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Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Private Practice

Learning Objectives
After reading these articles, you should be able to:
1. Identify the key business challenges involved in setting up a private practice. **2.** Describe how to use evaluation and management billing codes and how to document them in order to support your choice of codes. **3.** Evaluate whether antidepressant use in pregnancy is related to the increased rates of autism spectrum disorders.

E&M Codes for Fun and Profit: A Story of 4 Psychiatrists

Daniel Carlat, MD
Editor-in-Chief, Publisher, The Carlat Psychiatry Report

Dr. Carlat has disclosed that he has no relevant financial or other interests in any commercial-companies pertaining to this educational activity

Since 2013, all psychiatrists have had to use new CPT (Current Procedural Terminology) codes. We published a primer on the system in our May 2013 issue, but the codes are still complicated. The good news is that the new system values psychiatric services at a higher level, and reimbursements per

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In Summary

- The updated CPT code system has increased insurance reimbursement rates for psychiatric visits substantially.
- Using evaluation and management coding practices requires that you document the 3 main elements of your visit: the history, the exam, and the medical decision-making.
- Under the new coding system, the amount of time you spend with a patient is not necessarily related to the amount you are able to bill.

Q&A With the Expert

Starting Your Own Private Practice: A Business Model

Jennie Byrne, MD, PhD

Private practice psychiatrist, Chapel Hill, NC; consultant to psychiatric practices

Dr. Byrne discloses that she receives income from consulting with psychiatrists on their practices, and that she has created a video series, "Transform Your Private Practice," and an e-book, "Opening Your Private Practice."

TCPR: How did you go about setting yourself up in a group practice?
Dr. Byrne: After completing my residency, I moved to North Carolina and initially started out as a solo practitioner in 2010. Now, 6 years later, my practice has 5 psychiatrists, 3 full-time administrative staff, 2 part-time administrative staff, and we are probably adding some more next year. I also do consulting work.
TCPR: Can you tell us a little about your consulting work?
Dr. Byrne: Sure. I work with local psychiatrists to help them figure out if they want to start a private practice, what kind of model they want for their practice, and then to troubleshoot problems in their practice model.
TCPR: Interesting. I think that most of us consider starting our own practice at some point in our careers. Based on your experience, what is the number one question we should ask ourselves before taking the leap?
Dr. Byrne: If you are doing a private practice, whether it's solo or group, it's going to be a small business. So here's the question: Are you ready to run a small business? You have to be willing to learn how to think like a business person to some degree to do well in the current environment.

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visit have increased substantially, by 20% or more. Hopefully, this will encourage psychiatrists who have fled insurance networks to return to them—you can now be assured of a robust income with an insurance-based practice, even if you choose to see many of your patients for therapy.

I don't intend to rehash all the guidelines—I've added some links at the end of this article for those wanting to immerse themselves in the details. Instead, in this article I'll give you a quick overview of evaluation and management (E/M) coding, and I'll share the experiences of 4 psychiatrists who have been using these codes over the last 3 years. Each clinician has a somewhat different approach, but they have all found ways to integrate E/M coding into their busy practices, and they will offer some shortcuts and other tips.

The new CPT codes have essentially split up our old procedure codes into two: The E/M codes reflect what you do when you evaluate a patient for medication management, and the revamped psychotherapy codes are for the therapy component of visits. Since many of us do both med management and therapy, we now use 2 codes for most of our patients—an E/M and a psychotherapy code.

The psychotherapy codes are pretty easy. For short visits (around 20 minutes), you can code 90833 (requires at least 16 minutes of face-to-face time), and for longer visits (around 40 minutes), code 90836 (at least 38 minutes of face-to-face time). To document therapy, write something like, "provided supportive therapy for family stressors;" in other words, lots of detail is neither required nor advised, since these are notes that can be shared with other practitioners under HIPAA guidelines. Take-home point: Don't neglect these therapy codes, since they may pay as much if not more than E/M codes, and it is perfectly kosher for you to add a therapy code to your E/M visit.

