), a complete (10 or more areas) review of systems (ROS), a complete past medical, family and social history (PMFSHx), and then perform and document a comprehensive exam (two or more bullets in 9 or more areas or a complete single organ

*See "Presenting Problem" 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;**

**Lehi, Utah**  
September 16, 2006  
**Phoenix, Arizona**  
November 3, 2006

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

### **CONFERENCE LECTURES;**

**NPACE** September 14, 2006  
Chicago, Illinois  
[www.npace.org](http://www.npace.org)

**NJAPN** November 11, 2006  
New Brunswick, NJ

## Opinion

I really think that friendly staff has to be one of the most essential considerations in any practice. I can't even attempt to tell you how many times I have been greeted by someone at the front counter of a practice with a less than friendly demeanor. When the first words out of their mouth is, "Do you have an appointment?" or worse yet, you don't get acknowledgement, not even a glance while they are on the telephone, but you are just left to stand there and wait, well it is not a great first impression.

Instead, I am much more impressed when I am greeted with a smile and welcomed to the practice. That seems to go a long way in making me feel welcome. Indeed, most complaints that I have received from patients have dealt with the way they were treated by someone during their office experience. Whether it be the receptionist, medical assistant or anyone else, how our staff responds to and treats a patient and their family has a lot of influence on how a patient perceives their overall patient care experience.

I have heard from more than one patient that they may like a particular physician, PA or NP, but that they can't stand the receptionist or someone else in the office. These patients then choose to seek care somewhere else. If they are telling me their experience, I am sure that they are telling others too. Those "others" may be potential patients.

The front desk can be such a hassle for patients, but it is so important to verify insurance coverage, addresses, identity, and so forth. We recently had a case here in Utah where a pregnant woman went to a hospital, was admitted, delivered her baby and was then discharged. When the bills and statements were sent, they arrived at the house of the correct person according to the information the hospital had, but the woman of the house had not been pregnant. The woman in the hospital had used stolen insurance identification cards and driver's license. I guess that is a new way to get free medical care.

I have seen patients get very upset when asked for a Social Security number. Legally, Social Security numbers are NOT to be used for any identification purposes except within the Social Security system. That means we have to obtain other forms of identification. I believe that most insurance companies have moved away from using the Social Security number as part of their member insurance numbers.

The process of collecting all of the information needed to process medical claims and identify patients can be overwhelming for some patients, especially with language barriers or with advanced age or simply because they are having a bad day. I recommend that you assure that office personnel watch for those people struggling with office forms and offer assistance. That can be done privately as needed. It also goes a long way to help patients feel more cared for. Occasionally, I have seen patients take so long filling out a couple of forms that they actually miss their entire scheduled appointment time. That does not help an office run smoothly. We routinely ask new patients to come 15 minutes before their scheduled appointment time.

Telephone manners are also an area where I have heard some really interesting things happen. Answering a phone call should be done with kindness. I have sat in many a waiting room and overheard busy staff members using very short and abrupt language on the phone. Needless to say, that doesn't promote much good will when the patient is not greeted in a friendly and helping way.

Another area that I see that needs some attention is when patients are placed in the exam room to wait for the provider. I remember once, waiting for over an hour in a waiting room and then for another 45 minutes in the exam room. Not once did anyone bother to stick their head in and offer any reassurance or explanation. When the provider did arrive, he was rushed and never even acknowledged that he was late.

I think most patients understand the demands that we operate under. If we are behind, they can understand that too. Not expressing any validation of their inconvenience or anxiety only serves to increase those feelings. However, if our medical staff were to keep the patient status in mind and occasionally stick their head in the room and offer an update or progress report and a friendly comment, that would probably go a long way in helping promote an overall feeling of being cared for. Lets face it though, some providers just don't care.

It's just my opinion.  
Jim Meeks, PA-C

# 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](http://www.mpecs.org/tools). It is a must for every provider.



## Presenting Problem . . .

system exam) on an established patient that came in for a sore throat, you would be hard pressed to justify much more than a level 3 visit based on the nature of presenting problem.

If however, the patient had a number of other issues such as fever, headache, ear ache, cough and wheezing, nausea and vomiting with signs of dehydration, it would be much easier to justify a level 5 visit. Again, it is the nature of presenting problem (multiple systems, morbidity and mortality may be at risk if not treated) that determines the medical necessity for history, exam and medical decision making.

I once encountered a patient that was exactly like this. He had a sore throat. That was his primary complaint when he called for an appointment. During the course of the history I discovered that he had been ill for over a week. He had a high fever, and all of the other symptoms I described in the paragraph above. He was weak and had passed out at home. It turned out he had strep that had progressed to full blown sepsis. He died three weeks later in an intensive care unit. Although the chief complaint was only a sore throat as far as the patient was concerned, the other issues discovered by obtaining a complete history (HPI, ROS, PMFSHx) revealed a far more serious situation.

For as long as I can remember, I have been advocating that a complete HPI, ROS and PMFSHx be obtained on every visit. The HPI has to stand alone. That means that anyone reading today's chart note should be able figure out what is going on by reading today's HPI. In the case of a follow-up visit, referring to the previous note(s) is acceptable, but today's note should describe any progression of the disease process, response to treatment, side effects, new symptoms and so forth.

On every visit, the ROS and PMFSHx should at least be reviewed, and updated as needed. A simple statement in today's note that they were reviewed and no changes were needed is sufficient. Obviously, any new findings should be documented. Remember to specifically state what was reviewed, by whom and the date it was done to fulfill the requirements of accurate documentation.

