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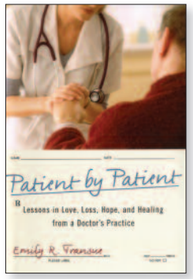


AVOIDING THE SHOALS OF CONTRACTS AND CODES

By Emily R. Transue, M.D.

When a Dartmouth Medical School graduate finishes her training and enters practice, she learns that the patient-care part of medicine, which she loves, is subsumed in a sea of insurance contracts and billing codes. In this excerpt from a book about her experiences, she tells of navigating a whole new aspect of medicine.

As I pressed the new parking sticker carefully onto my windshield, I paused to consider what the small sliver of plastic represented. At the age of 29, after 24 continuous years of education, I was about to begin what could be called my first real job. My new business card burned in my pocket: "Emily R. Transue, M.D., General Internal Medicine." I was starting practice as a primary-care physician.

With a laugh, I thought back to the day I'd decided to go to medical school. It was early in my senior year of college; a biology major, I was scrambling for a new career path after realizing I didn't want to spend my life at a lab bench. I'd done Parkinson's research with primates and reasoned that if monkeys were interesting, people must be even more so.

I called my grandparents to announce my momentous decision. "But we hate doctors," my grandmother protested. Through all my years of medical training, whenever a physician amputated the wrong leg, administered the wrong medication, or made some other terrible mistake, my grandmother would send me a news clipping. I was never sure if these were warnings about what might occur if I applied myself inadequately, or simply further evidence that physicians were an untrustworthy lot.

During my second year at Dartmouth Medical School, my grandmother called to tell me my grandfather had developed atrial fibrillation, an irregular heart rhythm. It's usually treated with blood thinners, to reduce the risk of clotting, and with cardioversion, a brief electrical shock to restore the heart's rhythm. "They're giving your grandfather rat poison," my grandmother declared. Rat poison is made from warfarin, the same compound used medicinally to thin blood. "Then they're going to electrocute him," she added. I had to admit that these were precisely the kinds of barbaric things people in my chosen profession did.

Still, here I was. Absurdly, the parking sticker brought home what my employment contract, application for hospital privileges, and order for business cards had not. During the eight years since I'd started medical school, everything I had done had been temporary. Student clerkships lasted four to eight weeks, residency rotations a month. My year as chief resident, helping run the program I'd finished the year before, was the longest I had spent in any single role; and even that was clearly defined as transient, for my successor had been chosen before I started. In all that time, I had hung temporary parking placards from my rearview mirror. The sticky teal rectangle I was now putting on my windshield seemed to symbolize an end to transience. After eight years of working toward this point, I was entering an unfamiliar permanence.

A few weeks earlier, the ink barely dry on my employment contract, I had signed another sheaf of papers, buying my first house. My possessions were still in boxes, the wonder of owning a piece of land

Transue, an internist in Seattle, Wash., is a 1996 graduate of Dartmouth Medical School. She began writing patient narratives while she was a student at DMS as a way to process the emotions of medicine. Many of her stories have appeared in Dartmouth Medicine *during the years since then. She is also the author of two books published by St. Martin's Press*—On Call: A Doctor's Days and Nights in Residency *and* Patient by Patient: Lessons in Love, Loss, Hope, and Healing from a Doctor's Practice. *This feature is excerpted from the latter book by permission of St. Martin's Press, LLC; it is copyright 2008 by the author.*

I could only begin to glimpse all that lay in my future, as the sliding doors of the clinic opened to admit me to the cool, quiet air inside. My heart sped with a mix of anxiety and excitement.

and the home that sat on it still fresh. As I finished affixing the parking sticker and walked into the angular brick and glass building housing the clinic I'd joined, I was bursting with the richness and strangeness of my new life. I had a job, a piano, two cats, a house. I was a long way from Ohio, where I grew up, and from New Hampshire, where I went to medical school. I was a long way from my family, who were spread from California to Massachusetts. My grandparents, the ones who hated doctors, were in Pennsylvania.

Nonetheless, I had put down roots in Seattle. I could feel them under the maple tree in my new front yard, even in the glue of the parking sticker. I was about to walk into the clinic and begin to grow roots of another sort—putting on my white coat and meeting strangers who would become my patients, as I grew into my role as their doctor.