The potential documentation nightmares arise with E/M codes, which require that you document 3 main elements of your psychiatric visit: the history, the exam, and "medical decision-making." Note that these elements correspond to what we've been doing all along, though we may use different terms. For instance, I tend to think about my follow-up visits as encompassing history, mental status exam, and an assessment/plan. Some think in terms of a SOAP note, in which case S, subjective, is "history," O, objective, is "exam," and A/P, "assessment/plan," is "medical decision-making."

In this article, my focus is on follow-up visits (and not the initial evaluation), and on psychiatrists who are not using complex electronic health record (EHR) systems. If you are using an EHR, you are likely engaging in a click-fest that may be tedious, but on the other hand, it generally guarantees that your documentation will survive an insurance company audit. There are advantages and disadvantages of EHRs, and if you are employed by a large practice or health system, you may be required to use the software which they have purchased. Research on EHRs has paradoxically found that they lower physician productivity in smaller practices (Adler-Milstein J and Huckman RS, *Am J Manag Care* 2013 Nov;19(10 Spec No):SP345–352.)—which is why many psychiatrists have avoided these systems thus far.

If you don't use an EHR, you're likely using paper, or perhaps you've created your own progress note template in Microsoft Word. Either of these lower-tech systems can play just fine with E/M codes. I interviewed several practicing psychiatrists so that you can learn from their real-world experience with E/M coding. All of my respondents requested anonymity, allowing me creativity in naming them. Spoiler alert: The best solution may be to ignore the guidelines and to simply write a good, thorough SOAP note for all your patients.

Dr. Old School: Pen and paper, baby

Dr. Old School is a senior psychiatrist in private practice who accepts insurance. She schedules most of her patients for 45-minute visits combining therapy and medication. Before 2013, she billed 90807 (individual therapy with medication management) for almost all of her sessions, writing out notes on paper during visits.

With the new CPT, Dr. Old School has changed only one thing in her practice: Instead of billing 90807, she codes all her visits as 99213 with the add-on therapy code 90836. Her notes, still generated via pen and paper, follow a loose format that usually includes a few lines about the interval history, the diagnosis, and some comments on meds. A typical note, for example, would be, "The patient discussed his guilt about not being able to support his parents. Appears to have some OCD symptoms of checking, in addition to depression. Currently taking Wellbutrin, which is

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helping, will add fluoxetine for OCD."

When the new codes were released, she spent minimal time reviewing the information—"They were so complicated they gave me a headache," she said. She decided to use 99213 for all patients primarily because it seemed to represent an average visit. "I didn't want to bill too high, because it seemed that they required a lot of documentation. I'm not very good at documenting." One insurance company asked to review some of her records, but it didn't give her any feedback (positive or negative), and the company continued to reimburse her charges.

Dr. Out of Network: Notes for the patient's benefit

Like Dr. Old School, Dr. Out of Network sees patients in 45-minute increments, combines meds and therapy, and he bills all of his patients 99213 plus 90836. Unlike Dr. Old School, Dr. Out of Network does not contract with insurance companies and charges $300 per session, with a sliding scale for those who can't afford his fee. However, he does provide his patients with a bill they can forward to their insurance companies, many of which provide out-of-network benefits after a deductible is met. For this reason, he uses a Microsoft Word template that encompasses the major elements of the HPI, the MSE, diagnosis, and meds. He does this primarily to support the billing code in case an insurance company asks for documentation before reimbursing a patient.

Dr. By the Book: Pathways to success

Dr. By the Book works in a group practice and schedules 3 patients per hour, accepting most insurances. She bills either 99214 or 99213, and for some patients also bills an add-on 90833 for therapy. She has made a careful study of the billing rules, and has developed shortcuts to ensure that she documents exactly what needs to be in the chart to support a given code—no more and no less.

Over the last 3 years, she has developed a limited number of documentation "pathways" for each code. Below are the main pathways for 99213 and 99214.

