Family Physicians’ Suggestions to Improve the Documentation, Coding, and Billing System: A Study From the Residency Research Network of Texas

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BACKGROUND AND OBJECTIVES: The study’s aim was to ascertain family physicians’ suggestions on how to improve the commonly used US evaluation and management (E/M) rules for primary care.


RESULTS: Study subjects supported preserving the overall SOAP note structure. They especially suggested eliminating bullet counting in the E/M rules. For payment reform, respondents stated that brief or simple work should be paid less than long or complex work, and that family physicians should be paid for important tasks they currently are not, such as spending extra time with patients, phone and email clinical encounters, and extra paperwork. Subjects wanted shared savings when their decisions and actions created system efficiencies and savings. Some supported recent payment reforms such as monthly retainer fees and pay-for-performance bonuses. Others expressed skepticism about the negative consequences of each. Aligned incentives among all stakeholders was another common theme.

CONCLUSIONS: Family physicians wanted less burdensome documentation requirements. They wanted to be paid more for complex work and work that does not include traditional face-to-face clinic visits, and they wanted the incentives of other stakeholders in the health care systems to be aligned with their priorities.

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In a companion paper (Young RA, Bayles B, Hill JH, Kumar KA, Burge S. Family physicians’ opinions on the primary care documentation, coding, and billing system: a qualitative study from the Residency Research Network of Texas. Fam Med 2014;46(5):378-84), we reported what family physicians like and don’t like about the existing Evaluation and Management (E/M) system. In this paper, we report their suggestions for improvement.

Methods

Our methods were reported in the companion paper.

Results

Documentation

Study subjects supported preserving the overall SOAP note structure. They found the E/M rules to be excessively burdensome, not very intuitive, and mostly unrelated to the quality of care they provide. They especially wanted to eliminate bullet counting.

|C|ounting out official bullets, ... needs to be dropped.

Coding

Some subjects wanted to be paid for work that family physicians often provide but are not paid for under the E/M rules, including time required to care for complex patients and non-face-to-face care. Time was felt to be a valid metric to base these new fees.

I would have some system that codes based on time and ... allows you to code or bill for the extra work outside of an office visit.

Several subjects wanted to modify or abandon the American Medical Association’s Current Procedural Terminology (CPT) system, because it does not allow them to code or bill for the number of issues they address in a clinic visit or the complexity of care.

From the Family Medicine Residency Program, John Peter Smith, Fort Worth, TX (Dr Young); and the Department of Family and Community Medicine, University of Texas Health Science Center at San Antonio (Dr Bayles, Mr Hill, Dr Kumar, and Dr Burge). All authors represent the Residency Research Network of Texas.
I think that the three things [to value] that I did are the complexity of each problem, the number of problems that I dealt with, and the amount of time that it took to deal with them, which are not really well represented [in the current system].

Billing/Payment
There was no significant consensus on a better payment system for primary care. In fact, there were a wide variety of opinions, though a few patterns emerged.

Work Effort
Many subjects felt that brief or simple work should be paid less; long or complex work should be paid more. Subjects said that taking extra time was appreciated by patients, their families, and even other stakeholders in the health care system, but that the lack of payment for this extra effort left the physicians caught between the altruistic imperative to provide the best care versus the opportunity cost of an unreimbursed service.

In all of these situations where the family physicians complained about their lack of reimbursement, they also noted the inconvenience to the patient to make multiple visits. Subjects also called for reform in other special federal payment mechanisms, such as rural health clinics.

Global Fees and Pay-for-Performance
A few subjects expressed support for payment concepts such as global or monthly fees from patients/payers and salaries for physicians. However, many expressed skepticism about co-existing negative consequences.

Subjects expressed doubt that any risk adjustment system could adequately correct for patient characteristics and their impact on physician work and payment. Characteristics included patient comorbidities, mental health status, social support, and behaviors, especially adherence to recommended treatment plans.

Medicare savings innovations that rewarded family physicians for “good” behavior and disincentivized “bad” behavior.

Discussion
We found that family physicians wanted less burdensome documentation requirements. They also wanted to be paid for complex work and work that does not include traditional face-to-face clinic visits, and they wanted the incentives of other stakeholders in the health care systems to be aligned with their priorities.

Because the highest-cost Medicare and Medicaid patients are those with multiple chronic diseases, the lack of incentives for family physicians to provide comprehensive care to complex patients should concern payers.

Incentives for Other Stakeholders
Though all of our questions focused on family physician work, many subjects also mentioned other payment reforms, including hospitals, insurance companies, and patients, suggesting that meaningful payment reform for physicians required other types of payment reform at the same time to be effective.

Patient Incentives
Subjects wanted patient incentives aligned with physician incentives.

Patient incentives have the incentive to try and cram as much into [a clinic visit] as they can because obviously they have to take off of work…, and they want to get their value out of the visit.

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addressing many issues in one visit—and to eliminate incentives to schedule the patient for multiple visits for the same list of concerns.

**Implications and Future Research**

Though many primary care enhancement demonstration projects have begun in the United States over the last 5 years, our study provides further insight on problems with the existing E/M rules and payment system that could inform future primary care payment reform efforts. We hope that our findings will stimulate payment reform experiments that match the suggestions we elicited from front-line family physicians.

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**References**