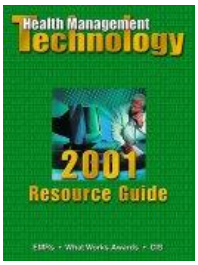

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Leaving Money on the Table?

How comprehensive coding can raise practice revenues by $40,000 per physician per year.

By David Winn, M.D., founder, President and CEO of e-MDs, Cedar Park, TX.

The value of the non-tangible benefits of an electronic medical record (EMR) is clear. But until real financial gain (or a neutral monetary impact but improved documentation and adherence to best practices) is proven, the decision to purchase an EMR as a component of practice management may never get off the drawing board. This is particularly true for smaller, independent clinics. With this in mind, we ran the numbers on a small practice that has been using an EMR for the past two years, looking for the return on investment.

The focus of the study was the recognized problems of under-coding and lost charges. In general, physicians often down-code the Evaluation and Management (E&M) levels assigned to office visits. This is variably attributed to the inability to apply detailed Health Care Financing Administration (HCFA) E&M regulations in a practical manner, inadequate time and resources required to produce full documentation, and fear of an audit.

The doctor who routinely down-codes by one E&M level forfeits $40,000 to $50,000 annually. Another contributor to lost revenue is poor charge capture for supplies used during procedures. This is particularly a problem in smaller offices, which either lack the tools that prompt staff to include particular codes such as charge sets, or do not utilize these tools because of time pressures and lack of integration with the core workflow.

Striving for Accuracy

Northwest Diagnostic, a family practice clinic in Cedar Park, TX, employed the full-time equivalent of 3.5 providers during the course of the study. *[Ed: Northwest Diagnostic is an independent practice that retains a professional affiliation with e-MDs.]* This paperless clinic is automated via the topsSuite software package from e-MDs. topsSuite integrates applications for clinical charting, patient billing and scheduling. To maximize the efficiency of the EMR, Northwest Diagnostic has installed a computer in each exam room so that progress notes can be created at the point of care. In the majority of cases, charting is completed before the patient checks out.

The EMR application, topsChart, facilitates rapid, extensive note documentation using best-practices templates and has built-in E&M coding support. The providers, a mix of physicians and physician assistants, tend to code higher E&M levels than average because of the ease in which detailed notes are created. They do this without fear of an audit, confident that their notes will stand up to HCFA scrutiny.

The doctors point out that they are merely recording everything that happens during the visit—a difficult feat to accomplish if dictating or writing in a paper chart. The speed at which a visit can be recorded in the EMR allows the providers more time to obtain a detailed history and perform an extended examination. The doctors at Northwest Diagnostic contend that the clinic's reimbursement is augmented by the EMR, because complete visit documentation leads to higher than average E&M coding.

In addition to more accurate E&M levels, the clinic benefits from built-in charge capture prompts. In the orders section of topsChart, HCPCS supply codes are linked to corresponding CPT procedure codes. When a physician orders a test, related HCFA common procedure coding system (HCPCS) codes are automatically displayed and the provider checks off those supplies that were used. The billing codes then transfer directly from topsChart to the patient's invoice in topsBill. topsBill includes several prompts for frequently forgotten CPT codes, such as those for venipuncture and for specimen handling of labs that are sent out.

Better E&M Coding

We first obtained statewide E&M coding patterns from Texas Blue Shield. [See **Figure 1**.] According to these figures, doctors code 4 percent of outpatient clinical encounters as level 1 E&M (i.e. CPT codes 99201 and 99211), 24 percent as level 2 (CPT codes 99202 and 99212), 54 percent as level 3 (CPT codes 99203 and 99213), 15 percent as level 4 (CPT codes 99204 and 99214), and 3 percent as level 5 (CPT codes 99205 and 99215).

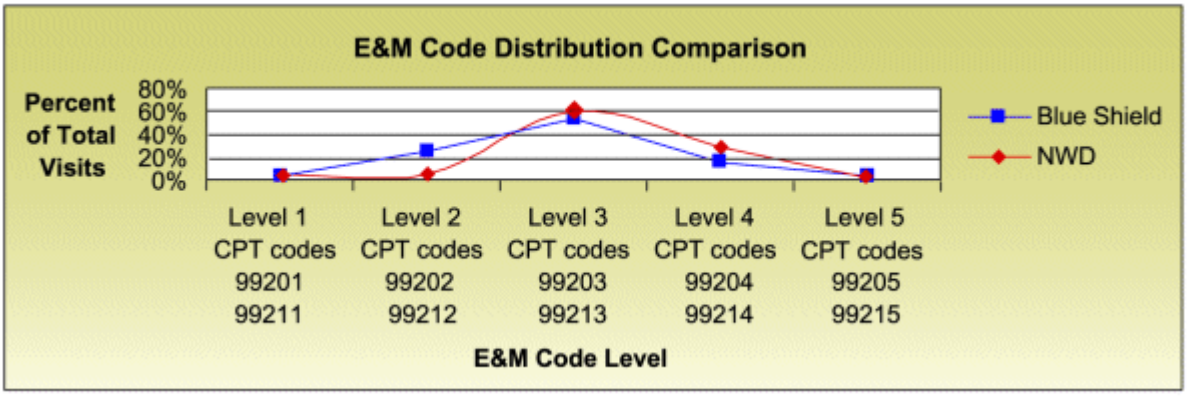
Figure 1. Average Statewide E&M Code Distribution per Texas Blue Shield

