LETTERS TO THE EDITOR

IN-ROOM DICTATION AND BROOK TROUT: A SATISFYING RECIPE

To the Editor:

I read with interest the article "Patient Satisfaction with Time Spent with Their Physician" *(Gross MS, Zyzanski SJ, Borawski EA, Cebul RD, Stange KS. J Fam Pract 1998; 47:133-7)* in which the authors conclude that patient satisfaction is enhanced by longer visits and by time spent chatting with the doctor. Beginning in residency, I experimented with ways to increase time in the room with patients, as well as ways to work with them on a more personal basis. Indeed, my experiences mirror the conclusions of the authors: Patients want to be treated as *people*, as part of the team, and they want to spend enough time with their doctors to feel that their concerns have been addressed.

To spend more time with my patients without extending the business day, I have adopted several practices. First, I dictate my notes in the examination room before the patient leaves. This serves several purposes: the patient hears a reiteration of my assessment and plan and knows what I'm saying about her; it allows the opportunity to correct any erroneous dictation; and the extra time I would have spent in another room is instead spent with the patient. In addition, by the time I leave the room, I am done with my dictation and do not need to stay late trying to remember the nuances of each patient encounter. If the visit notes are written rather than dictated, I review out loud the essence of what I am writing as I am writing it. I have yet to find any note that cannot be worded so that it is appropriate to dictate in the patient's presence. It is, after all, the patient's record and he or she has the right to read it at any time.

Another practice I have adopted is to complete forms that relate to the patient's care *with* the patient during the visit (but after their concerns have been fully addressed). This allows the patient to see that the form has been completed, and it encourages an appreciation for the amount of office work involved with a busy family practice. It also allows for increased accuracy and more time in the room with the patient.

Finally, I agree that a certain amount of peripheral chat is desirable. Toward that end, I do not walk into the examination room with the chart open, asking about the problem that incited the visit. Rather, the chart remains closed, an outstretched hand is offered, and a sincere welcome with direct eye contact is sent forth. An open-ended "What's going on?" gives the patient the freedom to immediately address their medical concerns or to comment on the recent lack of good-sized regional brook trout. Patients are more likely to be satisfied with their visit when they see that we are real people who care for them as fellow persons and respect them enough to give them the one commodity that cannot be purchased or replaced: time.

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The *Journal* welcomes letters to the editor. If found suitable, they will be published as space allows. Letters should be typed double spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with our style. All letters that reference a recently published *Journal* article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication. Send letters to Paul A. Nutting, MD, MSPH, Editor, The Journal of Family Practice, 1650 Pierce St, Denver, CO 80214. Telephone (303) 202-1543; Fax (303) 202-5136. E-mail: paul.nutting@aspn.amc.org

BILLING CODE ACCURACY

To the Editor:

The study by Chao at al[1] in the July issue was a very timely and informative study, filling a void in the literature on this matter. The information about physician billing that has previously been presented is either outdated or is derived from the databases of large organizations.[2-6] One recent citation on family physician billing stated that data from the AAFP suggests that family physicians generally undercoded for their services.[5] In contrast, data citing HCFA as the source states that physicians overcode for their services.[6]

The findings by Chao and coworkers showed that 45% of the coding by family physicians is done incorrectly and that the errors are equally divided between over- and undercoding.[1] Given this high error rate, I disagree with the conclusion that physician's are "generally accurate" in their coding. On inspection, the data suggests that physicians have little knowledge of the actual guidelines, and may be guessing a large part of the time when determining the CPT E&M code. The vast majority of office visits for established patients would be expected to be coded 99212, 99213, or 99214. If only 55% are correct, and approximately half of the incorrect codes are overcoded and half are undercoded, then it would appear that there is a great deal of guesswork and little working knowledge of the guidelines for deciding the CPT code for any particular visit.

