



KNOW YOUR RVUs

Alternative payment models and value-based payments may be increasing in medicine, but most physicians still receive incentive pay tied to relative value units (RVUs). Knowing how many RVUs you generate for each office service you perform can help improve your productivity. RVUs change annually, however. The AAPC, which trains and certifies medical coders, maintains an online work RVU calculator (<https://www.aapc.com/practice-management/rvu-calculator.aspx>) that is regularly updated, but to ensure accuracy ask your office manager or coder for the set of RVUs your practice follows. Having a reference that lists codes and RVUs for common office visits and procedures will help you quickly determine which ones are more productive. For example, if you are seeing a new patient who was discharged from the hospital eight days ago and whose office visit meets the criteria for moderate complexity, you can charge either 99204, "level 4 new patient office visit," or 99495, "transitional care management services with moderate medical decision complexity" (assuming your office made the required telephone call within two business days of discharge and that other transitional care management requirements are met). Which one should you charge? Code 99204 generates 2.43 work

RVUs while 99495 generates 2.11 work RVUs, at roughly the same payment rate, so 99204 would have higher production.

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SET ANTIBIOTIC EXPECTATIONS BEFORE A SORE THROAT EXAM

Whenever I see a patient with a sore throat, *before* the physical examination I explain to the patient (or the patient's parent or guardian) that he or she has pharyngitis, which is either viral or bacterial. I then tell the patient that if it's caused by bacteria we *must* treat with antibiotics, but if it's a virus we *must not* treat with antibiotics because doing so may be hazardous. I have found that after this explanation patients are more willing to accept that they don't need antibiotics if the physical examination and testing, if necessary, indicate their illness is viral. I also use this approach when I see patients with cough, fever (especially in infants), diarrhea, otitis media in children, and rhinosinusitis.

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USE A WHITE BOARD TO TRACK HIGH-RISK PATIENTS

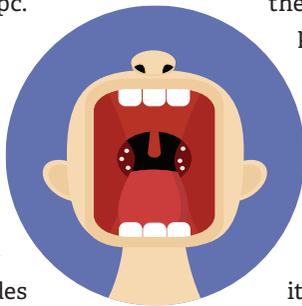
We use an erasable "white board" to help our team intensely manage high-risk

patients and reduce hospitalizations, readmissions, and emergency room (ER) visits. Anyone on the team, which includes physicians, advanced practice providers, nurses, medical assistants, care managers, and behavioral specialists, can identify a patient who is high risk or emerging risk and ask to add them to the board. This can include patients who use emergency services excessively, have had a sudden life-changing event that threatens their health, have serious infections requiring close follow up, have uncontrolled chronic conditions, or have poor health awareness.

We write the patients on the board (identified by number not by name) and assign a staff member to each one. Our team holds 30- to 45-minute meetings biweekly to share pertinent information on these patients and improve communication between team members and the patient. For example, we use the board to make sure we schedule and track specialty referral appointments, post-hospitalization visits, or post-ER visits for these patients. We also identify and try to eliminate barriers to care, such as high medication costs, a lack of transportation, or inadequate care support at home. We also give patients the phone number of their care manager for easier communication. Once a patient has improved, we remove him or her from the board, which allows the team to focus on other high-risk patients. Graduated patients are still followed up by care managers on an ongoing basis.

Over time, our initial cohort of patients saw a 50-percent drop in hospitalizations and ER visits, which they maintained for a year after being removed from the board.

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GOT A PEARL?

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