The Millennium Primary Care Reimbursement Plan: A Proposal for Debate

Robert L. Bratton, MD

Despite a trend away from primary to specialized care, family physicians still fill an important need in providing comprehensive health care to the US population. However, due to complexity of coding and billing procedures, required documentation, and inadequate reimbursement, family physicians have less and less time to spend with patients. To stimulate debate on means of alleviating this problem, I propose a fundamental change in coding and billing procedures, called the Millennium Primary Care Reimbursement Plan. Under this plan, billing would be based on 15-minute increments reimbursed at a standard rate. Time spent on phone calls, e-mails, insurance forms, and documentation would be included. The intent of the plan is to provide increased reimbursement so that family physicians can devote time to patient problems and education, to renew interest in family practice as a profession, and to improve job satisfaction among family physicians, with the ultimate goal of improving patient outcomes and satisfaction.

The Problem

In recent years, there appears to have been movement away from primary care to specialized health care. This trend reflects, at least in part, technological advances and increased knowledge in specialized areas. At the same time, however, there is an increasing need for primary care services, since most individuals in the United States want a “medical home” in which a majority of their health care needs are addressed.1

Although as family physicians we pride ourselves on providing comprehensive care, we have less and less time available to spend with each of our patients. One time-consuming aspect of medical practice is the laborious and ineffective system of coding and billing. Physicians are confused and worried about overbilling at times and underbilling at other times. Further, without much warning, the coding system continually changes. Adding to the problem are concerns about malpractice lawsuits and insurance company requirements, both of which have necessitated increased documentation, which serves to further heighten the problems experienced by clinicians in practice.

Patients’ cases have also become more complicated, since we have many more treatment options than previously available. While a specialist may often spend up to an hour addressing a problem involving only one organ system, a family physician typically must address multiple chronic diseases in multiple organ systems, as well as health maintenance, in a 15-minute office visit. The reimbursement rate for such activities may be so low that it is not financially feasible for the family physician to manage the patient’s problems. As a result—although family physicians may have the knowledge, training, and skills to manage a problem effectively—they often refer the patient to a series of specialists simply because it is not cost-effective to deal with the patient’s problems.

Despite family physicians addressing multiple medical problems, making difficult clinical management decisions, and providing time-consuming patient education, we have not achieved the same level of financial reimbursement as our specialist counterparts. As a result, a “paradox of primary care” has evolved. We have stepped onto a merry-go-round and cannot get off. We try to see more and more patients in less and less time to maintain our current level of income. Morrison and Smith2 have called our predicament “hamster health care.” Much like hamsters on a treadmill, we must run faster just to stand still.

I believe we provide more comprehensive care and counseling than can be given by our specialist counterparts—in many situations, the same level of care as a specialist but at a fraction of the cost. We deserve fair reimbursement. We should not

1 From the Department of Family Medicine, Mayo Clinic, Jacksonville, Fla.
seek inflated salaries, but we should seek equitable reimbursement for our valuable services.

Proposed Solution

To alleviate this rapidly growing problem, I propose the following plan, which I call the Millennium Primary Care Reimbursement Plan, as an individual attempt to offer an alternative to the current billing and coding reimbursement plan for family physicians. The plan is not endorsed by any group or governing body. I am no expert on this subject, and I am not sure whether my proposal represents the best possible proposal. I offer it only for debate. It may not solve all problems, but unless innovative proposals are brought forward, we must continue to accept our current situation without recourse. I believe such a plan would simplify and improve our current system. Although details need to be addressed, it is imperative that the plan remain as simple as possible to ensure its viability.

I want to emphasize that the purpose of this plan is not to limit the income of family physicians but, rather, to provide them with a larger income. Those who perform more efficiently can make more than the base income, as in our current reimbursement system.

The immediate goal of the proposed plan is to allow more face-to-face care of patients, with a comprehensive focus that reimburses primary care physicians fairly for their multiple tasks and simplifies the billing process. The ultimate goal is to improve health care.

The Millennium Primary Care Reimbursement Plan

Principles

The main principle of the Millennium Primary Care Reimbursement Plan is a change in our current schedule of billing to a time-based method that separates care into time blocks. I have arbitrarily selected 15-minute increments. A standard (universal) reimbursement rate is given to these time intervals, with no discounts. All payers, including private insurance, managed care, self-pay, and government reimbursement (Medicaid and Medicare), would be required to pay this rate, and all family physicians would accept it.

In this plan, billing is based on the time spent to interview, examine, and document the patient’s visit, in 15-minute intervals, regardless of whether the entire interval is used. The basic characteristics of the plan are listed in Table 1.

Details

It is important to remember that if the visit takes less than the total 15-minute interval, the patient is still billed for the entire 15-minute block of time. The physician may see another patient and bill for those additional visits. For example, a patient presenting with simple pharyngitis would be billed for a 15-minute visit, even if the time needed to examine the patient and document the case takes only 9 minutes. The physician may then use the remaining 6 minutes to recheck a resolving otitis media or check a wound that takes only 6 minutes to see and document. The physician may bill an additional 15-minute interval for this visit as well. Likewise, if a patient requires a 16-minute time block for the interview, examination, and documentation (including billing), two 15-minute intervals are billed to the patient.

