The Quest for Independence

STAKE YOUR CLAIM to medical practice freedom

PLUS: TAKING ON RISK
What you need to know about the new world of physician payments
As an employee, I had absolutely no control of my own schedule. They just wanted to run as many people through there as they could.”

—BRIAN FORREST, MD, DIRECT PAY PIONEER

$54,000

The amount it will cost physicians to upgrade an EHR to meet meaningful use stage 3

WHY SOME PHYSICIANS ARE OPTING OUT: PAGE 38

“It’s all coming down to the data. That’s how we’re going to be judged, whether we like it or not.”

—STEVEN DUKES, MD, ON TAKING ON PAYMENT RISK

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OWNING A PRIMARY CARE PRACTICE HAS RARELY—IF EVER—BEEN MORE CHALLENGING THAN IT IS TODAY. FROM STAGNATING REIMBURSEMENTS TO CONFLICTING GOVERNMENT MANDATES TO EVOLVING TECHNOLOGIES, SOMETIMES THE ODDS AGAINST SUCCESS—AND THE TEMPTATION TO LEAVE INDEPENDENT PRACTICE AND WORK FOR SOMEONE ELSE—CAN SEEM OVERWHELMING. FORTUNATELY, IT DOESN’T HAVE TO BE THAT WAY. THERE ARE PHYSICIANS WHO ARE BEATING THE ODDS.

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FIGHTING BACK, PT. 1:
OVERCOMING CHALLENGES

Owning a primary care practice has rarely—if ever—been more challenging than it is today. From stagnating reimbursements to conflicting government mandates to evolving technologies, sometimes the odds against success—and the temptation to leave independent practice and work for someone else—can seem overwhelming. Fortunately, it doesn’t have to be that way. There are physicians who are beating the odds.

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Every physician receives assessments of what patients are missing, what they need, and what medicines they shouldn’t have. I don’t know of anybody who reads them because *the one thing they have in common is that they’re never applicable to the patient*.

**Susan Hawn, MD, ATHENS, GEORGIA**

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**PROFIT IS REAL REASON BEHIND PRIOR AUTH RULES**

The article, “Experts: Prior authorizations are here to stay, but could get easier” (June 25, 2015) was a lovely propaganda piece. If you say a thing long enough and often enough, people come to believe it, including the speaker.

Laura Coughlin states, “[prior authorizations will continue]...because the desire to ensure people are getting safe effective quality care is not going to go away.” She completely left out the most important operator or the actual complete phrase, “...safe, effective quality care designed to save as much money as possible for the CEO to take home at the end of the year.”

She may get away with that when addressing the Rotary Club but not with physicians. (And isn’t ensuring safe, effective quality care not the physician’s job rather than a bean counter’s?) Later, she asserts that physicians can’t keep up with “the velocity of change.”

Although the government and insurance companies work as hard as they can to consume our time with stupid, mind-numbing documentation that adds nothing to patient care, we do keep up. Insurance companies and pharmacy benefit managers, not so much.

Every physician receives assessments of what patients are missing, what they need, and what medicines they shouldn’t have. I don’t know of anybody who reads them because the one thing they have in common is that they’re never applicable to the patient.

“Quality of care” measures are frequently flawed or out of date. Not adhering slavishly to every newly-promulgated guideline does not indicate ignorance but may represent disagreements.

Before the bean counters rush to say that not following all EBM is arrogant, ask Ms. Coughlin to have her secretary (because we know she does not do mind-numbing paperwork herself) to Google how many times the recommendations for blood pressure treatment have changed in the last 20 years, including several turns through the “evidence-based medicine machine.” And they have miraculously landed pretty much back to the numbers recommended then.

Finally, Patrick Dunham asserts that prior approvals originated as a “safety measure.” This one almost makes you giggle. Who is he talking to? The local garden club? Is he so young he doesn’t remember that coincidentally these “most powerful medications” were also the most expensive? That there was never any question but that it was all about money?

They would do much better to stay away from the “garnish” and just be forthright about the fact that prior approvals have one object and that is to keep healthcare costs down and their profits up. Being honest.
from the Trenches

The documentation [for chronic care management billing] is...unreasonably burdensome. My already overstretched staff revolted at the idea, even when offered half the potentially sizable pot. No one is going to use these codes...because the codes are impossible to use, just a gesture, not for real.”

Bob Williams, MD, OPP, ALABAMA

BILLING FOR CHRONIC CARE NOT WORTH THE TROUBLE

We do piles of chronic care management, and had high hopes for the new CCM billing opportunities, (“Chronic care management success,” March 25, 2015) but find the rules for billing are so onerous that they have made the project a cruel joke on hard-working primary care providers.

Under the Medicare rules, the patient has to agree, in writing, to pay his or her part, about $10/month. Why would a patient agree to pay for something that they’re already getting for free? (The CCM concept acknowledges that PCPs are already doing this work, unpaid.)

Another game-stopper is the requirement that the physician be available to the patient around the clock, 24-7, year-round. These last facts are not mentioned in your recent article on the matter.

The documentation is also unreasonably burdensome. My already overstretched staff revolted at the idea, even when offered half the potentially sizable pot. No one is going to use these codes, not because physicians are ‘unwilling to change’, but because the codes are impossible to use, just a gesture, not for real. As usual, bureaucratic overkill and rule-making enthusiasm are the obstacles.

Susan Hawn, MD
ATHENS, GEORGIA

MALPRACTICE SYSTEM HURTS DOCTOR-LAWYER DIALOGUE

Joseph C. Eichel, MD’s response (“Advice on midlevel liability is flawed,” April 25, 2015) to Christopher Bernard, JD’s article (“Physician liability for the actions of midlevel providers”, February 25, 2015) was right on.

The attorney’s comment that midlevel providers do not increase physicians’ liability because payments made on their behalf were much lower than for doctors may be true but is also misleading. Why? Because the midlevels generally are not responsible for making critical decisions on complicated patients.

The point is that because doctors have greater exposure to liability, Eichel’s suggestion that suing the doctor has greater profitability potential than suing the midlevel provider is understandable. As long as the adversarial nature of the plaintiffs’ trial bar and its predilection to pervert the truth persist, constructive dialogue between doctors and plaintiffs’ lawyers will remain difficult.

Edward Volpintesta, MD
BETHEL, CONNECTICUT
ICD-10 FLEXIBILITY

MEDICARE WON’T DENY PAYMENT FOR SPECIFICITY CODING ERRORS

The U.S. Centers for Medicare and Medicaid Services and the American Medical Association announced in late July that ICD-10 compliance for physicians will have increased flexibility to reduce financial penalties from coding errors.

For one year up after the October 1, 2015, transition to ICD-10, Medicare claims will not deny codes “based solely on the specificity of the ICD-10 diagnosis code” so long as the code is from the right family. For example, the family code for type 2 diabetes is E11, which contains a number of subcodes that can expand to as long as seven digits depending on the specificity of the code.

Valid ICD-10 codes will still be required after October 1, and ICD-9 codes will not be accepted because Medicare’s claim processing systems won’t have the ability to accept them any longer.

5 efforts to make ICD-10 Easier for physicians

1. Medicare won’t deny claims solely based on diagnosis code specificity if the code used is in the correct family of codes.

2. Claims will not be audited in the first year based on specificity of diagnosis codes.

3. In some cases, Medicare may authorize advance payments to physicians if ICD-10 claims can’t be processed.

4. CMS will establish an ombudsman’s office, which will work with CMS’s regional offices to address physician issues and concerns.

5. Physicians will not be penalized by meaningful use, PQRS, or value-based modifier regarding specificity of ICD-10 codes, so long as codes are in the correct family.

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Physician advocates take aim at Aetna-Humana, Anthem-Cigna mergers

A WAVE of proposed mergers among the nation’s largest payers has raised questions about what the increasingly consolidated insurance market will mean to physicians.

In recent months, Aetna agreed to purchase Humana in a $37 billion deal, while Anthem announced its buying Cigna for $54 billion. If these two deals pass regulatory muster, that means the big five payers—these four and UnitedHealthcare—will become the big three, reshaping the insurance marketplace in ways that will have wide-ranging consequences for physicians and patients alike.

Physician advocates, notably the American Medical Association, are concerned that the mergers will harm patient choice and reduce competition. “We have long cautioned about the negative consequences of large health insurers pursuing merger strategies to assume dominant positions in local markets.”

The AMA notes that, based on federal guidelines, the proposed Anthem-Cigna merger would be considered anti-competitive in nine of the 14 states in which Anthem provides coverage.

No one knows yet what action federal and state regulators will take, but an analysis of the recent merger activity published in Health Affairs suggests the impact on physician payments may be a factor considered during the review.

“Complicating the analysis even more is the possibility that the government might find a competitive harm resulting from a merger’s effect on providers, that is, the enhanced market power of the merged firm might enable it to ‘unduly reduce’ payment to physicians,” the author writes.