I had finished the hard years of residency, the 100-hour weeks and 36-hour shifts, the drama of the hospital and the emergency room. I had seen a lot of people die or nearly die during those years, and I thought I knew plenty about grief and loss and healing. I little imagined how much more I would learn in the coming years. Much of my newfound knowledge would come from patients I would care for, not just in the episodic crises of the hospital but in the slower, richer arc of sickness and health that a primary-care doctor sees.

I could only begin to glimpse all this in my future, as the sliding doors opened to admit me to the cool, quiet air of the clinic. My heart sped with a mix of anxiety and excitement as I stepped inside, savoring the newness and looking forward to a time when I could savor familiarity instead.

The first patient I saw that first morning was a young woman with sciatic back pain. "I bent over to pick up a pile of books," she said, "and there was this sudden, terrible pain in my back. It shoots down my leg all the way to my foot." She was uncomfortable but not in crisis. It was a simple problem; a medical student would have known what to do. I gave her medication to reduce the inflammation and calm the pain. I told her what activities she should and shouldn't do, when to expect the pain to get better, when to call me if it didn't.

The interaction went just fine, but I don't know that I had ever been as nervous managing a heart attack or a massive stroke as I was with that young woman's sore back. I schooled my voice carefully to keep it from trembling. I double-checked the details of the prescriptions I wrote, which looked oddly unfamiliar on the fresh pad printed with my name. A question kept popping into my mind: What if what I'm telling her isn't right? I had to keep reminding myself that I did know how to do this. I'd had similar conversations many times during my training. But afterward I'd always gone to present my findings to my supervisor, getting either further advice or a stamp of approval. From here on, though I could and often would ask for advice from my colleagues, there would be nobody above me. I was on my own. With that first patient, I found that fact terrifying.

My second patient had a urinary tract infection and was a little easier. The third one was in for a physical exam, and soon I was so caught up in learning about her history and her concerns that it didn't occur to me to be nervous. By the end of the day, the fact that I didn't have to run things by anyone didn't seem strange. By the end of the first week, I had stopped even thinking about it.

My clinic is a large, doctor-owned group that includes almost all the medical specialties. I chose it partly for this fact, so I'd have colleagues to talk to, to ask questions of, to learn from. I had completed four years of residency training on top of four years of medical school. I had passed the specialty boards in internal medicine. ("It's like being a pediatrician for adults," I explained to friends who didn't know what an internist was. "No kids, no OB, no surgery, but pretty much everything else.") I had the tools I needed, but there was a lot of practical, day-to-day knowledge I had yet to learn. They call it "practice" for a reason, I reminded myself.

The clinic building has several wings built at different times. Medical buildings, ever-expanding according to need, have always reminded me of swallows' nests—the structures of one era tacked onto those of the age before. My office was on the second floor in an older part of the building, its window looking out onto a quiet street and the steeple of a nearby church. I had my own medical assistant and would soon hire a receptionist (whose title would change later to "patient service representative," as staff roles shifted and evolved like the building, like medicine itself).

I had two examination rooms—small and neat but a little dark. After years of rotating through exam rooms in the resident clinic, I realized to my great delight that these were mine to set up and outfit as I chose. I replaced the ugly industrial mirror in each room with a pretty, modern one, and I added a floor lamp. Suddenly the spaces seemed brighter and the note of dinginess was gone. I began to fill the walls with photographs, the plain yellow paint giving way to scenes of mountains and wildflowers. I put fuzzy covers on the cold metal stirrups of my exam tables. After a few weeks, I realized that the rooms no longer felt like exam rooms; they felt like *my* exam rooms. It was a subtle difference but a transforming one. My new life was beginning to take shape.

A saving grace as I struggled to learn one new thing after another was that I had several friends from residency going through the same process. Periodically we would gather to debrief about the strangeness of this new world.

"I saw this guy in coverage today that I wanted to steal from his regular doctor," one friend said.

"Steal?"

"To have him come to me for primary care. You know? He was just such a nice guy—we had a great chat. If all your patients were that nice, it'd be the perfect job."

I laughed. "I've had people like that. I smile every time I see them on my schedule." I thought of a sweet 70-year-old I had seen that day for recurrent nosebleeds. She was anxious to have them stop before she went to Europe with her son. We'd talked about my trips to Europe with my mother, about Italy, about grown children traveling with their mothers. As she was leaving, she'd smiled and said shyly, "You're nice . . ." In that moment, all the years it had taken to get there felt worth it.

"It's so weird having such an open schedule," my friend went on. "We didn't have this much time for new patients when we were residents."

