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LRPHO NewSource is a Quarterly Publication for our Clinical Providers, Office Management, Staff and Contracted Facility Members

NewSource

2026—1st Quarter Edition

7 Coding Mistakes Quietly Costing Your Practice

[by Austin Littrell - from PhysiciansPractice.com]

1. Undercoding E/M vsits out of habit

Many primary care physicians still select lower-level evaluation and management (E/M) codes based on long-standing habits rather than current guidelines. Under current rules, office and outpatient E/M levels are determined by medical decision-making or total time on the date of the encounter. When documentation supports moderate or higher complexity but a lower code is chosen out of caution, practices may consistently underbill for care that is fully compliant.

2. Not billing based on time when time is clearly supported

Time-based E/M coding is allowed when total time spent by the physician or qualified health professional on the date of the encounter meets the requirements for a given visit level. This includes both face-to-face time and certain non-face-to-face work performed that same day, such as reviewing records, documenting and coordinating care. Despite documenting total time, many clinicians still default to medical decision-making or select a lower-level code. This is especially common during visits involving extensive counseling, complex chronic disease management or coordination with outside providers.

3. Missing add-on codes or modifiers when payer policy allows them

Some revenue loss occurs not because physicians are unaware of codes but because add-on codes or modifiers are overlooked during routine billing. When documentation supports additional, distinct work — and payer policy allows billing — these services may be eligible to be reported alongside a primary E/M visit.
The problem is often workflow-related. Documentation supports the work, but the billing process fails to capture it consistently. Over time, missing allowable add-ons or modifiers can quietly reduce revenue without triggering denials or compliance concerns.

4. Failing to update ICD-10 specificity as documentation improves

Physicians often document clinical detail that exceeds the diagnosis code ultimately submitted.
When International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes are not updated to reflect the appropriate level of specificity, claims may still be paid, but documentation and coding become misaligned. Accurate diagnosis coding supports medical necessity and clean claims. In Medicare Advantage and other risk-adjusted payment models, diagnosis specificity can also affect risk adjustment, though not all ICD-10 codes are risk-adjusting.

5. Treating all payers like Medicare

Medicare coding rules are widely understood, but commercial insurers and Medicare Advantage plans may apply different coverage policies, documentation expectations or payment rules. Applying Medicare logic universally can lead to missed reimbursement or avoidable denials. Practices that do not track payer-specific differences may undercode defensively or fail to appeal inappropriate adjustments. Understanding how major payers interpret E/M services and modifiers can materially affect revenue over time.

6. Letting EHR templates drive coding instead of clinical reality

Electronic health record (EHR) templates can improve efficiency, but they can also limit how clearly complexity is captured. Templates that are overly generic or not periodically reviewed may fail to reflect the true scope of medical decision-making or time spent. When documentation does not fully support the care provided, coders are constrained in what they can bill, regardless of what occurred clinically. Templates should support accurate coding, not dictate it.

7. Assuming coding rules don't change often

Coding and documentation requirements evolve every year, even when visit workflows stay the same. Updates to Current Procedural Terminology, ICD-10-CM and payer guidance can change how services are reported or interpreted. Practices that do not periodically review these updates may continue using outdated assumptions, leading to systematic undercoding. Staying current does not require constant retraining, but it does require

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CARTOON CORNER

Ten ways to motivate your staff

Treat them as individuals

Not everybody is the same, find out what makes them tick, their interests and aspirations and explore how the business might help them realise them.

Maintain good communication

Keep regular contact with your direct reports, in one-to-one catch-ups or team meetings. It helps develop relationships and facilitates feedback in both directions.

Promote honesty and transparency

Be honest with people about their performance and what is going on in the organisation. Get rid of the rumour mill – it's corrosive.

Build mutual trust and respect

Building trust is about giving someone space to do a task, being there to help if needed and recognising when they do a good job. Don't micromanage – it's very demotivating.

Be Flexible

Offering, where possible, a flexible environment to work in can be incredibly valuable for some staff, particularly for those with caring responsibilities at home.

Give credit where it's due

Employees appreciate recognition of a job well done. It doesn't have to be monetary, it could be an announcement in a staff meeting or simply verbal praise.

Offer training and development

Opportunities to learn and try new things don't just exist in formal training courses, it could take the form of carrying out research or heading up a standalone project.

Show your human side

This can be a challenge the larger the business gets. Facilitating volunteer or charity work shows that the organisation values more than just profit.

Make it fun where you can

Fun at work can get lost if you're under pressure, but allowing occasional distractions or treating staff to a day out or team lunch can help regenerate spirits.

Make it a great space to work

Invest, if you can, on good quality equipment that doesn't constantly break down, and ensure your offices and shared spaces like the kitchen are clean and pleasant to work in.

VERY IMPORTANT REMINDER:

PLEASE ALWAYS make sure, BEFORE RETURNING TO US, that the *REFERENCES [Professional Peer] Section* on the Credentialing Application is COMPLETED and that a CURRENT/VERIFIED EMAIL ADDRESS and FAX NUMBER for EACH listed REFERENCE is provided. This missing information will delay the completion of the application. THANK YOU!

Access Before Appointment: How Response Time Affects Patient Engagement and Practice Outcomes

[by Heather Reaves - from www.physicianspractice.com]

Patient perception of access has quietly become one of the most important signals in healthcare delivery. Long before patients walk into the clinic or engage in a clinical assessment, they form impressions based on ease of access, responsiveness, and clarity around next steps. For busy practices striving to balance patient flow, care quality, and operational efficiency, the first response moment has become a benchmark of organizational reliability.