These mergers are far from done deals. Each merger will be examined for anti-trust consideration in each of the states and regions where the companies do business, according to the New York Times.

“Antitrust laws that prohibit harmful mergers must be enforced and anticompetitive conduct by insurers must be stopped,” Stack says.

The lack of competition clearly exists today and speak loudly against any further consolidation in the health insurance industry. Bigger insurance companies mean increased leverage and unfair power over negotiating rates with hospitals and physicians.”

– REID BLACKWELDER, THE BOARD CHAIRMAN OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

The U.S. Centers for Medicare and Medicaid Services (CMS) is seeking public input on the future of Medicare payments. The merit-based incentive payment system (MIPS) and alternative payment models (APMs) are poised to go into effect starting in 2019, and will consolidate many physician evaluation programs such as meaningful use, physician quality reporting system (PQRS), and the value-based modifier program.

CMS is seeking input on three aspects:

1. **Volume threshold**
   Should CMS only subject physicians to MIPS if they reach a certain threshold of Medicare patients in their practice?

2. **Clinical practice improvement**
   What activities should be classified as clinical practice improvement activities?

3. **Alternative payment models**
   What criteria should be used for assessing APMs? What quality measures and other requirements should be considered?
Tracking your denials will be critical after October 1, 2015. Classify them and get to the root cause.”

—Renee Dowling CODING CONSULTANT
The last lesson

I knew there was something wrong when I visited her at her home. I had known her for a long time, and she was in reasonably good health, except for moderate dementia, for a woman of 91, soon to be 92. Normally she would have done anything to stay away from the hospital, but she looked pale, felt weak, and had been having some blood in her stools.

When I told her I thought she needed to come to the hospital, she paused a moment, looked at me and whispered, “Okay...okay.”

That was Friday. By noon Saturday, she felt better after two units of blood and looked more like the woman I knew. The CT scan that morning confirmed what I suspected, a malignancy, but not in the intestine.

Rather, a tumor of the pancreas was present with evidence of metastasis—a death knell for a patient of 91.

THE SLOW, CONTEMPLATIVE WALK
Those of us who care for patients are all too familiar with that walk down the hall to a patient’s room to give him or her bad news. We know that in the span of a few minutes we will significantly and irrevocably change the course of that person’s life. It is a slow, contemplative walk, almost like a walk down death row as in some cases, we are delivering just that.

She had just finished breakfast; her husband was visiting her. After a cheery, “Good morning,” and exchange of the usual pleasantries, I sat on the edge of her bed and tenderly held her hand as I conveyed the bad news. I’m not sure exactly how I expected her to react—tears, sorrow, anger?

Instead she looked at her husband of 67 years, then at me and with a tone of resignation, and perhaps relief, said, “Well...I’ve lived a long life and I’m ready to die.”

She had been trying to hold her dementia at bay by looking at familiar pictures and playing endless games of 5-card stud poker on her iPad. Her husband had begun writing everything down on a notepad in the kitchen, but even then she asked the same questions over and over.

Her 89-year-old sister and life-long best friend came to live with them to provide the additional care that her 92-year-old husband would find difficult. Between the two

“For my patients for whom a cure is not possible, I vow to them relief of pain and compassionate care.”

Roger Wujek, MD is a family physician in Litchfield, Illinois

HONORABLE MENTION

Roger Wujek, MD
is a family physician in Litchfield, Illinois

2015 ANNUAL PHYSICIAN WRITING CONTEST

Medical Economics is proud to unveil the honorable mention entries in our 2015 Physician Writing Contest. We believe the essays exemplify what connecting with your patients is truly about, and demonstrate the levels of heart, determination, and empathy you strive to bring into every exam room, every day. Thanks for reading.
of them, she was never alone. What I thought would be two to four weeks stretched to nine weeks. This additional time, an unexpected blessing, provided opportunity for her to visit with all her family, attend birthday parties for two of her great grandchildren, and hear the things her family needed to say about love, loss, gratitude, and the sorrow that would fill them when she was gone.

Medication and compassionate care from hospice kept her comfortable for the most part. I visited her often. In the evening before her passing, when she was taking a turn for the worse, I whispered in her husband’s ear that I thought she might have a very bad night and to call me. He called me at 2:20 in the morning to say that she “...was having a hard time dying.”

I've cared for dying patients before and had planned for this eventuality, arriving at their home with morphine and lorazepam in hand to help her comfortably transition from this world. I had promised all my terminal patients that they would not die in pain. Unfortunately, when I arrived a few minutes later, she had already passed.

HIPAA regulations would preclude me from mentioning her by name, but suffice it to say that I had known her all my life and I called her mom.

TRADING COMFORT FOR LONGEVITY

It is said that dementia is the last of life’s great lessons in patience, love, kindness, and understanding that your parents give to you.

During that last nine weeks, I learned more about the value and importance of these to patients who are dying or demented than what my 35+ years in practice taught me. I learned the importance of sustained family contact, of open, loving, and caring conversation, of relieving pain and suffering, and of the value of the most important but perishable resource of all, time.

For my patients for whom a cure is not possible, I vow to them relief of pain and compassionate care. They don’t need to come to my office to see me; I’ll make a house call to see them. I work closely with the hospice nurses, aides, and chaplains as a team, and I give the families my cell phone number to call me with any questions and concerns at any time. (And by the way, patients and families have never abused this.)

As clinicians we all too often ameliorate our emotions by offering technology as a substitute for compassionate listening, complex surgical procedures in place of reason and understanding, and the hope of a healthy and endless life instead of the reality that all life is finite.

By failing to have discussions about the quality of life, we often spend countless hours in search of the elusive quantity—trading enjoyment for time, comfort for longevity.

Thanks, Mom, for this last most valuable and enduring lesson.

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The Quest for Independence

Stake your claim to medical practice freedom

by JEFFREY BENDIX, MA Senior Editor

The fight against the pressures facing independent primary care practices can take many forms. For some, it has meant joining forces with other practices to attain the benefits that come with size without sacrificing their day-to-day autonomy. Others are taking a different route—minimizing the bureaucratic obstacles to practicing medicine by adopting direct pay practice models."
INDEPENDENCE THROUGH DIRECT PAY

The lure of a direct pay model became apparent to Brian Forrest, MD, after working as an employed physician with two large integrated systems in his native North Carolina. “As an employee I had absolutely no control of my own schedule. They just wanted to run as many people through there as they could,” he says. “It was all based on how many people you could roll through the door and how good a coder you were.”

He recalls the aftermath of one day where he saw 63 patients. “I couldn’t sleep that night, wondering ‘what did I forget? How many tests did I miss, how many prescriptions didn’t I give?’

Forrest’s solution was to found Access Healthcare, which he describes as “a direct primary care micro practice model,” in Apex, North Carolina. Apex accepts no third-party reimbursements, either public or commercial. Instead, patients pay a monthly membership fee ranging from $45 to $85, plus a $20 “scheduling charge” to cover the variable overhead of the visit, primarily lab work.

The different fees are designed to cover additional services, Forrest explains. While the overwhelming majority of patients opt for the basic $45 monthly charge, for an additional $20 per month Access will provide a patient with up to four generic prescription medications. “If the patient can pay just one monthly fee and not have to bother with going to the pharmacy to get their prescription filled, it’s something they really like,” he says.

Other services beyond the basic level Access can provide include monthly massages and visits from a dietician, who will go grocery shopping with the patient and teach him or her how to read nutrition labels. “These are all services people told us they needed over the years,” Forrest says. “Imagine for $20 a month having someone come to your house 12 times a year and be willing to shop with you or review food diaries. We’ve had three patients in the last year who’ve lost over 100 pounds doing this.”

Forrest estimates Access’s net profit per patient is two to three times that of the typical fee-for-service primary care practice, despite charging patients about 80% less than the typical practice. He’s able to accomplish that by keeping overhead low. The practice has three providers including Forrest, and two staff members who function as medical assistants, receptionists, and referral coordinators. (Forrest calls them “the ultimate cross-trained patient care coordinators.”)

“They are able to handle all that since we don’t file insurance there’s no reasons for billing and coders, and all that bureaucracy goes out the window,” he explains. “It’s a complete contrast to the idea of traditional insurance, where three-fourths of your job is making sure you get paid for the visit.”

Forrest says he schedules one patient per hour, even though most visits take less time than that, so as to create availabilities for walk-ins. During a typical eight-hour day he will see between 12 and 15 patients.

Access also looks to technology—specifically, its electronic health record system—to help improve efficiency and keep costs down. Without having to worry about meaningful use and Medicare quality initiatives, Forrest says, providers can focus on using the system for charting.

“We use an EHR that’s really intuitive and that allows me to get all my notes done in about 30 seconds per patient and in a much more complete way than when I was writing them down or dictating them,” he says. “Now when a patient walks out our door their note’s completely done.”

