RETHINK
REVENUE STREAMS
Weighing new services

PLUS
3 STEPS TO SMARTER INVESTING

ANSWERS TO COMMON TCM CODE QUESTIONS
One of President Donald Trump’s first-day priorities—a complete repeal of the Affordable Care Act—remains unfulfilled as we pass his first month in the White House. The president did sign an executive order (perhaps his least controversial one) minimizing the economic and regulatory burdens of the law, giving federal agencies the ability to interpret the legislation in a loose manner when it comes to enforcement. This paved the way for Congress to pass a reconciliation bill to repeal parts of the law with a self-imposed deadline of January 27 to create repeal legislation. That deadline too has clearly passed.

Depending on what day physicians pick up a newspaper, ACA 2.0, Trumpcare, or whatever you want to call it, will either arrive this spring or by the end of the year. This has left many physicians in a state of limbo, operating as usual with health coverage in place for 2017, but always with one eye on the news, just in case something arises. (See our feature story on how physicians are dealing with this uncertainty on page XX).

The current atmosphere in D.C. has gone from “repeal” to “repair,” with some prominent Republicans (notably Sens. Orrin Hatch and Lamar Alexander) conceding that perhaps some of the law’s provisions can remain versus a massive shift that would change the lives of the 22 million or so who rely on the law for their insurance coverage.

And even popular opinion on the law has changed. A recent NBC News/Wall Street Journal poll found that public support for Obamacare is at an all-time high.

So there appears to be a window of opportunity where what was once the target of a wrecking ball is perhaps in line for a renovation instead. And this is where physicians come in.

Eight years ago, physicians lamented chatter coming from the nation’s capital about what healthcare reform would look like. Many, including some reading this very column, noted that large healthcare organizations weren’t speaking on their behalf or in the best interest of doctors nationwide.

And here we are again, at a pivotal moment in healthcare coverage, patient access and physician reimbursement requiring the input of those on the front lines of improving care.

 Politicians should not be the ones repairing or replacing the Affordable Care Act. Physicians should be the ones to decide what is working, revise what isn’t and suggest new advancements for the betterment of their patients.

So rather than waiting for lawmakers to come up with a plan physicians may or may not agree with, doctors should write a letter, make a call, gather colleagues and go to the local newspaper office or television station to make a case and share insight.

Tell us too. Send me an e-mail at keith.martin@ubm.com with your thoughts on how to improve healthcare in the U.S.

Bottom line: Physicians need to make their voices heard.

In medicine, second chances are rare. Physicians have an opportunity to make this medical limbo work for them and help drive change versus being an unhappy passenger. It’s time to take the wheel.

Keith L. Martin is editorial director of Medical Economics. How would you improve U.S. healthcare? Tell us at medec@ubm.com.
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Weigh the risks and rewards of adding new services

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Healthcare policy is chaotic right now, but physicians are using strategies to cope with the unknown

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How to combat TV drug ads the right way

During the recent election, much was made about the unprecedented level of spending on political advertising, with more than $4.2 billion spent on Congressional races alone.

But consider this: Direct-to-consumer-advertising (DCTA) for prescription medications, for TV and print ads alone, hit the $5.2 billion mark in 2015, according to STAT, an online health publication launched by Boston Globe Media. Note, that the $5.2 billion figure does not include the fast-growing, but harder to measure, amount being spent for eDTCA, drug ads online including ones on social media.

Physicians often find that advertisements for prescription drugs generate inappropriate demand among patients and lead to time-consuming conversations that might otherwise not be needed.

Although pharmaceutical marketers say that DTCA provides consumers with valuable health information, most research suggests that the ads create a range of serious problems, including excessive costs for patients, payers and the U.S. healthcare system overall.
Having the freedom to control your professional and personal life is just one of many advantages to locum tenens—as a single assignment or a full-time career. Hear what physicians have to say, and take an online tour of an industry dedicated to helping doctors take back control of their careers.
Price will protect physicians from medical liability

I was surprised in reading “Physicians react to Tom Price nomination (MedicalEconomics.com, December 14, 2016)” that those who reacted favorably did not mention his position on medical liability.

The news media has mentioned that as head of Health and Human Services (HHS) he wants to tighten up the requirements for bringing malpractice suits against doctors.

As a physician, Congressman Price knows how physicians are often hit with lawsuit threats based on questionable evidence—and how they are forced to spend time, sometimes several years, defending these suits.