When Communication Becomes Care Access

Despite the rise of online portals and digital forms, phone communication remains a dominant channel for scheduling appointments and initiating care in outpatient settings. Across medical offices, research consistently shows that most new and acute visits begin with a phone call. When calls go unanswered, patients do not always retry the same office. Many simply seek the next provider who responds faster, delaying or abandoning care.

The Operational Toll of Missed Access

Missed appointments cost the U.S. healthcare system more than $150 billion annually in lost revenue and inefficiency, with individual providers reporting an average of around $200 in lost revenue per unused appointment slot. Missed calls are frequently the first failure point that leads to unused appointments, idle capacity, and last-minute scheduling pressure.

Wait Times and Patient Perceptions

Longer hold times and slower responses correlate with poorer patient perceptions of access and lower satisfaction. Patients who encounter repeated communication barriers during scheduling or early outreach are significantly more likely to disengage and seek care elsewhere.

Efficiency vs Perfection: Rebalancing Early Responses

Applying clinical standards of completeness to the first response moment often creates unintended delays. Early acknowledgment does not require full resolution. It signals attention, reduces uncertainty, and preserves the therapeutic relationship.

Scheduling Friction and Practice Stability

When patients cannot schedule appointments that fit their routines, they delay care or request last-minute accommodations, increasing lateness and no-shows. Practices that support routine-aligned scheduling see better adherence and smoother workflows.

A Quiet Standard Shift

The practices that thrive are not perfect in every response. They are consistently responsive. Fast and friendly is not a shortcut. In medical practice, it is now the baseline expectation for access.

RRMC Trauma Grand Rounds

ECMO & TRAUMA USAGE

[A Live CME Event – *1.5 AMA PRA Category 1 Credit(s)™* offered]

March 25, 2026

Cayefuego Restaurant
3632 Monroe Hwy
Pineville, Louisiana
5:30 – 7:00 p.m.

[Dinner will begin @ 5:30 p.m.]

Critical Care Physician and ECMO Medical Director – Medical City Dallas

Speaker:
Andrew S. Fredericks, M.D.

RSVP to Shawn Moreau: shawn.moreau@researchcollege.edu

SAVE THE DATE

2026 Trauma Symposium

Friday, May 8, 2026
Randolph Riverfront Center
Downtown Alexandria

Rapides Regional Trauma Center

How to Cut No-Shows in Your Practice

[by Keith A. Reynolds - from www.physicianspractice.com]

What exactly counts as a no-show?

Before you can reduce no-shows, you have to agree on what you're measuring. Is a no-show someone who never arrives? Someone who shows up 25 minutes late and can't be worked in? Someone who cancels two hours before a visit? It sounds basic, but this is where many practices trip up. And it's also where documentation becomes your friend, especially for follow-up needs and risk management. If you want a clean framework for what to record and why, Physicians Practice has a practical guide to documenting no-shows.

What's the quickest win that doesn't add work for staff?

Two-way reminders. Not "we left a voicemail." Not "we sent an email that nobody opened." Actual reminders that let patients confirm or reschedule without a phone tag marathon. If you're building a texting workflow, you can borrow language and timing ideas from this Physicians Practice walkthrough on how to text appointment reminders. The best reminder system in the world doesn't help if it can't reach anyone.

When should reminders go out?

You don't need to overthink this, but you do want more than one touchpoint. A cadence many practices can pull off: 1 week out: "Confirm or reschedule", 48 hours out: "Confirm plus here's what you need to know", Day of (2 to 4 hours before): quick nudge plus a "running late?" option.

What should the reminder message actually say?

Keep it short, clear, and easy to act on, because if a patient has to search for the time, address, or what to do if they can't make it, you've already lost. Easy templates: "Reminder: Dr. Patel visit Tue 2/25 at 2:20 p.m. Reply C to confirm or R to reschedule." / "Need to switch? Call 555-0101 or reschedule here: [link]" / "Running late? Reply L and we'll tell you if we can still see you." Also, practices that use texting for more than reminders, like outreach and care gaps, often see better engagement overall.

Should we charge a no-show fee?

Sometimes. But fees are the hard edge of the policy, and they tend to work best when the practice has already done the basics: reminders, easy rescheduling, and a clearly communicated cutoff window. If you go the fee route: Put it in writing and get acknowledgment, use a clear cutoff (for example, 24 business hours), consider one annual forgiveness. Apply it consistently and document exceptions.

Do written policies help, or do they just annoy people?

A clear policy helps patients, but it really helps your staff. It gives everyone the same script and reduces inconsistent enforcement. What if our no-shows are really an access problem? That's common. Some no-shows are just friction: patients can't get through, can't find a slot that works, or give up when scheduling is slow. Access fixes that usually help quickly: Allow online scheduling for appropriate visit types, keep a few rapid access slots each day, add a text-enabled waitlist for earlier openings and tighten callback standards for scheduling requests.

What do we do about repeat no-shows without torching the relationship?

Think escalation, not punishment. A common ladder: After 1: friendly outreach plus confirm the best contact method ; After 2: require confirmation to keep the appointment; After 3: limit advance scheduling, or consider dismissal with your policy and documentation in order.

What should we document after a missed appointment?

At minimum: that the patient missed the visit, what outreach you attempted, and what follow-up steps you advised, especially when clinically important results or symptoms are involved. Quick documentation checklist:
Missed appointment date/time plus visit type; Outreach attempts (call/text/portal) with dates/times; Patient response plus rescheduled date (if any); Clinical context (labs pending, abnormal results, follow-up need) and
Return precautions when relevant.