Why I Love Coding but Hate Fee-for-Service

When we talk about the evils of coding, often what we're really talking about are the evils of fee-for-service.

I'll be honest. I love coding.

(Sorry if that opening statement induced mass syncope! But I needed to get it out in the open. Thank you for letting me share.)

I'll explain. You see, I am one of the rare types interested in the minutiae of coding. I will sometimes look through the list of CPT II codes to find a code I can submit. CPT II codes are never reimbursed, so this is just for my own edification. It's odd, right? Some people go to flea markets on weekends to collect figurines; I scroll through lists of ICD-10 codes. Why do I like it? Because I get a sense of "completion" knowing I've captured every code I can. It's almost like watching *The Matrix* and seeing the falling green lines of code behind the picture.

"This new *FPM* medical editor is weird," I can hear you say.

Perhaps. But the reason for my revelation is that I'm an outlier. Few physicians think this way, and there's a simple reason: Coding is horrible. It's inefficient. It's time consuming. And I'm not aware of any data showing that accurate coding improves clinical outcomes. In fact, an interesting 2020 study showed that critical access hospitals (CAHs) and non-CAHs have similar short-term mortality rates when you strip away risk-adjusted disease acuity based on hierarchical condition categories and instead use hospital pre-existing conditions as the risk adjuster.[1] The reason? The federal CAH designation allows a hospital to receive cost-based reimbursement, and they don't have to focus on aggressive diagnosis coding like a non-CAH might. (That said, there are data to support the benefit of risk stratification,[2] and coding may be a piece of that puzzle.)

Whenever *FPM* publishes an article on coding, value-based care, or anything to do with payment, the comment section is typically flooded with talk of direct primary care (DPC). The DPC community is passionate about their model of care, and it's understandable. From *FPM* in 2020: "Direct primary care physicians are paid directly by patients or their employers, usually with a monthly membership fee, and don't bill third parties (like insurance companies) on a fee-for-service basis."[3] Thus, DPC physicians can look beyond fee-for-service and be free of the burden of coding. I can see the attraction to that.

My mom used to say that no matter how thin the pancake, there's always another side.

The other side is that coding can be a powerful tool to understand and manage a population of patients. I guess I'm really referring to ICD coding here, and we'll talk more about CPT coding in a bit. In a value-based care (VBC) model, accurate coding is critical for disease management. In all transparency, I'm part of a practice that is all-in on VBC, with several full-risk contracts. This is the most fun I've ever had in practice, as I now have the resources to help those patients who really need it. I'm off the fee-for-service hamster wheel, and I have more time to spend with my patients. For example, we recently rolled out a care management program for our patients with chronic kidney disease (stages 4 and 5) and end-stage renal disease. How did we identify them? Through both chart abstraction and claims review, looking for N18.4, N18.5, and N18.6. If we had coded them incorrectly (e.g., N18.9, "chronic kidney disease, unspecified," or R94.4, "abnormal results of kidney function studies"), we would not have been able to identify them for our program.

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When it comes to CPT coding, you might have picked up on a theme here: Fee-for-service is bad. It drives utilization. It steamrolls

over quality. When we talk about the evils of coding, what we're really talking about are the evils of fee-for-service. Last summer, another time-in-primary-care article was published, showing that we need almost 27 hours a day to complete all the chronic disease, acute disease, preventive health, and administrative tasks to successfully manage a panel of patients.[4] Twenty-seven hours a day! Not only is that undoable, but it's also soul-crushing. No wonder burnout seems to be at an all-time high. The American Academy of Family Physicians is attempting to reduce administrative burden,[5] but even with those efforts, the fee-for-service system is still a buzzsaw waiting to chew us up and spit us out.

The DPC and VBC folks have something in common: They both want to divorce payments from services. Pay me based on how well I take care of my patients, not how many visits I can provide in a day. And maybe that's why, when I talk to my colleagues who are doing DPC or VBC arrangements, they seem less frustrated. These "subscription-based" models are going to continue growing for that reason.

We all say the same thing: "I just want to see my patients and not worry about all the other drivel." I don't know the right answer, other than it's not fee-for-service. In the meantime, I'll go back to my comfort of coding. FPM

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