"I know," I agreed. "It's neat—you feel like you really have time to talk."

"Sure. But I find myself doing these ridiculous things, just because I have time. I feel like I need to do all the health care that people haven't had in five years. Someone comes in for sinusitis, and I have an empty schedule so suddenly I'm reviewing their whole family history and giving them a tetanus shot and trying to check their prostate. They're like, 'I just wanted antibiotics!'"

I nodded. "I did a Pap smear yesterday on someone who came in with an earache."

He giggled. "Poor people . . ."

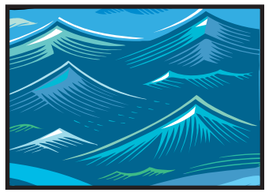
"It's kind of like an assault."

"Leave me alone!" I imagined such a patient saying. "I felt bad enough when I came in here!"

Meantime, I was learning a new kind of medicine. Residency had trained me brilliantly to think of things to worry about; I was not so adept at deciding which of those I needed to take seriously. Much of my training had been in the hospital, where we were dealing with urgent issues and often doing lots of tests at once, in hopes of identifying the problem as soon as possible. The rhythm of clinic medicine was different; few problems were emergencies, and it was usually better to approach the evaluation one step at a time. Furthermore, in contrast to the hospital, where almost everyone had something seriously wrong, in the clinic half of my job involved figuring out who was *not* sick. And a good part of the remaining half involved reassuring the people who were really sick that their bodies just needed time to heal on their own.

Though the approach was different, the learning curve was as steep as it had been in residency—those packed years of specialty training after medical school. A lot of the time I felt the way I had then: excited, exhausted, and thrilled to finally be doing something I'd been learning about for so long. I wasn't yet efficient at clinic medicine, so the difference between a too-quiet schedule and a too-busy schedule was only a few patients. I could turn on a dime from feeling restless to feeling overwhelmed. My practice grew quickly, though, as did my skills. I was startled to realize one afternoon that I'd comfortably seen more patients in half a day than I'd seen in my entire first week at the clinic.

Some weeks after my first day, a young woman who looked vaguely familiar came in to have a physical exam. She smiled brightly and told me that her back pain had gone away just when I had said it would. Glancing down at her chart, I realized that she had been my very first patient on my very first day. It seemed much longer ago in my mind than on the calendar; I couldn't imagine having been quite so nervous over a simple problem just a month or two earlier. She looked around the room and admired a photograph of a rose from my front yard.



In contrast to the hospital, where almost everyone had something seriously wrong, in the clinic half the challenge was figuring out who was *not* sick. And a good part of the remaining half involved reassuring people who were really sick that their bodies just needed time to heal on their own.

I had a long and baffling meeting with the people from the Coding and Compliance department. They had the unenviable task of teaching me in a few hours how to bill for the work I do.

"Looks like you've settled in," she said.

"I have," I replied, realizing how true that was.

Seeing patients was easy to get used to, but the financial and administrative side of medicine was considerably more challenging. During my first week, I had a long and baffling meeting with the people from a department I had never previously heard of: Coding and Compliance. The coding and compliance staff had the unenviable task of teaching me in a few hours how to bill for the work I do. This had barely been addressed during my four years of postgraduate specialty training, much less in medical school. I'd had eight years of medical education, and nobody had acknowledged that this was a business as well as a calling.

The medical billing process is based on codes that are marked down for each visit. There's one type of code for the visit itself, which depends on the appointment's length and complexity. There are also codes for procedures—everything from heart surgery to a flu shot has a distinct code. Each of these is then linked to a separate diagnosis code—what the visit or procedure was for. This seemed simple enough. But when the coding and compliance specialists—Karen and Linda—started explaining the details, nothing they said made sense. I recalled a time when I'd tried to speak French with someone who was Belgian; the words sounded right, but no actual communication occurred. I wondered if, as on that earlier occasion, it would be better to use hand gestures.

Karen began. "You've got your basics, your E and Ms, and your preventatives." I took a breath to ask what these terms meant, but she had already moved on. I vaguely remembered having heard "E and M" somewhere before. Random paired letters flashed through my mind: A&P grocery stores, A&W root beer, B&O railroad . . . Wait, I had it! "E and M" stood for "evaluation and management," the code for a visit about a problem.

