E/M Coding: Bridging the Gap Between Coders and Providers

Session Number: 6C
Session Date: Tuesday, April 15, 2014
Session Time: 11:15am-12:30pm

My Background

• Active in health care since 1998 and at Physicians’ Ally since 2007.

• Masters of Health Administration in 2006 and CPC designation in 2010

• Combination of experiences influence consulting projects

• Performed chart audits for hundreds of physicians. Usually present findings to only administrative staff or in tandem with physicians.
Objectives

1. Why your practice should care about E/M Coding
2. The most frequent E/M Coding audit findings
3. Guidelines for presenting E/M Coding to providers and staff

Objective #1

Why your practice should care about E/M Coding
Prominence E/M Codes

- Numerically, it should be at the end of the CPT coding book
- Brought to the front because this is where most services begin with a patient
- Most highly utilized codes
- Between 2001 and 2010, Medicare payments for E/M services increased by 48%, from more than $22 billion to more than $33 billion.

Source: oig.hhs.gov

Potential Fraud

- CMS definition: an intentional deception or misrepresentation that a person knows is false or does not believe to be true, and the person aware that the deception could result in some unauthorized benefit to him/herself or some other person.

- Most frequent kind of fraud: false statement or misrepresentation made that is material to entitlement or payment under the Medicare program.
**Potential Fraud continued**

In 2010, the Dept. of Health and Human Services Office of Inspector General reported that nearly 442,000 physicians billed E/M services in 2010. Of those physicians, 1,669 were found consistently to bill higher-level E/M codes.

Source: http://www.ama-assn.org/amednews/2012/10/01/gv11001.htm

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**Average Distribution of New Patient E/M Codes**

Source: MEDPAC data for benchmarking

[Graph showing average distribution of new patient E/M codes]
Verify documentation

- Recovery Audit Contractor Program
- To detect “improper” payments
- Complex medical reviews: medical records examined for billing documentation
  - Incented by amounts found in error

**RECOMMENDATION:** Conduct an internal audit!
RAC AUDITORS

The Recovery Auditor Contractor (RAC) in each region:

Region A: Performant Recovery
Region B: CGI Federal, Inc.
Region C: Connolly, Inc.
Region D: HealthDataInsights, Inc.

Physicians who practice in Region C, will be the first RAC audits to focus on claims using higher-level E/M codes (specifically, CPT codes 99214 and 99215). Auditors will review claims with dates of service as far back as Oct. 1, 2007.

Source:
http://www.amednews.com/article/20121001/government/310019952/1/

Motivation to Audit

The RAC auditors are paid based on the recoveries they are able to find. For example, RAC auditors are paid 9 to 12.5%.


Payors are motivated, too...

Sample Payor Letters

Your practice has been identified as one that billed 90 percent or higher for E/M codes at the top two levels in one or more of the E/M categories listed above. Please review your billing practices in accordance with the guidelines of the E/M section of the CPT Coding Book and the CMS 1995-1997 E/M documents guidelines.
Sample Payor Letters

Anthem Blue Cross and Blue Shield has contracted with EquiClaim to review the use of the Evaluation and Management (E/M) codes for all physicians participating in the network as part of ongoing claim review activities. EquiClaim analyzed the E/M claims paid between May 2011 and April 2012 for the purpose of identifying those physicians who are billing level 4 & 5 codes significantly more often than other physicians within the same specialty.

As demonstrated in the attached E/M Profile Report(s), the percentage of level 4 & 5 codes billed by your office is considerably higher than the expected billing distribution as determined by the average billing behavior of other physicians within your specialty.

EquiClaim will continue to monitor your billing practices, and will send updated E/M Profile Report(s) periodically. If subsequent analysis reveals that the proportion of level 4 & 5 codes continues to exceed the expected distribution, EquiClaim may contact your practice to request medical records of members with the intention of identifying any improper coding and recovering associated overpayments.

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Sample Payor Letters

In order to ensure that you and your staff understand the documentation required by AMA CPT Guidelines for high level office visits, we would like to review five clinical notes of our members. Once the review has been completed, feedback will be provided regarding the findings. Anthem will be conducting data analysis on a regular basis to ensure that the education is being applied appropriately. Please be advised that if the requested documents are not received, Anthem will assume that you wish to be exempt from receiving education and are following the Anthem's Documentation Policy for E&M correctly. However, future phases of this program may result in audits of E&M services rendered by you and your peers with respect to appropriate coding.
Denials for E/M

Palmetto GBA reviewed claims with CPT 99214 (from July to September 2012 for California, Hawaii and Nevada)

Denial rates from the reviews of thousands of claims ranged from 43.8% to 64.6%.