The system’s e-prescribing feature is also a significant improvement over writing out prescriptions manually, he says, particularly when refilling multiple medications for a patient. Instead of having to write the patient’s name and medica-
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Fighting back, part 2

As an employee I had absolutely no control of my own schedule. They just wanted to run as many people through there as they could.”

—BRIAN FORREST, MD, APEX, NORTH CAROLINA

Financing for her start-up is coming from proceeds of the house her family sold when they left North Carolina to return to Louisville, along with a loan from her husband. “I don’t want to take a public loan if I don’t have to,” she explains.

To begin building up a patient base, Klein is contacting pediatricians in the Louisville region, many of whom she knows from her previous practice. “I tell them, ‘this is what I’m doing and I’d really appreciate if you’d refer me patients,’” she says. “They’ve all been very supportive and say just let us know when you go live.”

She also plans on visiting many of them personally with gifts of organic fruit and vegetables, rather than more traditional fare like donuts and pizza. “I feel like I should practice what I preach,” she explains. “Also, my focus is going to be on a more personalized type of preventive approach, so I feel like getting off on that sort of foot would be beneficial.” A marketing communications firm is developing a logo and website for the practice.

Klein acknowledges that self-employment will bring its own challenges, including a reduction in income. But she’s willing to accept those in return for the ability to practice medicine how she sees fit. “The only way I can do what I want is as a business owner.”

23

tion directions on each script, “now you can do each of those refills in less than five seconds. And when the bulk of people’s prescriptions don’t necessarily change every visit, it really speeds that workflow up.”

Access recommends a mail-order pharmacy to its patients that, in addition to being cheaper than most retail pharmacies, will generate a weekly report of which patients didn’t take delivery of their prescriptions. “We love that, because it allows us to call the patient and say ‘we sent this prescription but apparently you told the pharmacy not to fill it, and what happened there?’ It really helps with compliance,” Forrest says.

Forrest says he is contacted frequently by other doctors wanting to know about his model.

Typically, “they either sold their practice to a hospital system or they went to work for a system right out of residency, and now they’ve had enough, because they’re seeing the same things I did. It’s all based just on seeing as many patients as they can and coding as high as they can. We’re seeing a huge number of those folks saying they want to change over to a direct care model where they don’t have to deal with that baloney.”

RETURNING TO INDEPENDENCE

Lisa Klein, MD, FACC, a pediatric cardiologist in Louisville, Kentucky, is one who has tired of “the baloney” that frequently accompanies health system employment and has decided to strike out on her own. When she spoke with Medical Economics she had recently given notice at UK Healthcare and was in the process of setting up her own practice.

“I decided to leave corporate/academic medicine because I felt tired of being told how many patients I needed to see and when I needed to be there, and having every aspect of my professional life micromanaged,” she explains. “After 23 years of being in practice I just got fed up with it.” Before UKHealthCare she had worked with a practice owned by the University of Louisville Hospital, and the Sanger Heart and Vascular Institute in North Carolina, part of Carolinas HealthCare System.

Klein will be starting small in her new practice to reduce the financial risk. At the outset, she says, her staff will consist of a receptionist, an electrocardiogram techni-
CONSIDERING DIRECT PAY

By Robert Lamberts, MD

I have been operating my direct-pay practice (I accept no insurance; patients pay me a low monthly fee for care) now for more than two years. I am out of the “start-up phase” of the business. I am successfully making a living using an entirely different business model than most doctors in this country. Here are the tools I have found most useful in building a successful direct-pay practice.

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**Essential #1: A good office space**

I am not in a typical medical office area, but instead intentionally found a homey-looking space in a commercial office complex. I designed it to feel different from most doctors’ offices: comfortable and welcoming. From the outside it looks like a house, not a medical office, and I’ve filled it with comfortable furniture, pleasing decorations, and coffee for patients on request. Patients will make a point to come in just to chat; and we can because our schedule allows us the extra time to connect with our patients.

This was my biggest start-up expense, but I believe it was absolutely essential in building a new mindset in my patients.

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**Essential #2: A staff that believes**

I now have two nurses (to handle 600 patients), both of whom came from my previous practice. Both of my nurses are zealous in their belief in the direct-care model. Part of their zeal comes from the fact that their lives are so much better in this new office setting, but also, much of it is because they truly like to help patients. My practice model is all about customer service and exceeding expectations. I am really fortunate to have staff to whom that focus comes naturally.

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**Essential #3: The right communication tools**

The one thing my patients value the most in my practice is access to me and my staff. If they have questions, they can call the office or reach me via secure messaging. While it’s technically OK to use e-mail for communications (as long as patients sign a HIPAA waiver), I found that most of my patients value security in communication over ease of use. Here are three ways I communicate with my patients:

- **A good phone system.** I use Ring Central which is a VOIP Internet phone system, which allows me to cheaply have a complex phone system. Voicemails are e-mailed to me; faxes are also received and turned into e-mails. I can text with patients as well as hold a conference call. It has its flaws, but overall we get a lot for a low price.

- **Messaging system.** I use Twistle, which is a HIPAA-compliant “chat” system. This might be the tool my patients value the most. It works like a secure chat, with apps available for Apple and Android phones. It also notifies me via e-mail when patients have tried to contact me, and my nurses can be copied on the messages as well. I can securely send lab reports (as PDF files) or handouts regarding conditions as attachments, and patients can send images (rashes, wounds, etc.) to me from their mobile app.

- **E-mail system.** While I don’t encourage e-mail communication, some patients prefer it. We use our own domain hosted on Google’s Gmail website. It’s very easy to use and extremely affordable.

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**Essential #4: Billing systems**

I experimented with several billing systems. I initially used Intuit Quickbooks and their integrated billing features. For a while I used ADP’s automatic billing system, which worked fairly well, but didn’t integrate well. Most recently, a new start-up, Hint Health has built a very elegant and easy-to-use billing system specifically designed for direct-care practices. They are very easy to work with, and solve issues quickly and easily. They also integrate with several EHR systems, and are always open to further integrations.

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**Essential #5: Facebook**

Hands-down, the best marketing tool I have is my Facebook page. Not only does it provide an easy communication tool for patients and those interested in my practice, but I can promote posts to the exact demographic I am interested in. I promote any specials I am running for new patients, but I also promote posts or articles that highlight how my practice is different. The money I’ve invested here has paid itself over manyfold.

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**Editor’s note:** This piece was first published in our partner publication, Physicians Practice.
I feel is best for the patient is not to care too much about how much income I’m generating,” she says. “Now I’ll be at the mercy of the insurance companies, but I’ll still have more control over my day-to-day life. I’ll be available to my patients but I won’t have to be available to an entire medical center.”

CARVING OUT YOUR NICHE
Even as an employee of a hospital or health system, there are ways of carving out some independence, provided you know what you want and are savvy about getting it.

Mary Ann Bauman, MD, an Oklahoma City internist and Medical Economics editorial adviser, discovered a few years ago when she decided to look for ways to reduce her practice hours.

A 26-year employee of Integris Baptist Health Center, Bauman wanted to devote more time to traveling on behalf of the American Heart Association (where she is a national board member), and visiting her parents and other family members around the country. She found the solution from a patient who described how he shared his job, spending two months on and two months off.

“I started thinking, ‘You could do that reasonably well in primary care medicine, because you see most of your patients at one month, three months, six months or one year intervals,’” she says. “So you could do it if you had someone who practiced the same way you did and could see patients when you weren’t there.”

Bauman sounded out a younger colleague—Erin Glasgow, MD—who wanted to spend more time with her pre-teen children. Together they approached Integris administrators and sold them on the idea. Now, Bauman says, she sees patients the equivalent of five half-days per week, 24 weeks per year. Glasgow sees patients the other two-and-a-half days.

Bauman emphasizes that the arrangement took a great deal of preparation, especially when it came to minimizing the impact on other providers.

“We always call in once or twice a day and the staff has permission to call us anytime with questions,” she says. “So even though we’re part-time, it’s never a burden on our partners. That’s really important in making this model work.”

PRIVATE PRACTICE SURVIVAL TIPS

Join forces
Consider joining an independent physician association (IPA) to align with other physicians. Some have found that membership helps them negotiate tricky situations with payers where they might not otherwise get reimbursed.

Look for high-impact savings
The major expense items that practices need to get right are occupancy and personnel costs. Find ways to save on property costs and how to get the most form your employees.

Focus on billing practices
Make sure that someone in the practice has clear accountability for checking that all services get billed. Physicians can eliminate work that isn’t reimbursed through better claims management.

Ensure collections
Check on referrals and insurance authorizations before providing services and ask patients for copays at the time of check-in.

Review the fee schedule
You may discover you’re losing money in ways you may not be aware of. Regular review and calibration of your fee schedule could help.

Similarly, they stayed in the same call rotation. “That’s the other thing that frustrates your partners, is if they have to do double-duty on call because you’re part-time,” Bauman says. She and Glasgow coordinate schedules travel schedules so that each can cover for the other when one is out of town.