Texas Blue Shield: Average E&M Code Distribution Report										
CPT Codes	**99201**	**99202**	**99203**	**99204**	**99205**	**99211**	**99212**	**99213**	**99214**	**99215**
Total Number of Visits	4,258	15,600	21,403	10,269	4,981	44,149	268,369	610,926	161,792	32,442
Percent of Total Visits	0.36	1.33	1.82	0.87	0.42	3.76	22.86	52.03	13.78	2.76

Next, all patient visits to Northwest Diagnostic between May 1, 2000, and Aug. 31, 2000, were tallied and the total was broken down by E&M level. (Note: Financial analyses required for this study were generated by existing reporting functionality in the topsBill application.)

Northwest Diagnostic was found to differ significantly from the average E&M distribution published by Texas Blue Shield, with a bell-shaped E&M distribution curve that is shifted to the right. [See **Figure 2.**]

Figure 2.



In particular, at Northwest Diagnostic, E&M level 2 represents only 6 percent of all clinic visits, a mere one-fourth the 24 percent state average. Also noteworthy is that E&M level 4 represents 28 percent of all visits to Northwest Diagnostic, almost twice the 15 percent state average. [See **Figure 3**.]

Figure 3. Distribution of E&M Code Levels as a Percentage of Total Visits: Comparison of Northwest Diagnostic (NWD) and Texas Blue Shield

E&M Code Level	NWD	Blue Shield
Level 1 (CPT codes 99201, 99211)	5%	4%
Level 2 (CPT codes 99202, 99212)	6%	24%
Level 3 (CPT codes 99203, 99213)	60%	54%
Level 4 (CPT codes 99204, 99214)	28%	15%
Level 5 (CPT codes 99205, 99215)	1%	3%

So, the doctors are correct in their assumption that the clinic's E&M distribution is skewed toward the higher level codes. The next step in the study was to record the actual reimbursement received for those E&M CPT codes (billed between May 1, 2000, and Aug. 31, 2000, and collected through Nov. 9, 2000). This would validate payor acceptance of the E&M levels billed.

We then calculated what the expected reimbursement would have been had the clinic's E&M distribution matched the state average, and compared this to actual receipts. Northwest Diagnostic's actual reimbursement was 19 percent higher than what would be expected based on average E&M distributions. Dividing this "excess" revenue by the total number of visits realizes a $9.01 per visit increase in E&M reimbursement. When annualized, this revenue amounts to nearly $120,000.

Based on 3.5 FTEs, this increased revenue equates to $34,286 per physician per annum. It is worth noting that this figure is expected to rise at Northwest Diagnostic for two reasons. First, the study was conducted during summer months, a period traditionally associated with a lower patient volume for family practice. Second, the practice had just relocated to a new facility, which opened May 1, 2000. As with most new practices, this one did not have the patient base to support a full schedule for the first few months.

In the three-month period since the study was conducted, the monthly patient volume increased by 25 percent, a new provider was added and the volume for the existing full-time providers rose by an average of 5.5 percent (with the heavy-volume winter period still to come). Thus, the total annual increase in revenue could realistically be expected to rise to more than $40,000 per provider.

Better Charge Capture

Charge capture in topsSuite is maximized via built-in prompts. We compiled a list of HCPCS codes from all invoices in the same study period. These charges were for supplies such as minor surgical trays, gauze, syringes, sterile gloves, oxygen tubing, orthopedic supplies and injectable drugs. In addition to these HCPCS charges, we also tallied the use of codes for venipuncture (CPT 36415) and specimen handling (CPT 99000).

Next, we totaled the actual reimbursement for these codes, which, when annualized, amounts to $118,768. This averages to $7.41 per visit. Without built-in prompts, these are the types of items that are frequently overlooked and unbilled, leaving money on the table.

Conclusion

Improved coding accuracy based on accurate documentation of patient encounters is one way in which a fully implemented, integrated EMR improves the practice's bottom line. As demonstrated, a real return on investment can be realized, even by smaller clinics. The doctors at Northwest Diagnostic directly attribute the augmented income to the coding documentation afforded by the EMR and to the charge capture prompts. At their clinic, these two items alone increase revenue by nearly a quarter of a million dollars, enough capital to purchase EMR software and hardware and realize a true return on investment in the first year of ownership.

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