Most frequent reasons for denials

- Documentation inadequacy
- Coding too high an intensity
- Illegible or missing signatures

Source: “Completion of Prepayment Service Specific Complex Review for CPT Code 99214,” Palmetto GBA at http://www.palmettogba.com/palmetto/providers.nsf/docsCat/Jurisdiction%201%20Part%201~EM%20Help%20Center~Medical%20Review
Documentation is Key

The provider should document what is medically necessary and code accordingly, not learn how to code and then document.

GREAT RESOURCE:

Potential Perils of an EHR:

With the advent of EHR, documentation is becoming more consistent and complete

There are traps with an EHR:

– Every chart looks identical, no matter the complexity
– Charting errors occur due to information carried forward from previous visits or from standard documentation
– It may be in the chart, but is it on the claim?
Objective #2

The most frequent E/M Coding audit findings

Determining the correct code

“Novitas E/M Score Sheet” available at:

http://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00004968

- History
- Examination
- Medical Decision Making
Remember contributory factors

- Counseling
- Coordination of care
- Nature of presenting problem

Overall, what does the documentation support?

- Levels 3-5* are reserved for “sick” or injured patients
- Lower levels are for patients who present with minor and/or well controlled condition/s
- Level 5 is not appropriate if patient not asked to follow-up sooner than 6 months.

Verify compliance with reporting requirements

**All Three Components Required**

- History component met or exceeded
- Examination component met or exceeded
- Medical decision making component met or exceeded

FOR:

- New patients
- Initial care
- Consultations
- Emergency Department services
- Comprehensive nursing facility assessments
Verify compliance with reporting requirements

**Two of Three Components Required**

- History component met or exceeded
- Examination component met or exceeded
- Medical decision making component met or exceeded

**FOR:**
- Established patients
- Subsequent or follow-up care

**Remember: CPT 99211**

Any established patient visit in which the physician is directly involved is a 99212 at a minimum

For a 99211, the following must be documented:
- Date of service
- Chief complaint and/or reason for the visit
- Service provided and/or information conveyed to the patient
- Appropriate vital signs
- Signature of the nurse or other provider
The First Component – History

Chief Complaint (CC)

Must be present 100% of the time.

CC is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter.

The CC is usually stated in the patient’s own words (i.e. I’m here for a rash)
History of Present Illness (HPI)

**Brief:** documentation of 1-3 HPI elements.

**Extended:** documentation of 4+ HPI elements

Elements include:

**Must document:** Duration (i.e. it started three days ago)

Location. (i.e. pain in ear)

Quality. (i.e. aching, burning, radiating)

Severity. (i.e. 10 on a scale of 1 to 10)

Timing. (i.e. it is constant or it comes and goes)

Context. (i.e. lifted large object at work)

Modifying factors. (i.e. it is better when heat is applied)

Associated signs and symptoms. (i.e. numbness)

Review of Systems (ROS)

- References signs and symptoms that are taken *verbally* or with *patient intake form*.

- Both positive and negative responses are considered.

- Pertinent negatives must be documented.

- Can be documented by MA or patient but must be reviewed and documented by provider.
Example: **ROS from Chart audit:**

<table>
<thead>
<tr>
<th><strong>Review Of Systems</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General Health</td>
<td>Reviewed, no change since first visit</td>
</tr>
<tr>
<td>Constitution</td>
<td>Good</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Ears, Nose, Mouth, Throat</td>
<td>Negative</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Negative</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Negative</td>
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<tr>
<td>Genitourinary</td>
<td>Negative</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Negative</td>
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<tr>
<td>Integumentary</td>
<td>Squamous cell carcinoma</td>
</tr>
<tr>
<td>Neurological</td>
<td>Negative</td>
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<tr>
<td>Psychiatric</td>
<td>Negative</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Negative</td>
</tr>
<tr>
<td>Hematologic/Lymphatic</td>
<td>Negative</td>
</tr>
<tr>
<td>Allergic/Immunologic</td>
<td>Negative</td>
</tr>
</tbody>
</table>

**Past, Family and/or Social History (PFSH)**

**Pertinent:** 1 patient history reviewed  
**Complete:** 3+ patient history reviewed  

**History defined as:**

**Past History** = The patient's past experiences with illnesses, operations, injuries/treatments, and medications.

**Social History** = An age-appropriate review of past and current activities, for example occupation, smoking, alcohol use (EtOH), sexual activity, marital status.