Because defending suits is exhausting and disruptive to their practices, many doctors try to ward them off by ordering tests and consultations that are not needed just to have a defense in case a suit is filed.

This “defensive medicine” approach—which most doctors now practice routinely—wastes immeasurably large amounts of money. Money that could be used to provide care for the poor and to lower costs for all of us.

Making the burden of proof for bringing suits against doctors more exacting has been a top priority for physician minds since at least the 1970s.

With Congressman Price as head of HHS, never have the chances for achieving this goal been within closer reach.

I believe that those who support his nomination far surpass those who do not.

Protecting patients is important of course. But, so is protecting doctors against false suits.

Edward Volpintesta, MD

BETHEL, CONNECTICUT

Obamacare is not healthcare

In response to “We must stay on the Obamacare course (Your Voice, December 10, 2016),” in the United States, the only choice for healthcare is corporate-sponsored insurance or Obamacare. Thus, all the mom and pop organizations, stores, shops or solo practices like mine, can only subscribe to Obamacare, or pay huge tax penalties.

This is what our government considers “good.” As many patients in my office state: Obamacare is not healthcare. It is $4,000 deductibles, it is 50% of hospital bills covered, it is constantly rising premiums, it is insurance companies bowing out (i.e. UnitedHealthCare). It offers no eyeglass or dental – unless you are in Medicaid.

Most of the 20 million [enrolled] agree it is just a big tax with healthcare paid out-of-pocket. On a personal note, the cost for my thyroid medicine is more expensive under Obamacare than I can buy online.

Saulius Skeivys, MD

WOODSIDE, NEW YORK
IN RESPONSE:
The essay’s author, E. Michael Reisman, MD, replies:

... The responder missed the whole point of the missive ... When someone goes in to a store three minutes before closing time, an employee will almost always say, “I’m sorry, we are closing now.” If it is the owner, they will say, “Come on in.” My point is that to go the extra mile will help all involved, [and] you will grow your practice by being available, affable and able. You also are pleasing the referring doctor, but most of all, you are taking care of a patient in need efficiently and relieving their suffering promptly.

I believe that those are things worth doing, and, yes, they will come at an inconvenience (no lunch some days). Sometimes you do have to stay late; if you are a surgeon you already know that this may happen and you will have a contingency plan, be it your spouse, day care or other arrangement.

I found the recent essay “Lunch is for Losers (Medical Economics, December 25, 2016)” to be anachronistic. While I admire the author’s obvious dedication to his career and his patients, his willingness to criticize others who do not share his philosophy is disheartening.

My objection to this article is the unacknowledged reality that it requires a supportive spouse to hold down the fort at home. More than 90% of the time, it will be a woman who sacrifices her own professional goals in order to promote her husband’s.

There are many of us for whom this model simply is not available, or not preferred, including most professional women and single parents. To write those physicians off as “losers” or less dedicated to their patients is offensive.

Medicine would be better served by promoting models which allow physicians to thrive in a variety of social models. There are many excellent physicians who sometimes need to take a lunch break and pick up the kids by 6 p.m.

Kimberly Zoberi, MD
ST. LOUIS, MISSOURI
Healthcare providers have continued to embrace population health over the past year, but are still struggling with key aspects of the management style, according to a recent national survey.

The online survey, conducted by Numerof & Associates for a second year in a row to study the evolution of population health management, had more than 500 respondents in urban, suburban and rural areas across the United States.

“The purpose of this research was to formally explore the progress that’s been made by provider organizations toward population health management,” the study said. “Our findings suggest that although some progress has been made over the last year, most providers have a substantial amount of work to do in order to succeed in population health.”

Key findings include respondents reporting that organizations are building out the infrastructure required for success in population health, however, still have little financial exposure tied to risk-based contracts, despite respondents reporting participation in alternative payment models.

**HEALTHCARE POPULATION HEALTH**

**NUMBER OF RESPONDENTS WHO...**

- 95% rated population health between moderately and critically important for future success; 43% said it critically important.
- 74% indicated their organization has a designated division, department or institute for population health programs.
- 75% said their organizations were in at least one agreement with a payer that included upside gain and/or downside risk.
- 17% said their organization is prepared to today take on risk.
- 43% said they still view their organization’s ability to manage variation in quality at the physician level as average or worse.