Important note: E/M coding criteria refer to "problems" rather than "diagnoses." Sometimes these are identical, (such as "depression"—usually both a problem and a diagnosis), but often patients present with more general problems that are not *DSM* diagnoses, such as weight gain, anxiety, forgetfulness, anger, etc. Keep this in mind as you read the next 2 approaches, since patients frequently will have only 1 or 2 diagnoses, but may have many more problems, each of which "counts" when you are deciding which code to use.

99213:

- Patients with 1 problem: Document the problem, one medical review of system (ROS) item, which can be psychiatric (eg, "denies anxiety"), and at least 6 items from the mental status exam. (No documentation of medication is required in this pathway, though she usually does so.)
- Patients with 2 problems: Document the problems, one ROS item, and the prescription of a medication.

99214:

- Patients with 2 problems: Document the problems, at least 4 symptom "elements" in the HPI (such as severity, duration, timing, and quality), at least 9 items on the mental status exam, 2 ROS categories (not necessarily psychiatric), and social history (such as "spending more time with friends").
- Patients with 3 problems: Document the problems, the social history, 2 ROS categories, and the prescription of a medication.

Dr. Volume: A systematic approach

Dr. Volume typically sees 5 patients per hour (a high "volume" practice), billing about 60% of visits 99214 and 40% 99213. He very rarely bills an add-on therapy code, and most of his patients see other clinicians for psychotherapy.

Like Dr. By the Book, Dr. Volume has studied the rules carefully, but he does not use distinct documentation pathways. He has created his own comprehensive progress note template, which includes all the elements of history, exam, and medical decision-making required for any E/M code. He fills out the template for all patient visits, ensuring that his documentation always meets criteria for the highest level of visit. However, he doesn't bill 99214 for all patients, realizing that there is meaningful variation in the complexity of visits.

His shortcut for deciding which code to use is a sort of streamlined version of Dr. By the Book's:

- One problem: 99213.
- Two problems that are stable: also 99213.
- Two problems, one of which is worsening: 99214.
- Three problems: 99214.

One insurance company audited his records and told him that he bills more 99214s than other psychiatrists. "I told them that I researched the regulations extensively, and I'm following all the rules, and they said, okay, that's fine, and I never heard from them again. I think a lot of psychiatrists are giving up a lot of money if they are billing only 99213s."

Conclusion

I've described 4 approaches to coding for follow-up visits, and they all work for the psychiatrists who use them. Everyone's practice style is different. The safest policy is to document all your visits thoroughly, but not so comprehensively that you are taking too much time away from your clinical work. If you document the interval history, the MSE, your assessment, and your plan, you will be able to successfully bill a combination of 99214s and 99213s—and probably more 99214s, which will significantly increase your income. The amount of time you spend with patients

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TCPR: If the answer is "yes," then what's next?
Dr. Byrne: The next question is, "What's my business model going to be?" The business model drives the clinical work. And whether you take insurance or not will somewhat dictate that model. In my opinion, with the limited number of psychiatrists taking insurance these days, you are going to be in high demand if you do accept it. On the flip side, though, that will push you into a high-volume practice.
TCPR: Why is that?
Dr. Byrne: Because of the way reimbursements work and the administrative overhead required to do the paperwork. If you want to do psychotherapy with your patients, you're not going to get reimbursed very well, so you are going to be pushed into doing medication management. And that is going to require you to see multiple patients in an hour.
TCPR: I've heard from some colleagues they have found the reimbursement with E&M codes to be much greater than it used to be, that it's much more lucrative now to have an insurance-based practice. Can you speak to that?
Dr. Byrne: Sure. Using E&M codes in combination with therapy codes may allow clinicians to provide therapy to many of their clients at a higher reimbursement than in the past.
TCPR: Do you mind sharing some insight about your practice? Did you ever go the insurance route, or did you start immediately with a private-pay model?
Dr. Byrne: I struggled with that a lot at the beginning. I ended up not going the insurance route. So as a doctor, I am not in network; I am what's called an out-of-service provider. For my business model, I use what I like to call a high customer service model in that I submit claims electronically for out-of-network patients who have insurance.
TCPR: Can you explain this model?
Dr. Byrne: Sure. We tell patients we are an out-of-network provider, which means that they pay us in full at the time of the appointment. But if they want to, we will take their insurance information and electronically send their claims to their insurance company for them. It has to go through a third party—what is referred to as a "scrubbing system"—to make sure that it will be accepted. If so, then insurance will receive the claim and apply the amount to the deductible. After the deductible is met, they will pay a percentage of that claim back to the patient. It does not come to us.