As a result of these actions, she says, the impact on her colleagues has been minimal. She still attends weekly physician staff meetings and continues with her women’s health-related activities for Integris. “And I’m in and out of the office, bringing things I’ve worked on at home. So it’s not like I’m gone for long periods of time.

“Some of the high producers in other clinics around the system have said they’re watching us closely.”
The only way I can do what I feel is best for the patient is not to care too much about how much income I’m generating.”

—LISA KLEIN, MD, FACC, A PEDIATRIC CARDIOLOGIST IN LOUISVILLE, KENTUCKY

because they would like to try something like this,” she adds. “So I think we’re pioneering something that looks very attractive to others.”

A bigger challenge than not imposing on other providers has been the impact on staff members. As part of the job-sharing arrangement the physicians agreed to merge their nursing staffs. But that has required overcoming what Bauman calls “pod-it is.” “It’s the attitude of, ‘I work for this doctor and I’ll help you out, but I don’t feel any responsibility to the other doctor,” Bauman says.

The problem surfaced when one the physicians would send in orders for a patient on a day when she didn’t have office hours. “The work wasn’t always getting done,” she says. “So then we set up a system where the nurse whose doctor is in takes care of their doctor, and the other one does referrals and correspondence of both doctors.

“We knew going in that the staff situation would be our biggest challenge, and it is,” she says.

On a personal level, she adds, the decrease in practice time has required both financial and psychological adjustments. She was prepared for the former, but the latter came as a surprise. “I knew my income was going down, because I wouldn’t be seeing as many patients. But the emotional response I had to the change was very challenging, because it felt like I was not being productive. That might not be true for everyone, but it certainly was for me.”

Bauman offers two pieces of advice to other employed physicians seeking a job-sharing arrangement. First and foremost is “to have a partner that practices the same way you do. And I would sit down with the person and hammer out questions like ‘are you going to be upset if I ask you to see a patient for me? What about taking calls when I’m not there? What are you comfortable with in terms of things like staff members doing prescription refills? ’ Things like that are critical, because you could end up hating each other.”

Second is to find a champion among the system’s administration. “If you have an existing relationship with someone, that’s where I would start, because they can really grease the skids for you,” she says. In her case it was the boss of her immediate manager. “He kind of smoothed it over with everyone else.”

In presenting your case to administrators, she adds, detailed preparation is vital. That means presenting information such as how much time you actually spent seeing patients in the previous year, how much time you expect to do so while job-sharing, and what the financial impact is likely to be. “Do your homework ahead of time so you really know your practice, and hammer out as many details as possible before you start.”
PRIME YOUR FEE SCHEDULE: FINDING HIDDEN REVENUE

by P. J. Cloud-Moulds Contributing author

When was the last time you took a good look at your fee schedule? A really good look. Would you know what to look for? Some people really just see a bunch of dollar amounts, but what do those amounts mean and how can you improve your bottom line by looking into the numbers?

You are contracted with Medicare, Blue Cross, HealthNet, and Aetna. You are charging your most common code at $77.84 per unit. If one of these payers is actually paying you $80, and you don’t bill that amount, you are losing $2.16 every time you bill that code to that plan.

If you code this 5,000 times per year, you have lost $10,800 of potential revenue. You could have used that for a nice year-end party, or employee bonuses. Just taking a few minutes to check these areas on an annual basis is really a way to “find the treasure” within your own practice.

Be sure to review your practice’s fee schedule annually to make sure you are collecting the maximum amount of revenue that you are due. It only takes a few moments and the payoff could be more than you think.

YOUR FRONT office calculates out a coinsurance or deductible based upon the contracted rate you have with a specific insurance plan.

If these numbers are not updated, you risk the chance of either undercharging or overcharging the patient. Either way, you are paying more in administrative costs to manage billing statements and pay out refunds. But what if you have a billing company or department to do that, you ask? Wouldn’t their time be spent more lucratively following up on denied claims that bring in revenue?

When you receive an explanation of benefits from the insurance company along with a payment check, are you spot-checking against the fee schedule to make sure you are being paid what you should be? It happens all of the time, and insurance companies are banking on the fact you don’t look closely enough. If they underpay and you don’t see it, they make money off of you.

Let me give you an example. You have contracted reimbursement rates with UnitedHealthcare. One code you commonly use is paid $77.84 per unit. If you code this, say, five times per day and bill UnitedHealthcare for 50 weeks (taking into account two weeks of vacation), that’s about 1,250 units per year. If you are paid $75.84 instead of your contracted rate, this equates to a $2,500 loss per year. That’s one code for one unit, to one insurance company. Think of the loss you may be incurring across all of your payers simply by not double-checking your payment against the fee schedule.

Similar to the example above, another problem is when you are not charging enough for your specific codes. You turn your fee schedule over to your billing department or third-party billing company. If they are not checking to make sure your charge amounts are higher than some of your payments, you’re losing money.

Here’s an example:

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P. J. Cloud-Moulds runs Turnaround Medical AR Recovery, a consulting firm in Encinitas, California. This piece was first published in Physicians Practice. Send your practice management questions to medec@advanstar.com.
LEGAL ADVICE FROM THE EXPERTS

Legally Speaking

PHYSICIAN RIGHTS IN THE OPEN PAYMENTS PROGRAM

by ZACHARY B. COHEN, JD  Contributing author

The Open Payments program requires the federal government to collect and publish information reported by certain pharmaceutical manufacturers and group purchasing organizations (GPOs) about the payments these companies make to physicians. Physicians should take seven steps to ensure their data is correct.

1 REGISTER YOUR ACCOUNT: Register at U.S. Centers for Medicare and Medicaid Services’ (CMS) enterprise portal and on the Open Payments system. Accounts are locked if there is a period of inactivity, so if you have not used your account recently, it may need to be reactivated. Register at bit.ly/CMS-enterprise-portal.

2 KNOW THE TIMING: CMS requires manufacturers and GPOs to submit data by March 31 of each year. Physicians are notified by CMS when the data is ready to review for accuracy. Physicians have a 45-day window to review and dispute information prior to publication, so be ready to examine the data when it is made available.

3 CHECK YOUR DATA ASAP: Check your profile as soon as possible to ensure that any errors in the data do not prevent you from initiating a dispute within the 45-day window.

4 CERTIFY CORRECT DATA: If the reported information is correct, you can electronically certify it. Physicians can leave comments regarding a payment to provide context.

5 DISPUTE INCORRECT DATA: If you disagree with your data, initiate a dispute. When a physician disputes a payment, the system will alert the applicable manufacturer or GPO. That organization will then work with the physician directly to resolve the dispute.

6 UNDERSTAND CORRECTION TIMELINES: In order for data to be corrected by CMS before publication, manufacturers and GPOs must notify CMS of a resolution within 15 days after the 45-day review period. An unresolved dispute will be published, but will be marked as disputed. Physicians can initiate a dispute after the review period, but any changes will not be made until the next time CMS refreshes the data.

7 CHECK DATA OFTEN: Physicians should become accustomed to periodically checking their profile and keeping accurate records of all dealings with pharmaceutical companies in the event they need to dispute reported payments.

The types of payments reported
- Speaking engagements
- Travel expenses
- Meals
- Entertainment
- Gifts
- Educational materials (text books, journal reprints)
- Paid advisory board membership

Zachary B. Cohen, JD is an associate at Garfunkel Wild, PC, in Great Neck, New York. Send your legal questions to medec@advanstar.com.
THE LAST WORD
With scrutiny falling on physicians regarding opioid addiction, tips on how your practice can protect itself [57]

Is meaningful use worth it?
Why some physicians are abandoning meaningful use and accepting the penalties

by SHELLY K. SCHWARTZ Contributing author

Faced with more rigorous requirements to use their EHRs, physicians have to choose investment in or independence from meaningful use.

DONALD FORDHAM, MD, started off strong. He successfully attested for Stage 1 of meaningful use under the Medicare EHR incentive program in 2012, and took the following year off to complete the highest level of certification as a Patient-Centered Medical Home. The family physician in Demorest, Ga., then turned his attention back to meaningful use, ready to roll up his sleeves for Stage 2. But the math didn’t work.

“I started looking at what it would require to continue to attest for Stage 2 and, for my practice, it’s not really financially logical at all,” he says, noting 30 percent of his patients are covered by Medicare. “As a solo practitioner, if it’s going to be done, it’s got to be done by me. I just don’t have the resources.”

By his account, none of the other 25 primary-care practices in his community plan to attest for Stage 2 either, which includes higher thresholds for the exchange of relevant health information and patient engagement. “I live in a small town,” says Fordham. “Everyone here is a solo practitioner. We’re providing the same quality care, but the regulatory burden is so great for meaningful use that when you look at the cost involved it would be a financial loss to try to continue.”