Source: Numerof & Associates
Four reasons to consider automated patient payments

1. **Treat patient payments like claims**
   Few practices look at patient payments the same way they view insurance claims. As a result, there's been little emphasis on standardization. Now is the time to standardize and automate patient payment processes, just as with insurance claims.

2. **Track patient payments**
   Staff often need to go outside the practice management system and into another program in order to process patient payments. Those payments then must be reconciled through yet another system and posted back to the accounting system. Managing these multiple payment channels can cause a lag in reporting, which in turn delays the ability to track payments and make data-driven strategic decisions.
   Practices should have access to a dashboard of metrics that shows how, when and where patients pay.

3. **Make payment easy**
   Making payment easy is the key to collections. That means offering patients the payment methods they find most convenient. Consolidating payment channels onto a single platform helps save money and cut down on complexity for staff members and patients. A patient who can easily pay is a patient who is more likely to pay.

4. **Consider the patient’s perspective**
   Consider Christina, a patient who receives an invoice from her provider, then pays half of the bill online and the remainder of the balance over the phone a few weeks later after she gets her paycheck. In her mind, Christina has made two payments to the same doctor to settle her bill. Imagine her confusion when, because of posting delays with the second payment, she receives a call requesting the payment she has already made.
   No matter how payments are taken by your practice, it’s important to recognize how patients perceive the experience and how that impacts the practice’s patient revenue.

---

**Bird Blitch** is co-founder and chief executive officer of patient payment technology firm Patientco. Send your practice management questions to medec@ubm.com.

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**TOTAL OUT-OF-POCKET PATIENT PAYMENTS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Out-of-Pocket Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$250 billion</td>
</tr>
<tr>
<td>2015</td>
<td>$420 billion</td>
</tr>
</tbody>
</table>

68% increase in only six years

---

The proportion of practice revenue coming directly from patient payments is increasing dramatically.

With no sign of slowing, it’s essential for practices to develop strong, automated patient payment strategies to stay financially healthy.

Although patient payments comprise the fastest-growing slice of practice revenue, they also constitute the segment over which physicians historically have had the least control.

Going forward, practices will depend on understanding the patient revenue cycle and making it seamless and transparent for patients. When building a business case for patient payment solutions, practices should consider these four strategies:
ANCILLARY SERVICES CAN boost practice revenue and be a major convenience for patients, but regulatory challenges and competition from hospitals and other players mean that physicians need to think more strategically than ever about their service menu.

Dallas internist Neal Sklaver, MD, FACP, has been providing ancillary services for 25 years and believes patients get better, faster care with in-house lab work and other on-site offerings like bone density scans and nutrition consulting.

Using in-house labs, he can have some results within an hour and others by the end of the day, allowing him to make decisions and get back to patients quickly, and at less cost to the patient.

Increasingly, however, payers are steering physicians to large third-party facilities for traditional ancillaries such as lab work as the insurers chase economies of scale. Regulations limiting the types of providers who can offer certain services, along with increasing competition overall also threaten margins for these ancillary businesses.

“The convenience more than warrants doing it, but we’re continuing to get squeezed,” Sklaver says.

The “squeeze” practices like Sklaver’s are feeling may be why independent physicians are putting fewer resources toward some of these services than others, notes David Gans, MSHA, FACMPE, senior fellow for

HIGHLIGHTS

- Laws governing the level of professional who can perform different services vary by state, as do reimbursement rates, so it’s crucial to calculate your own return on investment.
industry affairs for the Medical Group Management Association (MGMA).

For example, primary care single-specialty groups brought in $59,745 per full time-equivalent physician for lab procedures in 2015, roughly flat compared with 2011, according to MGMA’s 2015 DataDive for Cost and Revenue Report. During the same period, charges for radiology procedures more than doubled and revenue from non-procedural activities such as the sale of supplements, allergy antigens and onabotulinumtoxinA (Botox) rose substantially.

The growing number of regulations affecting lab standards and billing procedures have kept some physicians from continuing them, says Gans. At the same time, he says, the prospect of flat overall Medicare reimbursement rates in coming years—as well as its 20% cut to reimbursements in 2017 for analog X-rays—has some physicians diving more deeply into ancillaries that are either reimbursed at higher rates or for which patients pay out-of-pocket.

Other physicians are becoming more cautious about adding ancillary services as they await changes under Medicare’s new Quality Payment Program, says Nick Fabrizio, Ph.D., FACMPE, a principal consultant with MGMA’s Health Care Consulting.