When a patient presents with depressed feelings but no other diagnosis, the physician can receive appropriate reimbursement for the time needed for counseling. This concept would ensure a base income that is in line with that of our specialist counterparts, while at the same time allowing for added income for additional visits—much like our current system.

Many may argue that the Millennium plan is an invitation for abuse. I acknowledge this risk but would argue that any plan can be abused by those who wish to do so. I believe family physicians as a whole are honest, and they would prefer a simpler billing process that improves reimbursement. As with any plan, outliers will likely be identified and reviewed. A self-review process could be maintained that helps individual physicians know if they are billing above or below the norm, using peer-generated data that is collected and distributed by national organizations such as the American Academy of Family Physicians.

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Table 1

Basic Characteristics of the Millennium Plan

- Patients are billed on the amount of time necessary to manage their care. Each visit is billed for the greatest number of 15-minute intervals used.
- Because documentation is an increasingly important aspect of patient management, it is included in the time billed.
- Time spent on phone calls, e-mails, insurance forms, or additional documentation is also billed at $10 per task.
- Procedures are billed as separate entities.
- Obstetrical visits are billed as regular office visits, but deliveries are billed as procedures.
- A 10% to 15% copayment may be collected from patients to discourage overuse.
Models of Reimbursement

Time increments are calculated in 15-minute blocks of time. A typical workday is defined as 7.5 hours of direct patient-to-physician interaction and based on a 5-day work week. The yearly income is calculated on the basis of 44 weeks of work, with an 8-week period of vacation or continuing education time. With these assumptions, gross income would vary from $330,000 per year if the 15-minute increments were reimbursed at $50 each, to $495,000 if increments were reimbursed at $75 each. Subtracted from this gross income would be overhead, typically 50%–70% in most primary care practices to cover office expenses. Malpractice insurance and taxes would also be subtracted from this total gross income.

Advantages Over the Present System

Currently, family physicians are able to charge for the level of complexity of a case, but this requires time for documentation, for which we are unable to charge. Thus, many family physicians “down code or fail to code for multiple diagnoses and complex care. Therefore, they are not compensated appropriately, despite the increasing complexity of diagnosis and treatment. By greatly simplifying the existing coding system, the new plan would reduce the time required for billing, allowing suitable compensation while ultimately saving reimbursement dollars.

Time for Other Tasks

Because we now refer many of our in-office procedures to specialists, there needs to be a premium put on the other things we do, especially the time we spend with our patients in managing multiple health problems. Most family physicians agree that much of our time spent with patients involves counseling in one form or another. Although billing codes currently exist for counseling, the proposed plan would provide more appropriate reimbursement and would, therefore, increase the time spent in addressing patients’ concerns.

By allowing patients more time with primary care physicians to address problems in an unhurried environment in which prevention and education are the focus, the plan would enable better doctor-patient relationships and would increase the quality of care. The plan would also improve the convenience of health care by encouraging family physicians to provide comprehensive care that covers the broad range of medical problems and avoids duplicated and unnecessary testing by specialty consultants. This should translate to lower overall health care costs to consumers by reducing fragmented and expensive specialist care. Patients can benefit from “one-stop shopping,” in that a majority of their care is provided by a primary care physician.

Time for Other Tasks

An important component of the Millennium Primary Care Reimbursement Plan is universal (and expected) reimbursement for phone calls, filling out forms, presentation requests, e-mails, and other tasks that are necessary for provision of primary care. Increasingly, patients are demanding e-mail access to their physician, responses to phone calls, and various other tasks that we have provided free of charge in the past. I propose a nominal $10 charge for each of those tasks. As an example in this plan, if a family physician completes forms for one patient, answers another patient’s e-mail, and calls another patient, the physician may bill three separate charges for a total of $30. Additionally, the field of telemedicine remains a new frontier that could represent a model of primary care outside the office into the patient’s own home. Adequate reimbursement is an absolute requirement for this innovative approach to succeed.

Conclusions

One of the most important effects expected of the proposed plan is an improvement in physician and patient satisfaction. There appears to be growing dissatisfaction among our physicians concerning the current medical environment. Paperwork has replaced face-to-face patient interactions. Many patients feel threatened by managed care and skyrocketing health care costs fueled by specialist care and technology. This plan should help patients reestablish their relationship with their family physician and enable them to rely on their physician for the majority of their medical care. Further, the improved income and better work environment for family physicians afforded by the plan should encourage more students to choose family practice as a career.

Correspondence: Address correspondence to Dr Bratton, Department of Family Medicine, Mayo Clinic, 4500 San Pablo Road, Jacksonville, FL 32224; bratton.rob@mayo.edu.

References