"The idea is to design a sustainable practice that is not going to cause you to burn out and overload yourself, because that's what doctors tend to do. Only you can answer the question, 'What do I need to make to feel good about what I'm doing?"

Jennie Byrne, MD, PhD

TCPR: The third-party scrubber—what does that mean exactly?
Dr. Byrne: Again, when you're thinking about a practice, you're going to have to think about your electronic medical record (EMR). I don't think anyone should be on paper, in my opinion. There are free ones that are perfectly good. When you get your EMR, one of the things to look at is the billing component. Ours is integrated into the EMR so that it is fully integrated into one system. Insurance will pay the deductible if you process it electronically with a third-party scrubber. If you are trying to do it manually, maybe only 25% or so will go through because insurance will invent all sorts of reasons to reject claims, oftentimes saying they were coded incorrectly or something like that.
TCPR: You bring up a point that I think a lot of us haven't really thought about, which is that it might be easier to bill as an out-of-network provider if you use EMR.
Dr. Byrne: Right. Again, going back to the business component, if you're going to have a small business, you want to have customer satisfaction. Obviously a high level of clinical care is one kind of satisfaction, but there are other kinds too, and the ease of use of your submitting claims for them—people do really like that.
TCPR: So imagine a patient comes to see you and says, "Dr. Byrne, I understand that you have this system in your practice where you will try to bill the insurance company. How does that work, and am I really going to get money back?" What do you tell them?
Dr. Byrne: I would generally say something like this: "Once you hit your deductible, you're going to get some money back; the percentage will depend on your plan. Our administrative staff can take your insurance information and help you estimate what your deductible will be."
TCPR: And that deductible, does that include all healthcare spending that they might have, or is it just out-of-network outpatient visits?
Dr. Byrne: Typically insurance companies have an in-network deductible and an out-of-network deductible, as well as individual deductible and a family deductible, so the level of complexity obviously is growing. For our practice, patients would have to look up their out-of-network deductibles.
TCPR: In your experience, what's an average out-of-network deductible?
Dr. Byrne: I'd say the average is 1,500 dollars, and whether patients meet that depends on how many visits they have with you. If they're coming regularly for therapy, they're going to hit that deductible pretty quickly. If they're coming in quarterly for just stable med management (and we require a quarterly check-in), they're probably not going to hit it.

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TCPR: So if we decide to go the out-of-network route, do you have any suggestions for how much we should charge and how to determine that? Obviously we can look up people's practice fees on the Internet, but it's not as simple as that.

Dr. Byrne: When I first started, I looked around and talked to other practitioners, and what I found was that people were charging fees that varied widely. So I developed my own approach, which is one I use in my consulting work with new practices. The idea is to design a sustainable practice that is not going to cause you to burn out and overload yourself, because that's what doctors tend to do. Only you can answer the question, "What do I need to make to feel good about what I'm doing?" So start with how many hours you want to work a week and decide how much money you need to make. And working backwards from there, come up with an hourly rate for your services. You also need to figure out what your administrative overhead might look like and how many hours your staff would need to work as well. You base your fees on time, much like a lawyer does. Your time is the critical component; instead of the patient receiving a service, what they're getting is time with the doctor. So everything you do with patients is built on a time model.

TCPR: Can you walk us through an example?

