EDITORIAL

The Bundling Nemesis within E/M Coding: We Need Payment Reform Now!

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I was busy this week. I saw 60 patients as an 80% clinician, all members of the "village" of 1,500 or so who see me as their doctor.

So how much did I earn by doing my work? Here are the calculations. Let's assume that each patient was submitted at a 99214 level of E/M billing. (This is close to exact since there were a couple of short follow ups and the one new patient.) I generated 85.2 RVUs, calculated at 1.42 work RVUs per visit. This is the work component of Medicare payment. There is a separate practice expense component, which covers part of my office overhead.

With the current Medicare conversion factor of around $37, this would mean an income of $3252 for my week of work. For this income I spent 26 hours with my patients in face-to-face time. I spent an equal amount of time with 200 or so non-face-to-face encounters (reviewing labs, consult notes, answering calls from others "villagers"). So this equals 52 total hours. My fringe benefit rate is 30%; so my weekly "salary" was $2,207. This works out to $105,936 for a 52 week year (assuming a two-week vacation and another two weeks of holidays in the hospital schedule).

By comparison, the top take home salary for an adult nurse practitioner at my hospital is $145,000, after fringe. The nursing "market forces" in Boston have driven up the compensation for all nurses and nurse practitioners.

What has happened to the general internist? Why is it that I am paid so poorly compared to my specialty peers for each face-to-face encounter?

The CPT manual, a proprietary AMA product used by CMS as the official source of service code descriptions, stipulates what I must do and document to fulfill the requirements for the 99214 visit. It reads as follows: An "office or other outpatient visit for the evaluation and management of an established patient…requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity." The CPT also stipulates that on average I spend 25 minutes in "intra-visit" (face-to-face) time, 5 minutes in pre-visit time, and 10 minutes in post-visit time. These are the current "bundling" assumptions for the 99214 service code.

So there it is. I worked my 52 hours and got paid for 40 (60 visits @ 40 minutes a visit).

Virtually all the CPT service codes used by physicians have pre, intra- and post-visit times that are similarly bundled. For the radiologist, the total "visit" time with a single view chest x-ray is 5 minutes (for a minute's work); for a colonoscopist, it is 75 minutes (for maybe 30 minutes of work). For a surgeon doing an open splenectomy, it is 15 minutes for "dress, scrub and wait," 120 minutes of skin-to-skin time, and 193 minutes of post-op hospital time after the day of surgery—a whopping 7 hours and 22 minutes. These official CPT times are based on suspect and unsound data that has been sequestered by the AMA. The AMA's Resource-based Relative Value Update Committee (the RUC) is the invisible force that has sustained this system. CMS, the government agency with ultimate responsibility for monitoring the rules of physician compensation, has been complicit.

We generalists are at a profound disadvantage. Most if not all of our specialty colleagues have learned or chosen to reduce the time spent in all the separate activities bundled with each CPT service code. We have chosen (or been chosen) to struggle with the formulary prior approvals, phone messages, organizing and reviewing multiple sets of data, managing consultation notes, and more. As a consequence, our service times have grown.

We are plagued by the biases built into the current RBRVS system. We are forever confined by absolutely absurd bundling assumptions for our E/M service codes.

We need a compensation formula the reflects the current reality: There is more work associated with each visit (the tests and consults that come from our medically necessary efforts to closely manage many concurrent active problems), and there is more work associated with the management of each patient over time (the availability to answer non-visit-related care needs, manage formularies, ensure that the patient's electronic record is accurate, and more).

As generalists, we are compelled to act. We must demand a more equitable system of MD compensation. First, the value of the current CPT E/M codes used in outpatient primary care practice by primary care doctors needs to increase by around 50% to cover the increased post-visit "bundled" responsibilities of generalists. Second, a care management fee needs to be created in order to cover not only the professional work required to maintain useful and reliable medical information, manage medications, and provide emergency care but also to pay for the office infrastructure including personnel and hardware.

For general internal medicine to survive, we must have income parity with our specialty colleagues. Roughly 75% of total compensation should be based on face-to-face care and 25% on care management. Both are necessary due to the episodic care needs that emerge from each encounter and care management needs that are implied by each patient in our "village," regardless of how often they require face-to-face care.

Political forces to reform health care will be building over the months ahead. We within SGIM must consistently and strongly support a hybrid model for Medicare reimbursement that includes an enhanced RBRVS payment and a new and substantial care management payment adjusted according to clinically relevant patient characteristics.