I do agree with the authors that correct coding is critical for maximizing revenues and for avoiding the financial and legal ramifications that could result from incorrect coding. We conducted a small pilot study to look at physician coding patterns comparing the CPT E&M codes (for both new and established patients) with the progress note–documented level of service. We found that this

group of family physicians coded incorrectly 62% of the time, with 82% of those errors being undercoding. We hope that defining the nature of the problem of incorrect coding can help physicians improve their coding accuracy.

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REFERENCES

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4. Lawler FH, Purvis JR, Paris JA, Horner RD. The effect of faculty private practice experience on appropriate charging for professional services. Fam Med 1990; 22:487-9.
5. Sgammato J. HCFA answers questions about its new documentation guidelines. Fam Pract Manage 1995; 2:60-7.
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Dr King's letter was referred to Dr Chao and colleagues, who reply as follows:

The distribution of CPT E&M coding by family physicians in the Direct Observation of Primary Care Study for established patients was: 99211: 0.4%; 99212: 21.5%; 99213: 61.9%; 99214: 15.0%; 99215: 1.1%. The distribution of coding by study nurses directly observing these same office visits was 0.3%; 26.1%; 57.2%; 15.5%; 0.9%, respectively. We examined the concordance of billed CPT codes with those assigned by medical record review in a paper that is in submission. With the continuing emphasis on costs of medical care, there is a general perception that physicians primarily overcode. We did not find that to be true in our study.

Dr. King is correct in his expectation of the distribution of E&M coding. But he disagrees with our interpretation that physician coding is generally accurate. The distinction between CPT E&M visit levels is artificial, and better suited for narrow specialist office visits than primary care visits that often involve multiple complaints. Although we were able to standardize the coding performed by the nurses in our study, there is room for honest disagreement in many cases.

It is important to note that we found the vast majority (96%) of all differences between nurse-assigned codes and those actually billed to be no greater than 1 point on a 7-point rating scale, with differences ranging from -3 to +3 (where 0 = perfect agreement). The relatively small differences represented by these statistics and the approximately equal distribution of over-and undercoding favors an interpretation of random error rather than systematic bias. This led us to conclude that physician billing in this study was generally accurate.

Because physician documentation is notorious for omissions, it is somewhat surprising that Dr King found significant undercoding when comparing the chart with the actual billing code in his pilot study. In our study, the biggest source of actual error was not using preventive medicine codes. Although we did not specifically audit for preventive services, they translate to higher work value units, and not using the proper codes is a significant source of primary care undercoding. We agree that there is a need for further research on the reasons for incorrect physician coding.

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EDITOR'S NOTE

Retirement of Patricia Delano, Managing Editor of the *Journal*

This fall Pat Delano retired after 14 years with *The Journal of Family Practice*. Pat began her career with the *Journal* in 1984 as a copy editor and assumed the responsibilities of managing editor in 1988. During this time, she has worked with all 3 of the *Journal*'s medical editors (founding editor Dr John Geyman, Dr Paul Fischer, and I) and 3 separate publishers. She is well known by the many individuals who have served as associate and feature editors, editorial board members, authors, and reviewers.

I had the pleasure of working with Pat from the early 1990s when I joined the editorial board of the *Journal*. When I became medical editor several years ago, Pat applied her tactful and gentle approach to help me understand that the responsibilities of the editor include a great deal more than knowing how to write and review a journal article. Throughout our association her humor and capability marked all of our dealings.

Pat Delano's dedication to the *Journal* and attention to detail has resulted in a publication that meets the highest standards of quality and journalistic style. I am confident that I speak for the many family physicians who have been associated with *JFP* over the years in expressing our gratitude to Pat for many years of dedicated service to our journal.

Paul A. Nutting, MD

Correction

In the editorial on the development of an evidence-based approach to practice in family medicine (*Nutting PA. Advancing information mastery in family practice. J Fam Pract 1998; 47:182-4*), the concept of clinical jazz should have been attributed to Lorne Becker, MD.