Dr. Byrne: Sure. Let's say you need to make 250 dollars an hour and then take off your administrative overhead so that you walk home with 150 dollars an hour. And then you figure, well, if I see someone for a therapy appointment, it's about an hour. If it's a med management visit, I do half an hour. That's enough time for me to see the patient, write the prescription, schedule the next appointment, and write my notes. That's how you decide how much visits are going to cost. Maybe you live somewhere with a low cost of living and you don't need to charge that much to make what you want and work 40 hours a week or 20 hours a week. Or maybe you live in New York and it's super expensive and if you want to do those same work hours, you're going to have to charge a lot more, but it will be sustainable. It's a very different way of thinking about it, but I think it provides a higher quality of life and less chance of burnout if you do it this way.

TCPR: I think that's great advice, particularly since burnout is a big problem in our field. Within your practice, is there a specific structure to your patient appointments?

Dr. Byrne: Yes. First of all, patients have to be on time. We promise no wait time, so a lot of our business is structured to make sure that people are seen on time. If they arrive 15 minutes late, they don't get an extra 15 minutes. Administrative staff checks them in, calls us, then we come out and greet them. The actual appointments I structure into thirds. The first third is open-ended questions to let them talk: what's going on; how they are doing. The next third is more targeted questions: the things I need to know. The last third is to talk about what we're doing: the next treatment step, the overall plan, prescriptions. And when they leave the office, I'm pretty diligent about doing their notes immediately. I really strongly believe if you can walk home at the end of the day with no notes to do, you feel like a million bucks. I build time buffers into my schedule to do my notes.

TCPR: How long are your visits?

Dr. Byrne: Typically, adult psychotherapy is going to be a 45–50 minute appointment, and a medication management visit is going to be 20–25 minutes. For children, we're doing 60–75 minutes face-to-face and a 90-minute block for intake since you have parents coming. In our practice, what we say is 20–25 minutes face-to-face, but we block 30 minutes so we can do notes, go to the bathroom, take a break, etc. Our long appointments will be 45–50 minutes face-to-face, and again we build in that 10–15 minutes in between. I think it's really important to know what you need as a buffer between appointments and that you don't shortchange yourself because you'll regret it. And you have to be really practiced and skilled at starting and stopping on time.

TCPR: Definitely, and with some of us that does takes practice. In terms of billing time, how do you handle paperwork charges, phone time, and those sorts of things? I know that there are often misunderstandings when patients are billed for things they don't expect.

Dr. Byrne: Everything that our administrative staff can do that does not involve the doctor's time, they will do, and we will not charge extra. These are things like prior authorizations, nonclinical phone calls, and basic paperwork like an excusal note to an employer saying the patient was at a doctor's visit on a given day. If there's something that specifically requires the doctor's time, then we would bill in 15-minute increments, and it's at the doctor's discretion whether to bill for it or not.

TCPR: That makes sense. Do you talk to your patients about this in advance?

Dr. Byrne: That's a really good question. Let me start by saying this is where training your administrative staff is huge. In our office we practice with scripts to learn how to talk to patients about this. We say something to our patients like, "You can expect a really high quality of service from us, and we will respect your time. We don't double or triple book. If we call you on the phone, we're going to have your chart open and be ready to talk to you; we're not going to be taking other phone calls; we're not going to be doing other things. We want to make sure that your time with the doctor is used effectively and efficiently, and we ask in return that you respect our time as well." We have a "free pass" system that we don't really advertise, but if somebody cancels or misses an appointment, we will say, "Okay, it happened once. Let's reiterate the policy; next time it happens, we'll bill you for it." We do get some frustrated patients, especially if they're new to the practice, so we spend time up front going through these types of details.

TCPR: How would you explain to your patients the difference between a clinical and a nonclinical call, for example?