I struggled to catch up to what Karen had been saying in the meantime. ". . . remember that follow-ups are different than news, although if a new has been seen by someone else in the clinic in the past three years they're not new, unless it wasn't your specialty. Remember if it's a consult you have to code a 902 series instead of a 992 series. You have to dictate the referring practitioner or it's not a 902. Remember to differentiate a consultation from a referral, although that won't affect you so much—you're a primary care."

What's the difference between a consultation and a referral? I wondered, but Karen's tone suggested I should have learned that at my grandmother's knee, so I was afraid to ask. Then I thought, *I'm "a primary care"? I've been through eight years of training, and after two days of practice I've already lost "doctor" from my title?*

I wrote down "902/992" on my notepad and hoped it would mean something later.

"You can use V codes, but remember they're not always reimbursed," Karen continued.

"V codes?" I asked weakly.

Karen nodded but didn't elaborate. "And when you've got an eight or nine hundred then you need to remember your E code; nobody likes it but it's important or the claim will get denied."

"Excuse me?"

"Well, they won't pay for anything if they think someone else should be paying it. Like L and I."

L and I . . . Yes! That meant Labor and Industries, the federal department that administers workers' comp. I was thrilled to recognize an abbreviation but still didn't get what Karen had just said.

"I'm sorry," I admitted, "you lost me there again. Eight or nine hundred? E?"

Linda sighed as if I were a particularly truculent child. "Eight or nine hundred codes are things like injuries and accidents. Es are circumstances, location, and causes. Someone has a broken arm, you have to code an E for how it happened—motor vehicle accident, fall—or else it doesn't get paid. Or if it was at home you code that, versus if it was at work and then it would go to L and I."

I wrote down, "8-900, E." I was starting to feel a little nauseated.

"But remember, the eight or nine hundred has to be first," Linda added. "E is always a secondary code."

"E secondary," I wrote down on my pad.

Through most of the process of orienting myself to the clinic I'd been excited, albeit nervous. Yes, there was a lot to learn, and yes, this would be different from being a resident. But this was it—it was real, it was what I'd been working toward all these years. By the end of the Coding and Compliance session, however, I was a quivering wreck.

"I can't do it," I announced to a friend that evening. "This whole thing is a terrible mistake. I just can't do it."

"Of course you can," my friend said. "You've learned everything else you needed to, all along the way. You can do this, too."

The nice thing about complete ignorance is that you treasure every emerging glimmer of competence. After I successfully coded my first sore throats and sinus infections, I felt irrationally triumphant. I started to get excited about coding. I thumbed through the massive coding encyclopedia and discovered codes for obscure problems and even more obscure circumstances. Codes for eyeworms and familial Mediterranean fever. Codes for falling off a cliff or out of an airplane.

One day I recorded a 917.6 (foreign body, superficial, foot, noninfected) and the associated procedure code, CPT 28190 (removal, foreign body, superficial, foot, noninfected.) Linking 917.6 to 28190 meant that I'd removed a splinter. I added an E849.0 to clarify that the splinter was acquired at home, not at a place of work or business. I couldn't decide who would be more stunned: My mother, if she knew how many 917.6/28190/E849.0s she'd performed when I was a child. Or myself, if I'd known when I entered medical school that this was how I'd be applying my hard-earned education.

Luckily, my friends from residency who were also entering practice were going through the same torture. One sent me an e-mail with the subject line "Coding Seminar." The message went like this:

"911.0: Abrasion, superficial, trunk [includes penis]. E918.0: Caught between two objects. Really, they should put warning labels on zippers."

Despite my flights of coding fancy, I was still having trouble with the basics. Reluctantly, I dialed the Coding and Compliance number.

"I have a couple of questions . . ."

"We can come down."

Linda and Karen arrived with remarkable alacrity, smiling cheerily. They were very pleasant and very bright; they just didn't speak the same language I did.

They sat down across the desk from me. I'd already figured out that the process would go better if I had a clear question, so I started out briskly. "I'm trying to figure out this whole thing with the preventative exams," I said. "I understand that there's a distinction in billing between a preventative visit and a treatment visit. But I'm confused about what to do when there are elements of both."

"You shouldn't do both in the same visit."

"I understand that ideally they'll be separate. But I can't tell someone, 'I know you've taken the day off from work to come here and see your doctor, but three of the items on your list are preventative and two are nonpreventative, so you'll just have to come back another day.'"

"I know the doctors don't like it," Karen said severely. "But that's the way the system is."