**Family History** = A review of medical events in the patient's family, including age at death, diseases which may be hereditary or place the patient at risk.
The Second Component – Exam

CMS Guidelines

• 1992: E/M codes first introduced
• 1995: First set established
• 1997: Second set of guidelines published
  (expanded exam guidelines)
• 2000: Third set drafted, but tabled

• CMS instructs carriers and providers to use either 1995 or 1997 guidelines

• WHAT DOES YOUR PRACTICE USE???
### Specialty Exam Sample Sheet

#### Dermatology

<table>
<thead>
<tr>
<th>Performed and Documented</th>
<th>Level of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to five bullets</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>Two to seven bullets</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>At least nine bullets</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

#### Elements of Examination

- **History of Present Illness (HPI):**
- **Past Medical History (PMH):**
- **Social History:**
- **Physical Examination:**
  - **Head and Neck:**
  - **Cardiovascular:**
  - **Respiratory:**
  - **Gastrointestinal:**
  - **Neurological:**
  - **Endocrine:**
  - **Musculoskeletal:**
  - **Skin:**
  - **Lymph:**

#### Negative Exam Findings

- A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described. Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented.
Medical Decision Making is subjective

• Quick review of the complicated system behind Medical Decision Making.

• However... how a provider feels when walking out of a patient room always matters.
  ➢ Which is why documentation is so important.
Diagnosis/Management

• Problems are defined relative to the provider, not the patient.

• For each encounter, an assessment, clinical impression, or diagnosis should be documented.

• Problems which are not being addressed specifically by the provider during the encounter may still be counted if they significantly increase the complexity of the cognitive labor required.

• The initiation of, or changes in, treatment should be documented.

Data Amount/Complexity

• If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service (i.e. lab), should be documented on the exam form (in addition to the fee ticket). When applicable, the review of lab, radiology and/or other diagnostic tests should be documented.

• The review may be documented by initialing and dating the report containing the test results.
Table of Risk

Risk is somewhat subjective, so the more documentation to support the level of risk, the better.

EXAMPLE
Refer to Novitas Score Card

Please remember: Risk is somewhat subjective, so the more documentation to support the level of risk, the better.

Objective #3

Guidelines for presenting E/M Coding to providers and staff
Audit Results #1 – Sample of Findings

- Physicians’ Ally audited 4 charts (Code CPT 99213, CPT 99214, and CPT 99215, and one additional code) for each of the 16 providers for a total review of 63 charts.

The overall findings from the 63 charts audited are as follows:
- 46% (29 charts) were coded correctly
- 5% (3 charts) were under-coded
- 8% (5 charts) were on the borderline of being over-coded
- 37% (23 charts) were over-coded
- 5% (3 charts) were not legible to determine correct coding (for two specific providers)
Evaluation and Management

Audit Results #1 – Sample of Findings

As with any audit, the interpretation can be subjective. Physicians’ Ally’s approached this audit from a health plan auditor’s perspective and did not provide “benefit of the doubt” to the provider. The findings indicated the reason called the internal audit (the potential over-coding of CPT 99214), which was exactly where the predominant amount of incorrect coding occurred. Among providers, the areas representing over-coding were consistent and Physicians’ Ally is confident that with a few recommended adjustments to the documentation and charting process, future audits would indicate correct coding.

Audit Results #2 – Sample Detail

<table>
<thead>
<tr>
<th>Date</th>
<th>Bill Code</th>
<th>No. Form</th>
<th>C Cuts</th>
<th>ROS</th>
<th># Pts</th>
<th>History</th>
<th>Exam</th>
<th>Dy/Managing</th>
<th>Complexity</th>
<th>Risk</th>
<th>Audit Code</th>
<th>Notes</th>
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Evaluation and Management
Audit Results #2 – Sample Summary

Findings: Of the eleven charts audited, Physicians’ Ally determined that all charts were coded one level higher than the documentation supported. The two charts coded as 99215 fully supported a 99214. Eight charts coded as 99214 fully supported a 99213. One chart coded as a 99214 fully supported a 99203 (this was the only new patient chart provided).

