

Goodson response to Whittle John Goodson, MD

Any payment system will be at the mercy of those who want to exploit the embedded incentives. Yes, the 99211-5-established patient E/M family of CPT codes used by generalist physicians is no exception. The hypothetical practitioner proposed by Dr. Whittle could “work” the codes to achieve a spectacular income.

Statistics based on actual physician behavior show that this just does not happen. We as generalists take our work seriously enough not to abuse the system, though we could. We are willing to provide uncompensated care for our patients—care that is not bundled in the CPT codes—because we chose to do so. Current income figures for generalists are around \$160,000 (2006 figure for primary care physicians, Bodenheimer, *Ann Intern Med.* 2007;146:301-306), which is way below that of the exploitive practitioner feared by Dr Whittle. Yes, we could limit our care to that covered by the current model, but we don’t. Dr. Whittle describes the documentation criteria required for the typical complex outpatient follow-up visit, the 99214. The issues around charting for care and documenting for billing are complicated. Charting has become a difficult task for all physicians precisely because of the potentials for fraud and abuse. CMS has developed elaborate systems for auditing all MD work based on the components outlined by Dr Whittle—history, physical examination, and medical decision-making. The paradigm used is rational; clinical need drives medical decision-making, and the complexity and/or “intensity” of the clinical situation drives the coding choice. The E/M codes of interest can be chosen based on the charting requirements for a given situation or on the time spent with the patient, if more than 50% is spent in “counseling” (i.e., talking to the patient as opposed to doing something to the patient). A short visit with all the needed components documented does not have to meet the time

requirements, as Dr Whittle points out. But according to the salary data noted above, even allowing for the possibly of short intense visits, generalists are practicing differently. They are spending time in face-to-face care and, more importantly, spending time outside with non-face-to-face care.

The “bundling nemeses” is reflected in the realities of comparative income figures. Generalists are paid about 55% of what a specialist is paid. The compensation model fails to assign payment for much of the non face-to-face clinical work we do.

There is no CPT code for *inter-service* care. There is a small account of non face-to-face care bundled in the 99214—roughly 10 minutes. We and all of our colleagues spend an average of 20 to 40 minutes on each patient fielding phone calls, providing night and weekend care, answering emails, sorting out formulary questions, and so forth; these activities are *not* compensated.

Those of us who call for payment reform want new rules precisely because the old rules have been so dysfunctional. CMS should start by creating new service codes to cover the inter-service needs of patients, with both work RVUs (to cover the non face-to-face interactions with patients and families) and practice expense RVUs (to cover the infrastructure and personnel needs of non face-to-face care management).

New models of care, such as the patient-centered medical home, can be built from this new payment model. Groups can choose to consolidate payments to improve care effectiveness and efficiency. Like all federally funded care, there will have to be documentation requirements for different code levels. Yes, there will need to be years of health service research to understand how this system affects care and cost, but we cannot wait to prove new models work. We have to begin now, be prepared to analyze as we go forward, and adjust as needed based on our

commitment to establish a robust and self-sustaining generalist workforce to meet our national health care needs.