BRIEF
REPORTS

Family Physicians' Suggestions to Improve the Documentation, Coding, and Billing System:

A Study From the Residency Research Network of Texas

Richard A. Young, MD; Bryan Bayles, PhD, MPH; Jason H. Hill, MS; Kaparabonya A. Kumar, MD; Sandra Burge, PhD

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.

METHODS: A companion paper published in ***Family Medicine's*** May 2014 journal describes our study methods (Fam Med 2014;46(5):378-84).

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.

(Fam Med 2014;46(6):470-2.)

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.

> I get the same amount as the two local physicians who are very well known ….[to not] really spend any time with the patient.

Efficiencies of Family Medicine

Another common theme was that family physicians wanted rewards for creating systemic efficiencies. One example was providing E/M services and a procedure in the same visit.

> I think that we should be given more credit for adding procedures onto E&M stuff, … because that prevents the patient from having to come back a second time.

Subjects also wanted extra payment for providing urgent care services in their clinics more commiserate with the fees emergency rooms and hospitals are allowed.

> [W]e saved last year more than 6,000 hospital days. On average, each hospital day costs $2,000. So 6,000 hospital days savings times $2,000 a day is $12,000,000. How much do you think they paid me for that? None. I should get some.

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.

> I think that having global fees for management of hypertension or diabetes or some of the other things is fraught with difficulties and errors.

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.

> Why should I get paid a global fee for Ms Jones' diabetes treatment and Ms Jones does nothing that I ask her to do? I get penalized … because she is so noncompliant.

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.

> [Patients] 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.

Many subjects wanted shared savings innovations that rewarded patients for "good" behavior and disincentivized "bad" behavior.

> In fact, even a reward to [patients], if they take good care of themselves and they lose weight and so forth, they get to share in the savings.

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. Studies have shown that for a mostly middle-age insured population, a family physician addresses 2.5 to 3.1 issues in the average clinic visit.[7-9] The average number of issues per visit grows to 3.9 to 6 for elderly patients and 4.6 for patients with diabetes.[8,10] Direct observation studies have found that primary care physicians in clinic only spend 1 minute on other patient concerns after the chief complaint is addressed.[10] This leads to reduced uptake of quality chronic disease care services when other patient concerns are addressed.[11] Therefore, many of our subjects wanted to be paid for

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.

CORRESPONDING AUTHOR: Address correspondence to Dr Young, John Peter Smith Family Medicine Residency Program,1500 S. Main, Fort Worth, TX 76104. 817-927-1412. Fax: 817-927-1691. ryoung01@jpshealth.org.

ACKNOWLEDGMENTS: Funding was received from the Texas Academy of Family Physicians Foundation, Health Resources and Services Administration, Award #1D54HP16444, and the Office of the Medical Dean of the University of Texas Health Science Center at San Antonio.

Previous versions of this paper were presented at JPS Research Day, June 2012, Fort Worth, TX, and the 2012 North American Primary Care Research Group Annual Meeting, New Orleans, LA.

Dr Young discloses that he was paid a stipend to participate in the CMS Innovation Advisor Program in 2012, which did not directly support this research. There are no other conflicts to disclose.

We are grateful for medical student assistants: Les Alloju, Carlos Cardenas, Anna Haring, Ryan Horton, Laura Iglesias, Adam Kirkland, and Kristin Yeung.

We thank the participating physicians at each site for allowing our research team into their busy practices.

RRNeT investigators also include Swati Avashia, MD, Jerry Kizerian, PhD, Raji Nair, MD, Darryl White, MD, David Edwards, MD, Sunand Kallumadanda, MD, and Tamara Armstrong, PsyD.

References

1. 1997 Documentation Guidelines for Evaluation and Management Services. In: Centers for Medicare and Medicaid Services, ed.
2. Hawryluk M. E&M guidelines still don't work; panel says dump 'em. American Medical News; June 10 edition. Chicago: American Medical Association, 2002.
3. Medicare physician payment: time to act on E&M mess. American Medical News. Chicago: American Medical Association.
4. Arvantes J. MedPAC members characterize RBRVS system as subjective, "deeply flawed." AAFP News Now 2009 (Nov 3).
5. Spradley J. The ethnographic interview. San Diego: Harcourt, Brace, Javonovich, 1979.
6. Brett AS. New guidelines for coding physicians' services—a step backward. N Engl J Med 1998;339(23):1705-8.
7. Stange KC, Zyzanski SJ, Jaen CR, et al. Illuminating the "black box." A description of 4,454 patient visits to 138 family physicians. J Fam Pract 1998;46(5):377-89.
8. Beasley JW, Hankey TH, Erickson R, et al. How many problems do family physicians manage at each encounter? A WReN study. Ann Fam Med 2004;2(5):405-10.
9. Flocke SA, Frank SH, Wenger DA. Addressing multiple problems in the family practice office visit. J Fam Pract 2001;50(3):211-6.
10. Tai-Seale M, McGuire TG, Zhang W. Time allocation in primary care office visits. Health Serv Res 2007;42(5):1871-94.
11. Fenton JJ, Von Korff M, Lin EH, Ciechanowski P, Young BA. Quality of preventive care for diabetes: effects of visit frequency and competing demands. Ann Fam Med 2006;4(1):32-9.