The details of the audit are listed [in the slide before]. Elements highlighted in yellow are expanded upon in the Notes column and indicate audit findings in addition to the recommendations indicated.

Audit Results #3 – OVERALL FINDINGS:

<table>
<thead>
<tr>
<th>Appropriately coded</th>
<th>% of Charts</th>
<th>Dollars Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Overcoded</td>
<td>11</td>
<td>$512.38</td>
</tr>
<tr>
<td>Undercoded</td>
<td>19</td>
<td>-$833.25</td>
</tr>
<tr>
<td>TOTALS:</td>
<td>75</td>
<td>$320.87</td>
</tr>
</tbody>
</table>

Per Chart: +$4.28
OVERALL FINDINGS

Use same Pain Scale to present them

E/M CODING: Overall Findings

- Preventive
- 1
- 2
- 3
- 4
- 5

60%
History: Overall Findings

Exam: Overall Findings
MDM: Overall Findings

Coding by Time: Overall Findings
Coding by Time –  
When you can code by time

When counseling and/or coordination of care dominates (more than 50%) of the provider/patient encounter, time is considered the key or controlling factor to qualify for a particular level of E/M service if there is sufficient documentation.

Coding by Time –  
Documentation is ESSENTIAL

The Chart Documentation must support the time, and must list the total time of the encounter and that the coding was based on counseling regarding:

- Diagnostic or Treatment recommendations
- Prognosis
- Risks and benefits of treatment options
- Impressions
- Instructions for management
- Risks and benefits of management options
- Importance of compliance with chosen treatment options
- Risk factor reductions
- Patient and family education
- Discussion of test results
- Education for compliance
Evaluation and Management

Coding by Time – Guidelines

To determine the appropriate Code by Time, the guidelines are as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>If Average Minutes of Visit in general to support the Code…</th>
<th>…Then Actual Minutes of Counseling to support the Code by Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>5 minutes</td>
<td>3+ minutes</td>
</tr>
<tr>
<td>99212</td>
<td>10 minutes</td>
<td>6+ minutes</td>
</tr>
<tr>
<td>99213</td>
<td>15 minutes</td>
<td>8+ minutes</td>
</tr>
<tr>
<td>99214</td>
<td>25 minutes</td>
<td>13+ minutes</td>
</tr>
<tr>
<td>99215</td>
<td>40 minutes</td>
<td>21+ minutes</td>
</tr>
</tbody>
</table>

For example, if you were with an existing patient who would be a CPT 99213 (average 15 minutes) based on the documentation criteria, but you spent 15 minutes counseling the patient for a total of 25 minutes, then you could bill CPT 99214.

The Average Minutes of a Visit is a great guideline even if you are not Coding by Time. For example, if you choose CPT 99214, but you document that the visit only took 15 minutes (average minutes for a CPT 99213 office visit), it is important to confirm that the documentation supports the CPT 99214.

Potential Coding Opportunity?

Consultations - Office or Other Outpatient

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History*</th>
<th>Exam*</th>
<th>Medical Decision Making*</th>
<th>Problem Severity</th>
<th>Time Spent Face to Face (avg.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>Problem-focused interval</td>
<td>Problem-focused</td>
<td>Straight-forward</td>
<td>Minor or self-limited</td>
<td>15 min.</td>
</tr>
<tr>
<td>99242</td>
<td>Expanded problem-focused interval</td>
<td>Expanded problem-focused</td>
<td>Straight-forward</td>
<td>Low</td>
<td>30 min.</td>
</tr>
<tr>
<td>99243</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low complexity</td>
<td>Moderate</td>
<td>40 min.</td>
</tr>
<tr>
<td>99244</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate complexity</td>
<td>Moderate to high</td>
<td>60 min.</td>
</tr>
<tr>
<td>99245</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High complexity</td>
<td>Moderate to high</td>
<td>80 min.</td>
</tr>
</tbody>
</table>

*: Key component. All three components are crucial to select the correct code.
Questions?

Thank You!

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