According to Fordham, the reimbursement hit that his practice will take for failure to attest, which he estimates to be $10,000 based on current Medicare billing, will be far less than the cost of meeting all of the criteria for Stage 2 and what is proposed currently for Stage 3, even after incentive payments are factored in. Indeed, eligible profession-
The American Academy of Family Physicians has long lobbied for the abolition of punitive policies, and the AMA reports on its website that it continues to advocate strongly for making the EHR Medicare and Medicaid Incentive Programs more workable for physicians, “…by asking CMS to establish more reasonable reporting requirements, measurement thresholds, and overall flexibility so that all physicians who want to participate are able to do so.”

Unless and until that happens, however, Donald Fordham, MD, a family physician in Demorest, Ga., worries the penalties associated with meaningful use may ultimately hurt patients. “If you’re going to be penalized for taking Medicare patients, what’s the dynamic force that becomes active?” he asks. “You stop taking Medicare patients because you’re going to be doing the same work and getting paid less. It is going to impair access to Medicare and it’s not the patient’s fault. They didn’t ask for this.”

Fordham, who is pushing for penalty relief with the help of his state congressional representative, is a solo practitioner who opted out of meaningful use in 2013 due to the cost involved—after successfully attesting to Stage 1. “He faces tough choices in the years ahead, including whether to stop accepting Medicare altogether, or join a group practice with pockets deep enough to help him comply with meaningful use standards. “I would like to stay in small practice,” says Fordham. “We have physicians in our area who have already stopped taking Medicare patients and that’s a consideration I need to look at making five years down the road.”

Dale Gray beat him to it. The internal medicine specialist in Rockford, Ill., notified patients in 2009 that he would no longer accept Medicare. At the time, elderly patients covered by the government health insurance plan comprised 50 percent of his scheduled patient visits, but represented just 20 percent of his revenue. Roughly one-third of his Medicare patients chose to stay with his practice and pay out of pocket. But he’s since had a change of heart. “I found over the last six years, that there’s a subset of those patients who struggle to even pay the $59 I charge for a 20-minute office visit, so I end up seeing them for free,” Gray says. “Or, I charge them for a shorter visit to give them a break.”

Worse, he found, many of those same patients put off necessary office visits to avoid the expense, or ask for “telephone medicine” instead of coming into the office, which is not conducive to quality care. For the sake of his existing patients, Gray says, he’s going back to Medicare, but he still doesn’t plan to let new Medicare patients through the door. He’s also prepared to collect less than full fare, as he has no intention of attesting to meaningful use. “I never began the process of attesting for meaningful use,” he says. “I don’t plan to start trying now either, since I don’t feel it’s worth the effort for the marginal increase in revenue.”

For the average family doctor, who receives roughly $100,000 per year in Medicare reimbursement, however, such penalties do not represent a significant downside risk. A 1 percent penalty this year, for example, would amount to a $1,000 loss, a $2,000 loss in 2016, and a $3,000 hit in 2017 — a combined $6,000 in penalties covering $300,000 in reimbursements.

Of the nearly 256,000 eligible providers who are subject to “payment adjustments,” in fact, CMS reports that nearly 70 percent will lose less than $2,000 each. Roughly 34 percent will forfeit $250 or less, 21 percent will lose less than $1,000, 14 percent will lose less than $2,000, and 31 percent will experience a loss of greater than $2,000.

CMS has separately indicated it expects it will cost physicians roughly $54,000 to upgrade their EHRs to meet Stage 3 requirements, plus another $10,000 annually in maintenance costs. “Who spends $64,000 to avoid a $10,000 penalty?” asks Fordham.

Some of the physicians who are opting out are demonstrating their frustration.”

—ROBERT WERGIN, PRESIDENT, AAFP

Starting this year, those who are not yet “meaningful users” will be hit with a 1 percent penalty on their Medicare reimbursement, increasing annually to 3 percent in 2017. (That penalty could climb to a maximum of 5 percent after 2018 if fewer than 75 percent of eligible providers are meaningful users under the EHR incentive programs.)

DOING THE PENALTY MATH

Starting in 2015, eligible providers who are not yet “meaningful users” will be hit with a 1 percent penalty on their Medicare reimbursement, increasing annually to 3 percent in 2017. The American Academy of Family Physicians has long lobbied for the abolition of punitive policies, and the AMA reports on its website that it continues to advocate strongly for making the EHR Medicare and Medicaid Incentive Programs more workable for physicians, “…by asking CMS to establish more reasonable reporting requirements, measurement thresholds, and overall flexibility so that all physicians who want to participate are able to do so.”

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MAKING A MEANINGFUL EXIT
Fordham is not alone. The 2014 Medical Economics continuing study found that 18% of physician respondents did not own an EHR. Of those physicians, more than half said they had no plans to ever purchase an EHR, essentially consigning themselves to the penalties.

“Some of the physicians who are opting out are demonstrating their frustration,” says Robert Wergin, president of the American Academy of Family Physicians, noting he has anecdotally observed a higher rate of attrition between Stage 1 and Stage 2.

Stage 2 is simply more onerous, requiring providers to report on a total of 20 objectives—17 core objectives and three menu objectives—as well as nine of 64 approved clinical quality measures (CQMs), during a fixed quarter of the calendar year. The objective requiring the exchange of relevant health information between heterogeneous systems is also largely out of their control, as the EHR in use by their peers may not meet interoperability standards.

Doctors who practice in underprivileged communities where patients may lack access to computer technology, and specialists (pediatricians and obstetricians) who treat primarily younger (non-Medicare) patients, however, are most challenged by the

With meaningful use, it’s all or nothing

Close may count in horseshoes and hand grenades, but it won’t get you paid if you participate in the EHR incentive program. Indeed, doctors who commit the resources required to demonstrate meaningful use, which is estimated to be well over $50,000 for Stage 3 alone, don’t collect a penny of the incentive payments Medicare doles out to help defray the cost of IT upgrades if they fail to meet even a single metric.

“Some practices have made the effort to attest to meaningful use and at the end of the year find out they didn’t do one thing correctly so they spent all that money on infrastructure and didn’t collect the payment,” says Tom Giannulli, MD, a practicing physician who also serves as chief medical information officer for an EHR company.

Doctors who successfully attest to Stages 1, 2, or 3 also face audits of their supporting documentation, both random and targeted, for up to six years, which can result in their having to repay any incentive subsidy they received. The American Academy of Family Physicians maintains that’s unreasonable and causes “undue hardship,” noting it’s tough to produce supporting documentation for family physicians who have made changes to their practices or whose offices have merged with a larger healthcare system. “In the case of employed physicians, their employment contracts often require that all Medicare payments flow directly through the practice,” says Reid Blackwelder, AAFP board chair, in a letter earlier this year to CMS. He notes that creates problems when the individual physician is later held responsible for repaying the subsidy after a failed audit.
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patient portal requirement. To demonstrate meaningful use in Stage 2, for example, providers must assure that at least 5 percent of their patients view or download their medical records online, and that at least 5 percent of patients must send at least one secure message. “I practice in a Mennonite community so to meet the requirements [for Stage 2] our nurse had to get on the phone and call patients so we could qualify in the last two hours [of his reporting period],” says Wergin.

CMS this year proposed a modification for Stage 2 and Stage 3 requirements to help reduce the reporting burden on providers. For Stage 2, the new rules would reduce the requirement for patients to use technology to electronically download, view, and transmit their medical records from 5 percent of eligible providers to one patient. The proposed simplification for Stage 3 criteria, which when finalized, will take effect starting in 2017, would reduce the 20 objectives to a core of eight that focus on promoting health information exchange and improved outcomes.

READJUST OR RETREAT?

Still others object to the impact attestation can have on doctor-patient interaction. “When you’re looking at checking off boxes to get credit for meaningful use, it can take away from physician-patient personal interaction,” says Fordham.

As the requirements for meeting meaningful use criteria are currently more rigorous in Stage 2 and Stage 3, Wergin expects a growing percentage of physicians to take the penalty and run. If CMS builds in greater flexibility and relaxes some of its targets, however, he also believes the program can still achieve its stated goals: lower healthcare costs, improved continuity of care, and better patient outcomes.

“I think there is still potential there,” he says, noting many AAFP members who have already attested to meaningful use experienced an initial drop in productivity, but says they wouldn’t go back. “They’d just like it to work better with office flow,” says Wergin. “Simplification would help. I believe we can get there if we can focus on creating a system that helps us take care of our patients better. And isn’t that what it’s all about?”

Editor’s note: This article was first published in our partner publication, Physicians Practice.
The new role physicians can’t afford to ignore

Why the rising costs of treatment and increasing patient financial responsibility means its time to embrace the cost discussion

by HANNY FREIWAT Contributing author

These days the relationship between physicians and patients is expanding beyond medicine. Physicians play an integral role in a patient’s medical life, including fulfilling the role of financial advisor.