Dr. Byrne: If I start a patient on a new medicine and they call me a day later and say, "I'm having a side effect; what do I do?" I would not typically bill for that time. But if a patient wants to talk to me for 15 minutes to get through a panic attack, I would

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Research Updates IN PSYCHIATRY

AUTISM

Antidepressant Use in Pregnancy and the Risk of Autism

(Boukhris T et al, *JAMA Pediatr* 2016;170(2):117–124)

Background

Rates of autism diagnoses are on the rise. While no one knows for sure why, a new study explores whether the increased use of antidepressants during pregnancy might be one of the causes.

Methods

The researchers looked at databases from Quebec of nearly 150,000 full-term births and followed the health of the children for up to 10 years. Antidepressant exposure was defined as having at least 1 prescription filled during the pregnancy. Cases of autism spectrum disorders (ASDs) in children were identified by looking at ICD codes used in medical service claims. For example, if during an annual checkup, a pediatrician listed pervasive developmental disorder or Asperger syndrome as one of the diagnoses, this would be counted as an ASD case.

Because patients who take antidepressants are expected to differ from those who do not, the researchers attempted to control for things like socioeconomic factors, as well as maternal physical and mental health.

Results

Of the 145,456 infants followed, 1,054 (0.7%) received at least 1 ASD diagnosis—which is about in line with ASD prevalence rates. The mean age at first ASD diagnosis was 4.6 years, and boys outnumbered girls by about 4:1. In total, there were 4,724 (3.2%) infants who were exposed to antidepressants in utero. Use of antidepressants during the first trimester was not found to be associated with an increased risk of an ASD. However, antidepressant use in the second and/or third trimester was found to confer an 87% increased risk of an ASD diagnosis (or just under a 2% incidence rate rather than the 1%, which is the estimated prevalence of ASDs in the community) (*MMWR Surveill Summ* 2012;61(3):1–19). When antidepressant classes were examined, only SSRIs were statistically associated with the increased risk. The researchers concluded that SSRI use in the second and third trimesters increases the risk of an ASD in children.

Summary of findings

The findings are concerning, but there is one potential "fatal flaw" to the study: The researchers were unable to control for the *severity* of depression. Most women with only a mild depression would be expected to stop their antidepressant once pregnant. Those with a more severe illness, in contrast, would be much more likely to remain on the antidepressant throughout their pregnancy. Could it be that the increased rates of ASDs are due more to the effects of severe depression, and that antidepressant exposure is not the cause but merely a marker for greater severity? Two pieces of data from the study lend support to this possibility. First, SNRIs conferred only a 0.4% risk, which was lower than the average rate; if serotonergic reuptake inhibition is thought to be the mechanism of insult, as the authors postulate, we would expect SNRIs to confer a comparable risk as SSRIs. Second, there were 167 exposures to combined antidepressant therapy. It can be assumed that pregnant women who take 2 or more antidepressants during pregnancy are more severely depressed than those who take only 1. The risk for ASDs in this group was 3%—more than double that of the SSRI group. This finding is also more consistent with depressive severity being the causal link, rather than SSRI exposure.

TCPR's Take

We are left in the same place after this study as we were before: Untreated depression almost certainly poses a risk to a fetus (Suri R et al, *J Clin Psychiatry* 2014;75(10):e1142–1152), while arguably there is no proven substantial risk to SSRI use during pregnancy (Weisskopf E et al, *Expert Opin Drug Saf* 2015;14(3):413–427; Pearlstein T, *Best Pract Res Clin Obstet Gynaecol* 2015;29(5):754–674). Thus, in deciding whether or not to remain on their antidepressant, patients must choose between the known risks associated with untreated depression and the unknown risks that antidepressant use may incur.

—Michael Posternak, MD
Psychiatrist, private practice in Boston, MA.

Dr. Posternak has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CME Post-Test

This CME post-test is intended for participants seeking AMA PRA Category 1 Credit™. For those seeking ABPN self-assessment (MOC) credit, a 13 question pre- and post-test must be taken online. For all others, to earn CME or CE credit, you must read the articles and log on to www.TheCarlatReport.com to take the post-test. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by February 28, 2017. As a subscriber to *TCPR,* you already have a username and password to log on www.TheCarlatReport.com. To obtain your username and password or if you cannot take the test online, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning objectives are listed on page 1.