“Physicians are having a hard enough time managing the new healthcare of today, getting their arms around quality requirements,” he says, leaving little time or money to hire the appropriate care coordinators who can maximize the value of an investment in care management procedures.

Experts and those utilizing ancillaries offer the following considerations for physicians.

GROUND RULES
Consulting an experienced attorney is a must for avoiding legal problems associated with ancillaries, including possible Stark law violations, experts say.

Laws governing the level of professional who can perform the work vary widely by state, as do reimbursement rates That makes it crucial to calculate your own return on investment rather than relying on estimates from a product or service vendor, notes Keith Borglum, CHBC, CBB, a veteran healthcare business consultant and broker. (See accompanying worksheet.)

Even within states, he says, rules are of-

Ancillaries in action

As part of the 88th Physician Report (coming April 25), Medical Economics’ readers shared their use of ancillary services and the financial effects for their practices. The following is based on nearly 1,100 physician replies.

**Q:** What ancillary services does your practice offer?

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab services</td>
<td>48%</td>
</tr>
<tr>
<td>ECG</td>
<td>45%</td>
</tr>
<tr>
<td>Spirometry</td>
<td>32%</td>
</tr>
<tr>
<td>Radiology / imaging services</td>
<td>27%</td>
</tr>
<tr>
<td>Nutritional counseling / weight loss</td>
<td>23%</td>
</tr>
<tr>
<td>Holter monitoring</td>
<td>13%</td>
</tr>
<tr>
<td>Bone densitometry</td>
<td>12%</td>
</tr>
<tr>
<td>Urodynamics</td>
<td>10%</td>
</tr>
<tr>
<td>Cosmetic / aesthetic procedures</td>
<td>10%</td>
</tr>
<tr>
<td>Stress tests</td>
<td>10%</td>
</tr>
<tr>
<td>Drug dispensing</td>
<td>9%</td>
</tr>
<tr>
<td>Sleep medicine</td>
<td>7%</td>
</tr>
<tr>
<td>Optical services / sales</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Q:** What percentage of your practice’s revenue is generated by these ancillary services?

<table>
<thead>
<tr>
<th>Percentage Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%-10%</td>
<td>52%</td>
</tr>
<tr>
<td>11%-20%</td>
<td>22%</td>
</tr>
<tr>
<td>21%-30%</td>
<td>11%</td>
</tr>
<tr>
<td>31%-40%</td>
<td>6%</td>
</tr>
<tr>
<td>41%-70%</td>
<td>4%</td>
</tr>
<tr>
<td>More than 70%</td>
<td>0%</td>
</tr>
</tbody>
</table>
ten unclear regarding the required qualifications for administering various types of ancillary services, so getting a clear sign-off from practice attorneys is highly recommended.

Another cost of doing business is keeping up with pending changes to licensure rules, says Borglum. If a practice has been paying one type of professional $30 to $40 per hour to operate a laser, a change to the required qualifications for the position might double the cost of providing the service, he says.

Likewise, if an independent contractor is performing the service and splitting profits with a practice, that could run afoul of Stark-law and other legal requirements, he says.

Other challenges include inadequate reimbursements, which has long been a problem, notes Maria Ciletti, RN, a practice administrator for a one-physician, largely Medicare-based primary care practice in Niles, Ohio.

The year after starting up a lab unit, costs tripled for the practice under new Medicare rules. Later, the practice purchased a mobile radiology unit for bone density scans and ultrasound. Insurers denied claims because the practice didn’t have a licensed radiologist, and though the equipment provider promised a workaround, the practice wasn’t comfortable with the suggested solution.

“You have to be careful before investing a lot of money in these things,” says Ciletti. “My advice is to start small and go from there.”

START AT HOME
The best place to start when considering which ancillary services to provide is by bringing services in-house that patients already use regularly, Borglum says.

“Look at the testing, services and therapies you are referring out to others,” he says. “Are you having enough quantity to justify bringing that in-house?”

Echocardiography is a good example. Two providers with many seniors in their patient panel can easily add $50,000 to $100,000 in total revenue by bringing echo back into the practice, Borglum says.

Next, physicians should consider services that their current patient base would view as natural add-on conveniences. Office-based dispensaries of prescriptions and over-the-counter remedies are also logical extensions, he says.

But doctors need to be aware of the risks. Borglum recently got a call from a physician looking to start a pain management specialty, mostly to offer the use of topical cannabis in California, a business Borglum considers high-risk and unproven. Also, if practices are opening a dispensary, they should not offer opioids, because they are frequent targets for theft, he says.