I tried again. "The doctors don't like it because it doesn't fit the way people think. Our patients come in with questions, and we try to address them. These distinctions seem artificial. I'm trying to understand them so I can work with them."

Linda sighed and shifted uncomfortably in her chair. "Well, there is one thing you can do," she said. "If you really have to do both in one visit, you can do a dot-two-five."

"A what?"

"You can do it as a preventative and then do a dot-two-five modifier on an E and M." I remembered that "E and M" stood for "evaluation and management," so I didn't have to embarrass myself by asking what it meant. But "dot-two-five" was another matter.

"What's that?" As I asked the question, I noticed that Karen was looking at Linda in alarm, as if she had divulged a state secret.

"It's an extra code you can put behind the preventative code," Linda said, "and then you can bill an E and M for the same visit. Like, if at the end of a physical somebody suddenly had chest pain and then you evaluated them for that."

"So I *can* do both!"

"Yes," said Linda.

"But . . ." cautioned Karen.

"But what?"

"But most insurances don't take dot-two-five modifiers."

"So what happens if I try to code one?"

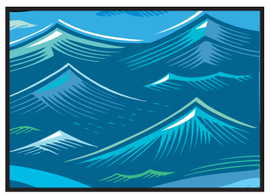
"Well, it's legal—you won't have committed insurance fraud. But they'll just pay for one of the two; usually they pick the cheaper one."

"So I can bill for both if I do both—I just won't get paid."

"Yes."

"Great."

There was a long pause while I rubbed my throbbing temples. "Okay," I finally said. "Let me think



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about that for a bit." What I was thinking was something like, *Boy, I could save myself a lot of headaches and just open a coffee shop instead. There are no dot-two-five modifiers for coffee.*

But what I actually said was, "My other question is simpler. I'm trying to figure out how to bill a physical. I had someone complain last week because I billed for a physical and it wasn't covered. But she said her insurance told her they would cover a Pap."

Karen stepped up to the plate this time. "A Pap smear is covered under the state Women's Health Initiative."

Linda added, "And a lot of HMOs will pay for preventative care." HMO, health maintenance organization, I thought to myself, trying to take comfort from recognizing another acronym.

"A V70.0 is a physical," Linda went on. "Are you doing the whole thing? Listening to her heart and lungs? Past history, family history? Of course, if she's a return, it's only an update." I was struck that my patient had been reduced to "a return," just as I'd become "a primary care." *We all get abbreviated to our billing functions*, I thought.

"Of course I am," I answered. "Most of the time in someone young those are pretty simple, but they could turn up something important."

"If you are just doing a Pap you could code a V72.3—gynecological exam with routine cervical Pap."

"So I should code that instead of a V70.0, physical exam?"

"No, V70.0 is better. A V72.3 assumes you're just swabbing her cervix and not doing anything else. There's less compensation." I'd noticed that the word "compensation" was used instead of "payment," as though money changed hands as a kind of apology for our inconvenience.

"But will the insurance pay for a V70.0? Is that covered under the . . ." I tried to recall the name of the program. ". . . the Women's Health Initiative?"

"Not necessarily," Linda responded. "Some insurances cover it, some don't."

"Which ones?"

"It's always changing."

"So if I code a V72.3, I don't get paid for the work I did. But if I code a V70.0, I do get paid but she might get the bill."

Karen nodded.

"Or she might not," I added, "and there's no way for me to know?"

She nodded again.

"And we're surprised that this confuses people?"

There was a long silence. Finally I looked down at my watch. "I think it's time for me to get back to the easy part of my job," I said, as gently as I could, "seeing patients."

Luckily I enjoy seeing patients, and by the end of the day I was cheery again and ready to tackle the coding labyrinth once more. Just before I left for home, I got a text message from a friend who was also just starting practice.

"Did you know there's an ICD-9 code for legal execution?"

"Really?" I wrote back.

"E978 covers lethal injection, death by firing squad, electrocution, beheading, and other means not otherwise specified."

"Thanks," I wrote back. "I'm glad to know how to code what I want to do to the person who designed this system."

As a new doctor at my clinic, I was a magnet for advice. Physicians I'd never met came up to me to offer gems and pearls of wisdom—things, they said, they wished they'd known when they were starting out. They meant well, all of them, but as a cumulative mass the advice was overwhelming.

"Don't give anyone narcotics," one colleague told me. "There will be people in your office acting out the death scene from *La Bohème* and telling you you're going to burn in hell if you don't give them OxyContin. Don't fall for it."