1. According to Dr. Byrne, the average amount of an out-of-network deductible is which of the following? (Learning Objective #1)
   [ ] a. $500.00 [ ] b. $1,500.00 [ ] c. $3,000.00 [ ] d. $5,000.00

2. E/M billing code 99214 is most appropriate for which scenario? (LO #2)
   [ ] a. A medication refill with therapy [ ] b. One problem with therapy
   [ ] c. Two problems that are stable [ ] d. Two problems, one of which is worsening

3. According to Dr. Byrne, what is the reason for charging a separate fee to patients for controlled substance refills? (LO #1)
   [ ] a. The high cancellation rate for this type of medication-check appointment
   [ ] b. The low reimbursement rate by insurance companies for these visits
   [ ] c. The extra time necessary on the doctor's part to evaluate the need and appropriateness of these refills
   [ ] d. The subscription cost for access to the controlled substance database

4. Which of the following would be an example of appropriate E/M coding for a medication and add-on therapy visit? (LO #2)
   [ ] a. 99213 with 99214 [ ] b. 99214 with 90836 [ ] c. 99213 with 90836] d. 90807 with 99214

5. True or false: According to a recent study, antidepressant use during the first trimester of pregnancy was found to be associated with an increased risk of autism spectrum disorders. (LO #3)
   [ ] a. True [ ] b. False

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Expert Interview

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bill for that phone time. I make the distinction this way: If my patient wants me to do therapy outside the sessions, which a lot of people do, then that time has to get billed. Another tricky area is refills.

TCPR: In what way?

Dr. Byrne: We have a separate fee for refills outside of appointments as well as controlled substance refills outside of appointments. We want to disincentivize people to miss their appointments because if we think they need to be here, there's a reason. And we charge more for a controlled substance refill because that requires extra work on the doctor's part to provide a proper level of high-quality care. You have to go into the controlled substance database, check the chart, make sure you're not trying to fill something too early. Patients will complain, "Well, I've never paid for a refill anywhere else." And we'll say, "You will always have enough medication if you come to your appointments as scheduled."

TCPR: On your website, you tell patients that they will need to provide a copy of their credit card at the initial visit. How did that come about? I would guess that many people would say, "Are you kidding me?"

Dr. Byrne: We tell them upfront: We keep your credit card on file for any charges outside of your appointment, like therapy phone calls or missed appointments. Sometimes people get upset, but at this point we have a system here that's been working long enough that the administrative staff handles these conversations really well.

TCPR: It sounds like you've put a lot of time and thought into running a successful, business-minded practice.

Dr. Byrne: I think it's a really great time actually to be in private practice. If you think about it as a business and you start out on that foot, you'll do very well. You're never going to be wanting for patients; we have something that people really need. And you can design your practice to be all sorts of different things depending on how much time you are willing to put into it.

TCPR: Thank you for your time, Dr. Byrne.

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This Month's Focus:
Private Practice

Next month in *The Carlat Psychiatry Report:* Burnout

E&M Codes for Fun and Profit: A Story of 4 Psychiatrists

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is not closely related to how high you can bill, within reason, of course. Dr. Volume will never bill a 99214 for a five-minute in-and-out medication refill patient. But there are plenty of fairly complicated patients with 3 or more problems that we can evaluate and treat in 15–20 minutes and who should be billed as a 99214.

For those who want to really get into the rules, I recommend going to the APA website for coding and reimbursement (http://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/coding-and-reimbursement) and downloading at least the following 2 documents:

- E/M Services Guide: Coding by Key Components (summary chart)
- Patient Examples Outpatient E/M Visits

There are additional longer documents on the site as well, one of which is a chapter from one of the definitive resources, *Procedure Coding Handbook for Psychiatrists*, 4th Edition. (http://www.amazon.com/Procedure-Handbook-Psychiatrists-Chester-Schmidt/dp/1585623741).