In addition, they should stay alert for new opportunities, particularly chronic care management incentives, experts say. Another area to explore: noticing procedures your payers reimburse well, and developing a specialty in one of them.

And they should try to be realistic when estimating demand, Fabrizio says. “When you listen to vendors, the sky is always the limit and the best-case scenario is always presented,” he says.

Think critically about which patients would likely use the new service or product, whether payers are reimbursing at appropriate rates and whether all the partners in a practice are in agreement and enthusiastic about referring patients, he says.

BE WILLING TO SELL
Also, just offering a product or service doesn’t guarantee added patient volume.

“It often perplexes me that what sells well in one office won’t do well at [the practice] next door. It typically comes down to the salesmanship of the staff.” — KEITH BORGLUM, CHBC, CBB, HEALTHCARE CONSULTANT AND BROKER

How to calculate your practice’s return on investment when adding services

Continued on page 38
How to code and bill for transitional care management

by NANCY ENOS, FACMPE, CPC-I and MICHAEL ENOS, CPC, CPMA Contributing authors

THE GOAL OF transitional care management (TCM) codes is to achieve increased involvement of primary care physicians (PCPs) in order to improve patient care and reduce mistakes in care coordination that can lead to readmission.

A 2007 Medicare Payment Commission Advisory Report to Congress indicated that 19% of all Medicare patients discharged from the hospital were readmitted within 30 days of discharge, at a cost of $15 billion. To help solve this problem, the American Medical Association (AMA) and the U.S. Centers for Medicare & Medicaid Services (CMS) worked together to introduce new CPT codes for TCM services and add them to the Medicare Physician Fee Schedule.

WHEN TCM IS REQUIRED

TCM services are required during the beneficiary's transition to a community setting following particular kinds of discharges. The beneficiary must have medical problems that require moderate or high complexity medical decision making.

The physician must accept and take responsibility for the care of the beneficiary post-discharge from the facility setting without a gap. The 30-day TCM period begins on the date that the beneficiary is discharged from the inpatient hospital setting, and continues for the next 29 days. The reported date of service should be the 30th day.

TCM services are furnished following the beneficiary's discharge from an inpatient acute care hospital, inpatient psychiatric hospital, long-term care hospital, skilled nursing facility, inpatient rehabilitation facility, hospital outpatient observation or partial hospitalization at a community mental health center.

One key consideration is that in order to qualify as a TCM service, the beneficiary must be returned to his or her community setting, such as his or her home or assisted living facility.

During the 30 days beginning on the date the beneficiary is discharged from the inpatient setting, the following three TCM components must be furnished.

01/ Interactive contact

Physicians must make an interactive contact with the beneficiary and/or caregiver, as appropriate, within two business days following the beneficiary's discharge to the community setting. The contact may be via telephone, e-mail, or face-to-face.

A successful attempt requires a direct exchange of information and appropriate medical direction by clinical staff with the beneficiary and/or caregiver and not merely receipt of a voicemail or e-mail without response from the beneficiary or caregiver.

For purposes of this requirement, business days are Monday through Friday, except holidays, without respect to normal practice hours or date of notification of dis-
Operations

Transitional Care Management

Transitional Care Management Codes: HOW THEY WORK

99495
Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge

99496
Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge

charge. For Medicare purposes, attempts to communicate should continue after the first two attempts in the required two business days until they are successful.

TCM cannot be billed if there was no successful communication within the 30-day period between the facility discharge and the date of service for the post-discharge TCM code.

02/ Non-face-to-face services
Furnish non-face-to-face services to the beneficiary, unless it’s determined that they are not medically indicated or needed.

Certain non-face-to-face services may be furnished by licensed clinical staff under the general supervision of a physician, however. For example, a physician or non-physician practitioner (NPP) may obtain and review discharge information (for example, discharge summary or continuity of care documents), review need for or follow-up on pending diagnostic tests and treatments, interact with other healthcare professionals who will assume or reassume care of the beneficiary’s system-specific problems, provide education to the beneficiary, family, guardian or caregiver, establish or re-establish referrals and arrange for needed community resources or assist in scheduling required follow-up with community providers and services.

Licensed clinical staff under the direction of a physician or NPP may communicate with agencies and community services used by the beneficiary, provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living, assess and support treatment regimen adherence and medication management, identify available community and health resources, or assist the beneficiary in accessing needed care and services.