NO, I’M NOT SUGGESTING you get financial credentials and advise your patients on their retirement strategy. Instead, what I’m suggesting is that you and your staff serve as trusted resources to help your patients find the most cost-effective services for the medical treatments you are recommending.

I see this as a sign of medicine coming full circle, returning to a time when the emphasis was on the relationship between a physician and a patient. After years of insurance companies being in the middle, the products have evolved in a way that creates a stronger dynamic between patients and their health care advisors.

This might seem like an impossible role for you because the healthcare system today isn’t set up to facilitate this type of relationship and to give you access to costs for services. But more access to this information is granted every day as technology advances.

This is great for physicians and patients. Patients appreciate having a relationship with a physician—and the physician’s staff—they can trust. They want to feel a sense of support from their physicians and know their doctor is there for them through the decision-making process, helping them evaluate what’s best for them, including the costs associated.

Your patients’ interest in cost is directly
correlated to their personal financial responsibility. High-deductible health plans are starting to dominate the market forcing patients to take on more responsibility for the cost of their healthcare services because they’re paying more out of their own pockets. They have more at stake than ever before, which gives them a higher incentive to pay the least amount of money.

DEALING WITH DEBT
Physicians can expect to see more and more patients with high-deductible health plans, usually with deductibles somewhere in the range of $3,000 to $5,000. This shift has a tremendous impact on physicians, as I’m sure you already know. Instead of collecting the majority of your payments for services from the insurer, you’re collecting a bigger portion from the patient than you have in a long time, putting you in more of a financial relationship than ever before.

According to a recent research report from Public Agenda, 67% of patients with higher deductibles in the range of $500 to $3,000 and 74% of those with deductibles higher than $3,000 have tried to find price information before getting care. There just aren’t a lot of tools for patients right now that allow them that transparent look at costs. This issue of transparency is affecting physicians as much as it’s affecting patients.

The most recent stats on bad debt for providers are from 2010, and the numbers were grim then. According to a report from McKinsey & Company, consumer bad debt in health care resulted in more than $65 billion in uncollected revenues in 2010. This is across all providers, including hospitals, but any physician can look at their practice’s books and tell you there is a good chunk of money that gets assigned to bad debt. ACA International conducted a survey in 2013 that showed non-hospital providers experience a 21.8 percent recovery rate from patients who have gone to collections. Primary care physicians are some of the hardest hit by bad debt and slow revenue cycles because their margins tend to be much smaller.

You are in a prime position to find solutions and get your patients to adapt to the responsibility they have and help them dial into their benefits. When a physician provides a sense of support and advocacy on a patient’s behalf, it leads to greater patient satisfaction and higher referral rates. And when handled properly it also decreases bad debt ratios and limits your exposure.

HAVE A CONSUMER FOCUS
If you’re ready to embrace this role and enhance the services you provide for your patients—for their benefit and your own—there are several things you can do.

It starts with your mindset. As I’ve outlined here, it’s in your business’s best interest to minimize your patients’ financial risk as much as you can. Embrace the role your patients are expecting you to fulfill. Then set the tone for your staff that you are all helpful advisors ready to help patients find the most cost effective treatment plans.

Next you want to train your front office to prepare for a patient’s first appointment to minimize the risk of unpaid services. And studies show it’s not that patients don’t want to pay. If you have the conversation about cost responsibility with your patients at their first appointment, or even prior to

3 ways to help patients understand costs

1. **Educate your practice**
   Teach yourself and your staff. Find out which insurers and employer groups have tools that will help your patients. Many of the larger health insurance companies are offering some kind of transparency tool.

2. **Encourage use of payer portals and mobile tools**
   Talk with your patients about using their insurer’s member portal and mobile tools, as well as any tools you offer to make payments easier to understand and more convenient. Take it a step further and assign someone in your office to help patients while they’re in the office with you.

3. **Turn to your software solutions**
   Look to your practice management software, eligibility platforms, and electronic health records. These tools can be a simple way for your staff to obtain information ahead of time and for you to be prepared with costs about services you’re recommending. Have a conversation with the patient when they check in for their appointment, at scheduling or a few days before the appointment. Show patients that you and your staff know them and are a resource they can count on while simultaneously protecting yourself against bad debt.
it, you will find they understand the responsibility they have and are more than willing to meet it.

While it’s essential that all physicians tackle their front office operations to increase payment collection at the time of service, I’m suggesting that you take it one step further and help your patients find care at reasonable prices. This increases your chances of being part of their payment plans.

For example, if you recommend an MRI and refer your patient to the hospital, which on average charges three times what the nearest imaging center charges, you are burdening them with unnecessary costs. Remember, they trust you. If you say to go to the hospital for an MRI, they are following your directions. But when the unexpected bill arrives, they will blame you, leading to lower patient satisfaction scores and decreased referrals. This example gets even more complicated with the introduction of accountable care organizations and narrow networks, or when you are a part of an integrated system and don’t have many options to navigate the patient.

Unfortunately there’s not a common mechanism at the time of service to understand how much is owed and how much is due from the deductible. But solutions do exist. You and your staff have to be proactive and creative about finding the information for your patients.

As the relationship between you and your patients goes beyond medicine, embrace the integral role you have in your patients’ medical life, including the role of financial advisor. Your outcomes will improve, your revenue cycle will shorten, and your bad debt will decrease. And you will have stronger relationships with your patients.

Hanny Freiwat is the co-founder and president of Wellero, developer of a mobile healthcare payment app based in Portland, Oregon.
Taking on risk: Understanding the new world of payments

Experts and physicians discuss how practices can take the first steps into risk-based payments on their own terms

by CHARLOTTE HUFF Contributing author

The move to value-based payment models means that physicians will soon, in some form or another, assume more financial risk for the outcomes of their patients. That means physicians need to begin exploring their options now to ensure their practices are ready and protected when they make the leap.

Among the consequences of Congress’ decision earlier this year to eliminate Medicare’s sustainable growth rate (SGR) formula, experts say, will be an almost certain increase in the number of accountable care organizations (ACOs.) That’s because the legislation ending the SGR contains a provision that will result in higher reimbursement levels for doctors in an ACO than doctors who are not.

Thus the question for doctors becomes less whether to join an ACO or other type of risk-sharing model and more how soon to make that first foray, and how best to protect one’s practice in the process, says Terry McGeeney, MD, president of Care Accountability, a Kansas City-based firm that works with doctors on that transition.

“My personal bias is they need to get on the train pretty quickly because they need to learn how to do this while there is only upside risk,” says McGeeney, a family physician and the founder of TransforMED, a subsidiary of the American Academy of Family Physicians. “If they don’t get any money, but they don’t lose any money.”
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money, they are still learning. But if they jump in when there is starting to be downside risk, it could be a very difficult journey for them.”

McGeeney is not alone in outlining such a stark scenario for doctors still weighing whether to participate in an alphabet soup of ACOs, CINs (clinically integrated networks), and other reimbursement models.

To maximize their opportunities, doctors need to prepare by, for example, looking for ways to improve patient care coordination and using data analysis to identify patterns in their practices, say healthcare consultants and physicians already operating under risk-sharing arrangements.

Meanwhile, they should be looking for like-minded practices with whom to partner before rapidly-consolidating networks leave them on the outside looking in, says Susan Quirk, a healthcare consultant in Colorado Springs, Colorado. “They have to move fast,” she says.

The legislation ending the SGR gives practices a choice for how they wish to be reimbursed in the future: One choice is to use a new formula called the Merit-Based Incentive Payment System (MIPS), which is essentially a fee-for-service plan containing an increasing financial risk for quality. The other choice is to join an ACO or other risk-sharing model.

In both cases, physicians will see their Medicare reimbursements increase by 0.5% from 2016 through 2019. After 2019, providers operating under a risk-sharing model (which in most cases means an ACO), have the potential to earn substantially more than those under MIPS, although they will also face greater downside risk if they don’t meet certain quality metrics.

ACOs already provide care to as many as 56 million Americans, or at least 15% of the U.S. population, according to an April, 2015 analysis from management consulting firm Oliver Wyman. Sylvia Burwell, secretary of the U.S. Department of Health and Human Services, has announced that the department’s goal is to tie 50% of Medicare payments to value-based care by 2018.

New Medicare-initiated models, such as the Next Generation ACO with higher potential levels of risk and reward, are on the near horizon.

Certainly not all doctors are convinced. An analysis of approximately 1,200 physician practices based on data from the National Survey of Physician Organizations, found that nearly 40% of those practices either had joined an ACO or planned to do so. But the remaining 60% reported no such intention, according to the findings published in 2014 in Health Services Research, based on survey data from January, 2012 through May, 2013.

Steven Dukes, MD, a central Florida obstetrician/gynecologist counts himself among those physicians who have decided that they can’t stall any longer. “We are still in a situation that if we make the right choices going forward, that there’s still benefit to be had by all,” he says.