A book published this year by the AMA Press titled *Practical E/M; Documentation and Coding Solutions for Quality Patient Care*, authored by Stephen R. Levinson, MD, advocates this very approach to patient care, a full history (HPI, ROS, PMFSHx) on every visit to fulfill the requirements for determining the Nature of Presenting Problem. With that in mind, lets look at the five types of presenting problem as outlined in the CPT book;

**Minimal:** A problem that may not require the presence of the physician (provider), but service is provided under the physician's supervision.

**Self-limited or minor:** A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.

**Low severity:** A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

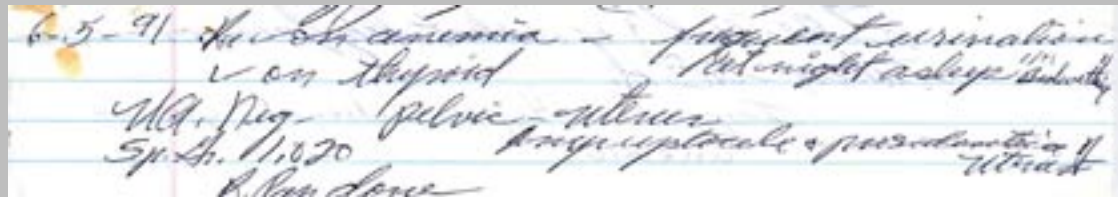
**Moderate severity:** A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged function impairment.

**High severity:** A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

To assist us in making sense out of these five areas of types of presenting problems, the authors of the CPT book have included a fairly exhaustive list of clinical examples in Appendix "C" of the CPT book. I recommend that you take a few minutes and read through them. An interesting exercise is to look at the code you use most often (99212 or 99213 or 99214, whatever) and read the clinical examples that are associated with those codes.

What you will find is that often in the 99213 level examples, the patients are stable and being seen for routine follow-up visits or minor new problems. In the 99214 level examples, patients are being seen for new problems or exacerbations to existing conditions. They often need new tests, medications or interventions.

You will find that there are clinical examples for new patients, established patients, hospital services, consultations, emergency department services and a few other areas of patient care. Once you understand the concept of nature of presenting problem, these examples serve as an excellent point of reference.



## Presenting Problem . . .

Last month I discussed Medical Decision Making (MDM), the third KEY component of E/M coding. It serves this discussion to look at the Table of Risk within the MDM chart that I provided in the last issue of this newsletter (see last months issue, page 5).

In the Table of Risk, Presenting Problems are identified as Minimal, Low, Moderate and High and include descriptions of the type of problems to be considered for Presenting Problems as they relate to risk. These serve as a good basis for considering the overall condition of your patients and deserve study so that we are familiar with their definitions.

The overall consideration of Nature of Presenting Problem overshadows all of the other elements of history, exam and medical decision making. Combined together, we are more able to make an appropriate determination of the correct CPT code. This is only possible if we have the complete picture to start with. That requires obtaining and or reviewing the essential information, a complete history (HPI, ROS and PMFSHx).

Before we all have a melt down as we contemplate the vast amount of work this requires, please remember that this information can be obtained by the ancillary staff in our office before we ever see the patient. One very practical way to gather this information is to ask the patient to fill out a form that asks the questions and obtains all of this information.

As I explained in the "Its Just My Opinion" article of this newsletter, patients can be overwhelmed by the sheer number of forms they have to fill out. If we are aware of that and have trained our staff to assist the patients, then gathering this information is easy to obtain and essential for good patient care and documentation.

Follow-up visits don't require a new form although some practices do use one. Training your staff to ask a few simple questions when a patient is seen in follow-up can satisfy the need for updated information.

"Since you were here last, have you started taking any new medications?"

"Have you stopped taking any medications?"

"Are the medications I have listed in your record correct?" (Instructing patients to bring all of their medications with them on every visit is invaluable for this review.)

"Have you seen any other physicians since you were here last?"

"Have you been a patient at any hospital or medical clinic since your last visit?"

At this point, a review (and update as needed) of the previously recorded ROS followed by inquiry about any changes in family and social history are recorded. All this can be done before the provider sees the patient. Notation is made in the chart about changes and the provider simply reviews the updated information at the beginning of the visit, asks any clarifying questions needed and then gets on with the visit. This process takes only a couple of minutes and provides valuable information. It serves as the basis for considering the nature of the presenting problem.

Once we have this information, we can look at the big picture (the patient's overall health) and have a greater understanding of the complexity or simplicity of the of the situation. We are then able to focus on the specifics of the sore throat (or whatever other condition they have). If we discover that the patient is having fever and syncope via the HPI and ROS and notice a low blood pressure, then perhaps the sore throat (minor severity) isn't the entire picture, but sepsis is. The treatment plan becomes much more critical for the patient. The nature of presenting problem is high severity.

Are you continually struggling with the Evaluation and Management Coding decisions in your practice? The Evaluation and Management Coding Essentials workshop can help. The next scheduled workshop is on September 16th here in Utah. Another is scheduled in conjunction with the AFPPA ([www.afppa.org](http://www.afppa.org)) conference on November 3, 2006 in Phoenix, Arizona. Other workshops are in the planning stages. If you are interested in having a workshop in your area, please contact me. Visit the MPECS web site often to check on other events.

The Evaluation and Management Coding Essentials workshop includes the topics of documentation, evaluation and management coding and medical decision making and a chart auditing exercise. Participants learn the fundamentals of good documentation and how they directly effect the E/M coding process. Medical decision making, easily the most complicated part of the process is discussed and illustrated with actual chart notes. The chart auditing session gives every participant an opportunity to look a the medical record from the perspective outside of providing care. This enhances the overall quality of all future medical documentation. Come join us!



**"Absolutely amazing!  
I can't believe I wasn't  
taught this stuff in  
school."**

After workshop comment by participant. See the "Feedback Page" on the MPECS web site.