03/ Face-to-face services
One face-to-face visit must be furnished within certain timeframes as described by the CPT codes: 14 days for 99495, or seven days for 99496. Medication reconciliation and management must be furnished no later than the date of the face-to-face visit.

This face-to-face visit is part of the TCM service and is not reported separately. The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

NON FACE-TO-FACE SERVICES
Despite the importance of the face-to-face service required as part of the TCM codes, the non-face-to-face services such as communication, referrals, education, identification of community resources, and medication management constitute the truly essential features that distinguish TCM from those services that are predominantly or exclusively face-to-face in nature.

When billing TCM services, only one healthcare professional may report TCM services, and TCM services may be reported only once per beneficiary during the 30-day TCM period.

The same healthcare professional may discharge the beneficiary from the hospital, report hospital or observation discharge services and bill TCM services. However, the required face-to-face visit may not take place on the same day that discharge day management services are reported.

Necessary evaluation and management services—other than the required face-to-face visit—to manage the beneficiary’s clinical issues should be reported separately. TCM services cannot be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner.

When using codes 99495 and 99496 for Medicare, practices must also report the following codes during the TCM period:

- Care plan oversight services: Healthcare Common Procedure Coding System (HCPCS) codes G0181 and G0182
- End-Stage Renal Disease services: (90951 – 90970)
- Medical Team Conferences (99366-99368)
- Telephone Services (98966-98968, 99441-99443)

Document the following information in the patient’s record:

- Date of discharge,
- date interactive contact was made,
- date the face-to-face visit occurred and
- the complexity of medical decision making.

OBSTACLES DOCTORS ENCOUNTER
The first obstacle practices often encounter when using TCM ser-
Strong pain relief, without the dosing gap.

Recommend ALEVE®, with the strength of naproxen sodium. Give your patients all-day relief from minor OA pain with just 2 doses.

- The Extra Strength Tylenol® label warns about acetaminophen overdose if patients take more than 4 g a day.
- To address this issue, it voluntarily reduced its daily dose from 4 g to 3 g—so patients may experience a 6-hour gap when pain persists for 24 hours.

Strong on pain. Long on relief.

Use as directed.
ALEVE is indicated for minor arthritis pain.
OA=osteoarthritis.
The Bayer Cross, ALEVÉ, and All Day Strong are registered trademarks of Bayer. Tylenol is a registered trademark of Johnson & Johnson.
Operations

Transitional care management

Answers to common Transitional Care Management (TCM) questions

**Q:** What if the patient is re-admitted within the 30 day period?

**A:** TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge.

Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service following the first discharge.

CPT guidance for TCM services states that only one individual may report TCM services and only once per beneficiary within 30 days of discharge. Another TCM may not be reported for any subsequent discharge(s) within 30 days.

**Q:** What if other medically necessary services are performed within the 30 day TCM period?

**A:** Other reasonable and necessary services may be reported during the 30-day period, with the exception of those services that cannot be reported.

**Q:** Could I bill for TCM services for every discharge?

**A:** TCM services shouldn’t be billed following every discharge. While most patients discharged from a hospital may be considered “moderate” in terms of complexity, they would not all have medical or psychosocial problems that require extra work to transition them back to their community setting. Remember, the essential features of TCM services are the extra non-face-to-face services that are needed to avoid adverse effects that may necessitate costly readmissions. If there was no additional work required beyond the discharge management services and a follow-up visit, then it would not be good practice to bill for TCM services, since none of the essential features were furnished.

**Q:** What would be an example of a discharge that would not require TCM services?

**A:** Here are a few examples:

- Patient admitted to observation for chest pain, later discharged home without any community resources or additional referrals.

- Patient admitted with pneumonia, treated, discharged on oral meds. Follow up with PCP arranged, but no other referrals, home care, community care or healthcare arranged. No need for non-face-to-face education. Patient able to return to independent living at home.

- Patient with fracture, surgical treatment, discharged home. Outpatient physical therapy arranged at time of discharge. No other follow up or referrals needed.

There are many challenges, including not knowing who the PCP is, lack of timely documentation of the discharge summary for the PCP and patients changing their minds about being seen by a visiting nurse or case manager once they arrive at home.

In healthcare systems with a shared electronic health record and where community physicians use the same system, the chances are better that the system can work. Where hospitals and practices remain on different systems, PCPs should try to work with the hospital administration, care management department, and hospitalist service to explore ways to communicate effectively.