“I’m certainly not a medical economist—that’s not my forte,” Dukes says. “But what I read and what I see, if you listen to those powers that be, there is a lot of waste in the system.” Dukes is among the physician leaders helping to launch the Florida Hospital Physician Network. The clinically integrated network, which is still in development and plans to start treating patients in 2016, is combining the resources of the non-profit Florida Hospital system with a targeted goal of at least 2,700 doctors, according to Dukes.

Initially, any risk-based compensation will be tied primarily to performance metrics, but with the longer term plan that the more closely knit hospital-physician team can pursue risk-sharing contracts, Dukes says. He’s part of a Winter Park, Florida-based group of seven OB/GYNs that has already committed to joining the network, but he remains sympathetic to the concerns of doctors contemplating the pros and cons of a similar move.

They’re not happy, he says, about the loss of the entrepreneurial autonomy that drew them to medical practice in the first place. Another worry, which Dukes tries to assuage, is that the practice data that will be collected could be used punitively. “There are certainly concerns that physicians think that they may get pushed out of the network if their costs are running higher than others and they’re not able to adjust for whatever reason,” he says.

**BOOSTING COST SENSITIVITY**

Even if a doctor hasn’t joined a risk-sharing model, he or she can start preparing for that reimbursement environment by scrutiniz-
ing his or her own practice procedures, such as working with third-party payers to get a better handle on the cost profile of specialists to whom they routinely refer patients, McGeeney says. "For example, a lot of primary care doctors really don’t know if the cardiologist they’re referring to is a high-cost specialist that caths everybody or is a low-cost specialist," he says.

Along with adjusting referral patterns if needed, says Quirk, doctors in multi-practitioner practices should ask questions such as, to what extent have we standardized treatment approaches? Have we agreed on the optimal drugs and medical supplies for our practice? What kind of patient care support are we providing for patients newly discharged from the hospital?

"And can we demonstrate that this consistent approach affects cost, quality and outcomes?" Quirk says. "Everyone likes to put a little bit of their special sauce into their approach to patient care. Let’s remove the special sauce and make sure that we are consistent throughout."

Doctors who don’t turn the spotlight on themselves may be affected in unexpected ways, Quirk says. Recently she conducted an analysis for a hospital chief executive officer who was deciding whether to renew the contract of a group of hospitalists or give it to others also practicing at the facility.

Quirk used case-mix adjusted data for pneumonia treatment and found that among the 10 hospitalists treating the most patients with that diagnosis, the number of specialist consultations per patient ranged from 1.2 to five per hospitalist, with an average of two referrals.

"The hospitalists that had the five specialists were the ones who had the highest patient load, and a patient load that was beyond reasonable," she says. "What they were doing is practicing fee-for-service medicine. So they are getting paid, but it’s costing the hospital money. Those are not the guys that these organizations want to affiliate with in the future."

BUILDING VALUE-BASED CARE

The good news for primary care practices attempting to focus more on value, McGeeney says, is that a new revenue stream is available to support that transformation: billing for chronic care management. Since the start of the year physicians and other qualified professionals have been able to bill for non-face-to-face care coordination services provided to Medicare beneficiaries with multiple chronic conditions, using CPT code 99490.

While providers must meet numerous detailed requirements to bill the code, the average reimbursement—about $40 per month per patient—can add up quickly, says McGeeney. He cites an analysis published by consulting firm Pershing Yoakley & Associates showing that a practice with about 500 Medicare patients that meets the chronic care billing requirements could gross nearly $238,000 annually in related revenue.

"It could be a game changer for primary care doctors," McGeeney says. With that additional revenue, practices can hire care managers and purchase technology to identify gaps in care, among other measures to better position for risk-adjusted contracts.

Currently, the available risk-based arrangements are primarily upside models, dependent on fee-for-service reimbursements with additional payments if the doctors meet quality benchmarks, says Graham Hughes, MD, chief medical officer for SAS Center for Health Analytics and Insights. "I think justifiably so, physicians are wary of getting into contracts where they are unsure whether the data accurately reflect their population, their case load, their practice patterns," he says.

Along those lines, the Florida Hospital Physician Network plans to start with opportunities for upside risk, by setting quality benchmarks that are still being developed by related subcommittees, Dukes says. Along with meeting specific treatment goals, such as annual mammograms, some likely will be designed to help practices get a better handle on the types of patient conditions they are treating, such as the percentage with diabetes or a body mass index of 30 or higher, he says.

After practices in the network have developed a more nuanced portrait of their patients, then future metrics can work toward improving certain risk factors, such as achieving weight loss or better glucose levels. Stated another way, Dukes quips, "Before you go chasing the chickens, you’ve got to know how many are in the yard."

SCRUTINIZING THE RISK

Lloyd Van Winkle, MD, medical director and
“It’s all coming down to the data at this stage of the game. That’s how we’re going to be judged whether we like it or not.”

— STEVEN DUKES, MD, FLORIDA HOSPITAL PHYSICIAN NETWORK

board chair of United Physicians of San Antonio ACO, believes that the physician-led approach his ACO has adopted enables it to be nimble as it pursues cost-effective care. “The idea is to improve quality and discourage unnecessary procedures which actually put patients at risk,” he says.

This summer, the ACO’s leaders began meeting with podiatrists and cardiologists as it considers adding sub-specialists to its cadre of roughly 65 primary care doctors. Given the high incidence of diabetes among its patients, the ACO wants to team up with foot specialists who provide good patient care without automatically defaulting to “selling unnecessary equipment like special shoes and things like that,” says Van Winkle.

For cardiologists, the ACO is talking to those who could perform some procedures, such as vascular studies, in an outpatient surgery center rather than a more costly hospital setting, he says.

To hammer out the details of such risk-adjusted arrangements—from the design to the eventual distribution of any savings—a high degree of physician comfort with the underlying cost and treatment data is paramount. “It’s all coming down to the data at this stage of the game,” Dukes says. “That’s how we’re going to be judged whether we like it or not.”

It’s also important that doctors understand upfront all of the underpinnings that drive any revenue sharing, McGeeney says. For example, if shared savings are distributed based on meeting certain quality metrics, does a doctor need to meet all of them to reap the payout? Or if they meet 70% of them, are they paid 70% of the shared savings? What are the benchmarks based on? If patient satisfaction is being tracked, are those numbers taken from a costly survey or a more informal email questionnaire, and what are the pros and cons of each approach?

A similar line of questioning should be pursued when calculating the metrics for a physician’s treatment costs, McGeeney says. If a doctor is asked continually to match the cost savings achieved the prior year, “you can only squeeze the turnip so much.” A better approach would be to compare the practice against city or regional metrics that will better reflect health costs trends over time, he says.

In addition, make sure that the underlying data fairly reflect the morbidity levels of the practice’s patients, says Rick Hindmand, JD, an attorney specializing in healthcare, corporate and regulatory law at McDonald Hopkins. “If you have a physician who is very highly regarded in terms of being kind of a miracle worker, he or she may be getting a lot more of the patients with the terrible conditions.”

As they negotiate the agreement, physicians should also consider if they want to include a contractual escape hatch, such as a termination clause or a stipulation that the parties reevaluate the terms periodically. Hindmand says. “Particularly when you get into risk-based contracting, I think that there is a real potential that there could be unforeseen consequences here that maybe the practice hasn’t really thought through, or things that are just different from what they had expected,” he says.

MOVING BEYOND CONCEPT

As he talks to physician colleagues in central Florida, Dukes emphasizes that the process of building a hospital-physician network will be collaborative rather than punitive. If a doctor is a low-performing outlier, then there will be a conversation to determine what might be the reason for that deviation, he says. “It’s meant to be a working environment where we can all learn from each other about the best way to care for our patients.”

Van Winkle anticipates that the number of doctors in the San Antonio ACO might reach 100 by year’s end, and he is already looking toward the next phase of revenue-sharing. The San Antonio ACO is joining forces with other ACOs to pursue designation as a Next Generation ACO, with the goal of being one of the first chosen under the new model next year, he says.

Van Winkle, who is also part of a clinically integrated network, acknowledges that he’s covering his bases with “a boot-and-suspenders approach” to the reimbursement future. But regardless of how models shake out, he believes that patient care will benefit from the process.

“We’re learning, and I’m learning, a lot more about wise business practices in the practice of medicine,” Van Winkle says. “Where waste is, how to recognize waste, how to apply evidence-based criteria rather than traditional criteria to medical care. There are a lot of things that we’ve done just because we’ve always done it that way.”
Coding Insights

LAST MINUTE ICD-10 CONVERSION TIPS

by RENEE DOWLING Contributing author

How ready you are for ICD-10 transition might depend on the type and size of your organization. It’s reported that 85% of hospitals have trained their staff on ICD-10, while only about 40% of physician practices have completed that training. Practices also are less likely to offer additional training for coders to maintain their skills.