In fact, during my first days on call, I got dozens of phone calls from people who said they'd just run out of Percocet, or the cat had eaten their codeine, or their ex-boyfriend had stolen their Valium.

"I had one guy who claimed to be on his way to his wedding," another colleague told me. "He said he had a kidney stone and he'd had them before and could I just give him some Vicodin to control the pain during the ceremony. And I was actually writing out the script when I realized his tux didn't fit. Nobody gets married in a tux that doesn't fit. From there the whole thing unraveled. But I tell you, I was this close."

"But some people really do have kidney stones," I said.

"Don't give out anything unless you are holding a positive CT scan."

"I had this nice young woman come in the other day with kidney stones," I persisted. "She'd had them before . . ."

My colleague looked at me knowingly. "Let me guess. She was allergic to contrast dye so she couldn't have a scan, or, no, it was under her deductible and she couldn't afford it."

My eyes widened. "There was blood in her urine," I said.

"People prick their fingers."

"I think she really had stones."

"Talk to me in three months."

In three months, the "nice young woman" had come back to me four times for refills of narcotic painkillers. I pushed her harder about getting a scan, or at least obtaining old records documenting her disease; even assuming her story about the kidney stones was real, I didn't want to miss a diagnosis or treat the wrong thing.

She responded with a scathing letter saying that I was hateful and mean and shouldn't be allowed to see patients. Then she started calling when other docs were on call, telling them an untrue story about how I'd put her on stronger painkillers than she wanted and asking them to phone in a prescription for "something milder." When the prescriptions dried up, she left our clinic.

I also got advice about managing calls on nights and weekends. "Send people to the ER," one colleague said. "You get someone calling in the middle of the night and you can't figure out for sure what's going on, just send them in."

"Don't send anyone to the ER unless you absolutely have to," another advised. "New docs always think that 'Worst comes to worst, I'll just send them to the ER.' But then you'll be getting calls from the ER docs at two in the morning to say, 'Hey, your patient is fine,' or, worse yet, 'They seem okay but they're here so I've decided to admit them, so you'd better come in.'"

And there were recommendations about managing my staff, my schedule, my office, my colleagues. "Be flexible," some people told me. "Say yes to anything anyone asks you to do; you can always scale back later." "Set firm limits," others said. "Once things spiral out of control you can never get them back in."

Some people recommended having a high threshold for referring patients out to specialists, others a low one. Everyone had a horror story from starting practice that they wanted to share. One had gotten so busy so fast he was overwhelmed and ended up being hospitalized with anxiety and depression. Another left her first job because she'd felt ostracized for refusing to work late hours.

"Play the game." "Don't be too nice." "You can spoil everything by taking the wrong steps at this stage in your career."

Then there were the conflicting instructions from our patients' insurance companies and from our malpractice insurer. Be efficient, we were told; the insurance companies are counting every dollar you spend. Be complete, our malpractice carrier told us; leave no stone unturned or you'll be susceptible to a lawsuit.

One day we had a long meeting about how expensive transcription was and how all the doctors in the clinic would have to cut down on the length of their dictations. The next day there was a risk-management meeting to inform us that if we didn't document every thought in our heads and every detail and nuance of each conversation with our patients, we were liable to get sued.

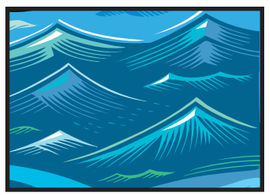
"This is crazy!" I complained to a friend from residency. "It can't be done."

"My office had those same two meetings last week," he said.

Every word of advice was well-meant, and undoubtedly the inundation seemed more ominous to me than anyone intended. People were only trying to prevent me from repeating their mistakes. Still, with every hour bringing a new piece of wisdom, each one contradicting the last, I was exhausted and confused. The message seemed to be: There is no way to do it right.

Happily, at last, I came to see this as a blessing as well as a curse. If there was no right answer, I couldn't be expected to have one. As the months went by, I made some mistakes and averted some others. There was a balance to be struck, I realized, between cynicism and gullibility, between offering too much and believing too little. There was usually a line of reasonable medical judgment that fell somewhere between spending a fortune to eliminate all uncertainty and saving money by accepting too much uncertainty. There would be pieces of advice I would take and pieces I would ignore.

Despite everyone's desire to help, I would have to find my own way. ■



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