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**Nancy Enos** and **Michael Enos** are independent consultants and coding instructors with Enos Medical Coding in Warwick, Rhode Island. Send coding and billing questions to medec@ubm.com.
Coding Insights

Proper billing of advanced care planning codes

Q: Can more than one physician from different specialties bill the advanced care planning codes 99497 and 99498? Or is it just the primary care doctor?

A: Yes, whoever does it and documents it can bill it. The payers may not want to see more than one of these services from different providers on the same day, but there are no frequency or specialty limitations.

Q: I have a question regarding billing E/M services with injection in office (20610). We have been getting denials for these indicating “separately identifiable evaluation & management service cannot be verified” or not separately reimbursable. Do you have any information on this?

A: The question here is whether or not there really is a separate E&M documented. If you have notes that say “here for injection” you’ll lose any appeals, but if there really is a problem that has to be assessed prior to treatment, and it is well-documented, you should get the additional E/M paid.

Remember that most insurers pay these modifier 25 claims when billed if there is adequate documentation of both services, but many will request that documentation or deny the first claim on a regular basis. Your success here will be largely contingent on the quality of your documentation.

Q: I would like to bill an emergency department (ED) visit for my work in the labor and delivery area of the hospital. The labor and delivery triage unit is really just an extension of the ED for patients who are above 20 weeks. When patients above 20 weeks present to the ED, they are sent to us even if they come from registering in the ER. Can we use the ED codes?

A: Per the CPT manual, the ED codes 99281-99285 represent services provided in an emergency department, in a facility setting that meets the definition of an ED. I’m sure that your labor and delivery area does meet the criteria of being open 24 hours a day and is prepared to take unscheduled patients at risk—but your real answer here will come from the hospital.

The hospital or its legal department would be able to tell you how that area is classified or what it supports. Is it a designated observation area, a wholly outpatient setting?

Theoretically you could bill outpatient codes, observation codes, same-day admit discharge codes, consult codes or even hospital admit codes in that setting. ED codes are unlikely, but possible. Check with the hospital’s legal department.

Bill Dacey, CPC, MBA, MHA, is principal in the Dacey Group, a consulting firm dedicated to coding, billing, documentation and compliance concerns. This article was first published by our partner publication, Physicians Practice. Send your coding and billing questions to medec@ubm.com.
How physicians can deal with policy uncertainty

With rapid change coming from the nation’s capital, doctors are wondering what it means to their practices

by KEITH L. MARTIN Editorial Director

PHYSICIANS HAVE always had to be keenly aware of changes in healthcare, from technological innovations to new approaches to patient care. But these days, palliative care internist Amy Davis, DO, is also keeping one eye on healthcare policy developments emanating from Washington, D.C.

From the final rule for Medicare payment reform late last year to the election of Donald Trump as president, a lot has happened in a relatively short timeframe. These changes have created an air of uncertainty for Davis and other physicians nationwide, as they await the fate of the Affordable Care Act, wonder what a physician—U.S. Rep. Tom Price, MD—will do as head of the U.S. Department of Health and Human Services, and whether other programs and mandates that have shaped healthcare over the last eight years will change or disappear.

“It’s getting harder, not just to be a physician trying to figure out what to do, but also as a small business owner,” says Davis. “I need to keep the lights on and I need to pay my staff.”

In her solo practice located in suburban Bryn Mawr, Pennsylvania, 146 miles north of the nation’s capital, Davis has added counselor to her role of physician, for her patients as well as her staff. Both groups are worried about their own medical coverage and financial well-being.

Davis recalls a recent encounter with a Medicare patient in need of physical therapy. The patient feared that his yearly allocation of services—something so certain in the past—would change under a Trump administration.

“I said to the patient, ‘You are set for the year, don’t worry,’ and he said in return, ‘Trump is changing things in the middle of the game and waiting for people to challenge him legally. What if things change in the middle of the game for me?’” says Davis. “I had no reply. The rules don’t seem to apply to [Trump].”

Davis’ approach jibes with advice from Bob Doherty, senior vice president for governmental affairs and public policy for the American College of Physicians (ACP). Doherty told Medical Economics that physicians can’t completely reassure their patients about what’s to come.

“Doctors like to be reassuring and say: ‘Don’t worry about it.’ Clearly, that’s not the case,” Doherty says. “I think the best thing [physicians] can do is hear [patients] out and let them know that you have their back.”