THAT’S NOT SURPRISING given the fact that practices are still reeling from the costs of electronic health records (EHR) and other updates to get to this point of finally transitioning to ICD-10. That doesn’t mean it’s too late for your office to prepare. The Centers for Medicare and Medicaid Services (CMS) just released a guide for organizations to get on track to implementation no matter where they are in the process.

Here are some additional tips to help focus your physician training and support so that the transition is successful.

Give physicians what they need
Do not try to teach your physicians the ICD-10 code. Instead, talk to them about what information they need to document so that coders can build the ICD-10 code.

Use simple templates
Most providers utilizing an EHR have developed templates for their most common chart entries. Find out what information is not included in the template and work with the providers and your IT staff to update the template to capture all of the information needed for an ICD-10 code. Ask your providers to explain what they’re doing. Ask what they mean by certain terms. Many of them will be happy to share their expertise.

This information is commonly the reason for the office visit or procedure. For instance, a pediatrician typically has a template for otitis media since this is a diagnosis that he/she sees on a daily basis.

Make sure that the template includes the information that will be needed to support the higher specificity of the ICD-10 code.

Here are some additional tips to help focus your physician training and support so that the transition is successful:

Incorrect or unspecified laterality is a simple mistake, probably caused by lack of familiarity with the codes or a lack of documentation. The payment isn’t going to change, so you may think of it as “no harm, no foul.” And you would be right, to a point. A problem could arise when the patient comes in for a follow-up visit and checked the wrong ear. The patient may or may not remember and correct the physician.

But keep in mind, not all errors or mistakes are so minor.

Updating templates is a win-win situation, and the best way to ensure that the provider will capture the required specificity. This will not only minimize the risk that comes from documentation mistakes, but alleviates the chore of querying the provider later, assigning a less specific code (and risking a denial from the payer), or spending time and manpower resubmitting a corrected claim.

So it’s important to allow your providers as much time as possible to practice these new documentation habits. This will help overcome one of
the top challenges facing all organizations: maintaining clinical workflow and productivity.

**Vendor readiness**

For both practices and small hospitals, another major challenge relates to vendor and partner readiness.

Even at this late date, some vendors are scrambling to ensure that their systems are updated and working properly. If you haven’t already, make sure your vendor provides you with an ICD-10 timeline.

Also, you need to consider addressing the following with your vendor:

- Go-live resource commitments for onsite and remote support
- Does the vendor have a contingency plan if products do not work as expected during go-live on October 1, 2015
- Vendor staff training for ICD-10

**Crosswalk correctly**

If your EHR includes an ICD-10 converter, check that the ICD-9 codes are crosswalking correctly to the ICD-10 code(s).

Only above 33% of the ICD-9 codes crosswalk to a specific ICD-10 code, so converting or crosswalking codes is definitely challenging.

Additionally, vendors typically purchase the mapping/crosswalking software from another company, so it is an issue that even large vendors are still struggling with. Simply put, the ICD-9 codes are crosswalking to wrong ICD-10 codes—and vice versa.

If these issues aren’t addressed, they could not only cause significant cost and workflow issues, they will confuse your providers, who could become overwhelmed by the amount of analysis and challenges that the ICD-10 conversion poses.

**Stay engaged**

Pull charts—standard recommendation is 10—and the associated billing claims.

Review the diagnostic statement from the chart and select the ICD-9 code. Do not infer anything that is not written.

Review the diagnostic statement and choose the ICD-10 code. Is there any documentation that would allow a higher level of specificity? Use an assessment tool and list out the missing elements. Educate the providers on what is lacking so they can continue to improve.

Also, tracking your denials will be critically important after October 1, 2015. Classify the denials and get to the root cause.

**Simple steps to improve your documentation**

1. **Identify most-often used codes**

   Take a look at your documentation to find the codes your practice commonly uses.

2. **Analyze the level of documentation**

   Answer the question: Is this level of documentation specific and detailed enough to select the best ICD-10 codes for the diagnosis?

3. **Sustain strategies**

   ICD-10 should not affect the way you care for patients. The change comes in documentation of your patient encounters. The information you need to properly code in ICD-10 is already being supplied in most patient visits. It’s a matter of documenting it properly for your coding staff.

Source: CMS

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**Coding Insights**

"TRACKING YOUR DENIALS WILL BE CRITICALLY IMPORTANT AFTER OCTOBER 1, 2015. CLASSIFY THE DENIALS AND GET TO THE ROOT CAUSE."

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**Renee Dowling** is a billing and coding consultant with VEI Consulting in Indianapolis, Indiana. Send your billing and coding questions to medec@advanstar.com.
5 STRATEGIES TO MAXIMIZE YOUR EHR

BY SAROJ MISRA, DO  Contributing author

The way in which physicians interact with data as it pertains to patient care has clearly identified the EHR as a critical tool. The statistics speak for themselves — approximately 78 percent of all office-based physicians had an EHR in place as of 2013, according to a recent study in *Health Affairs*.

HOWEVER, this doesn’t mean that physicians are satisfied with the EHRs they have; recent studies, including a 2014 report in *JAMA Internal Medicine*, have shown that even experienced EHR users find significant decreases in productivity, losing on average, 48 minutes of productivity every workday. It becomes critical, then, to find ways to maximize the use of existing EHRs in an effort to improve efficacy for patient care and reduce end-user frustration.

The biggest problem with an EHR system is not the product itself — it is the way we learn to use it and how we communicate with those who make and update it. These five strategies might help to reduce both the frustration level and inefficiency that many doctors feel come with their EHRs.

1. **Train and train again**

Most EHR training occurs prior to “going live” and is often not tailored to individual “teams” within the office (medical assistants, front-desk staff, physicians, billers). In addition, once the initial training is done, most offices rarely do any further training. The reality is that “relearning” your EHR is critical to maximizing its advantages. Consider appointing one individual in your office (or one from each stakeholder group) to set aside time each week or month to “retrain” on the EHR. The focus should be on capabilities (what can it do) and needs (what do we need it to do).

2. **Check your “flow”**

Work flows in your office need to be looked at before and after an EHR is implemented. Have your office manager and/or you (the physician) spend a day watching how a patient moves through the process of being seen — from check-in to check-out. When you identify choke points (be they people or processes), work on how to fix and redirect those tasks.

3. **Use shortcuts**

Most EHRs have huge amounts of customizability that physicians often forget to take advantage of. Learn how to use encounter templates and order sets to speed the process of getting data into the system. Don’t forget about dictation and transcription capabilities as well.

4. **Engage the portal**

Using the patient portal to allow patients to manage common tasks and requests can dramatically reduce the amount of work your staff needs to do. Recent CMS guideline changes allow for reimbursement of “non-face-to-face” visits for chronic diseases — using the patient portal as a tool for this type of patient interaction is an optimal strategy.

5. **Communicate with the vendor regularly**

It’s important to remember that you are a client when it comes to the EHR and that you are paying for services as well as product. Don’t hesitate to ask for further training or retraining if needed. Make sure the EHR vendor has regular meetings with your office staff designee to keep you updated on changes to the EHR system.

Saroj Misra, DO, is an osteopathic physician based in Warren, Michigan. This article was first published in our partner publication, *Physicians Practice*. Send your practice management questions to medec@advanstar.com.
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THE OPIOID ABUSE EPIDEMIC
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by JEFFREY D. BRUNKEN Contributing author

Earlier this year, the West Virginia Supreme Court ruled that patients could sue their physicians if the patients became addicted when their doctors negligently prescribed pain medication.

SHOCKINGLY, most of the patients in this case were already abusing controlled substances when they sought treatment from their physicians and then claimed they became addicted as a result of the doctors’ criminal abuse of prescriptions. After hearing the case, the court ruled in favor of the patients and that there was enough blame to go around for all parties, including the physicians involved. While this case is unusual, the fact that many patients are addicted to prescription opioids is not—and the numbers are growing.

Given these sad facts, physicians are wondering how they can protect themselves from malpractice suits when patients are so desperate for pain relief. These four steps—the first two are from the U.S. Centers for Disease Control and Prevention (CDC)—can help establish that you have been following best-practices, which will be key to your malpractice defense:

1. Use prescription drug monitoring programs to identify patients who might be misusing prescription drugs.

2. Follow best practices by screening for substance abuse and mental health problems, by avoiding combinations of prescription painkillers and sedatives unless there is a specific medical indication, and by prescribing the lowest effective dose and only the quantity needed.

3. Make sure to build a solid patient-physician relationship with each and every patient. Such a relationship will improve patient-physician communication, which, in turn, will help you to evaluate the patient’s clinical condition most effectively and perhaps recognize whether the patient is likely to abuse prescription medications.

4. Document all aspects of every patient visit thoroughly. In a malpractice suit, your attorney will want to see thorough documentation in the EHR of the patient’s condition and whether that condition improved or not at each visit. Your attorney also will want to know which medication was prescribed and why, the refill policy for each medication, and the steps for monitoring the patient’s condition over time, including whether the patient was adhering to your orders and showing up for successive appointments.
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