Similar anxiety exists among Davis’ employees, worried about their health coverage and paychecks. To keep morale high, she brings in the occasional treat and constantly

HIGHLIGHTS

➦ The combination of President Trump and a Republican Congress could mean a more free-market environment approach with fewer mandates.

➦ There is always opportunity in uncertainty, especially for physicians who are visionary and entrepreneurial in their leadership.

The combination of President Trump and a Republican Congress could mean a more free-market environment approach with fewer mandates.
reassures them that they are in good hands. “I’ve told them that you will get paid before anyone else, including me,” she says. “A happy staff makes me happy.”

**NO STRANGERS TO CHANGE**

Davis, like thousands of other physicians juggling their clinical and business duties, is no stranger to change. She acknowledges that it comes with the territory, and is maintaining an even temperament these days despite the unknown ahead.

While used to change, physicians don’t necessarily embrace it, notes Mark Werner, MD, national director of clinical consulting for The Chartis Group, a healthcare consult-

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**Five strategies to deal with the unknown**

Mark Werner, MD, national director of clinical consulting for healthcare consulting firm The Chartis Group offers these five strategies for physicians:

**Don’t hit pause**

Being cautious with finances is one thing, but Werner advises physicians not to put their heads down and try to wait out any changes, especially when it comes to the Medicare Access & CHIP Reauthorization Act (MACRA).

“MACRA is here and it is here to stay,” says Werner. “I think there will be, at best, minor, if any, modifications [at all] … and those will likely be things that sort of slow its implementation. There was extremely strong bipartisan support for MACRA.”

So if your practice has already taken steps to prepare data for reporting, stay focused on that path, he advises.

**Figure out ‘no regret’ changes**

Physicians should recognize the current uncertainty, but also take what Werner calls “no regret” actions, those that they believe will prove to be a good use of time and resources, regardless of how the next few months or years pan out.

These actions can include continuously looking for ways to reduce operating costs. Werner also recommends that practices understand and embrace the notion that population health is about “excellent access, strong patient engagement and creating and demonstrating value to those who pay for care … which includes your patients.” No matter what happens, this will be a constant, he notes.

**Review your efficiency**

Downward pressure on healthcare revenue will continue, says Werner, including in primary care.

“As a result, we need to make sure our practices are working very efficiently, that we have given some really good [thought] to how well we are optimizing the clinical operational and financial performance of our medical group,” he says. One example is ensuring your practice is performing in the top quartile for clinical outcomes.

**Continue to invest in technology**

Whether for MACRA or to manage the performance of your practice, investment in technology is an ongoing need.

“This is important both from a clinical operation and a financial point of view,” says Werner. “You need the tools for both.”

He notes that even if revenue is tight, practices should make the investments, which could require partnerships, being part of a clinically integrated network or even a learning collaborative. In any case, the focus should be on what technology the practice needs and how to get it.

“Under MACRA, this will quickly not be optional but a core capability for success,” says Werner. “Many medical groups will clearly not be able to fund this off their operations and existing revenue. That said, even simple EHRs have the ability to support quality improvement and decision support when used to their full extent.”

**Think about physician relationships**

From clinically integrated networks to building referral management capabilities with other physicians, Werner recommends doctors look to peers in the community and solidify those relationships to aid with value-based care.

“This goes beyond the informal [relationship] to really thinking about what … relationships you will need with fellow physicians [to] support you and enable you to perform in a value-based or performance-contingent environment,” he says.
Dealing with uncertainty

“Luck favors the prepared. Now is the time that will reward the more ambitious and the bolder-moving practices. Those that tend to be late adopters ... will find themselves more behind.”

—MARK WERNER, MD, NATIONAL DIRECTOR OF CLINICAL CONSULTING, THE CHARTIS GROUP

“Physicians in general don’t tolerate uncertainty very well,” says Werner. “We work in a field accustomed to facts and information and things that are tangible. Now we find ourselves in a period where things are really pretty unclear and our comfort level as a profession with this level of unknown is a bit challenged.”

Werner says the Trump administration will enact changes faster than its predecessor, making medicine more about price and cost, hence accelerating the importance of patient choice. The combination of President Trump and a Republican Congress will mean a more free-market environment, less regulation and empowering individuals to make more choices. Therefore, he says, practices must stay aware of what’s coming their way and how to take advantage of it.

Werner notes there is always opportunity in uncertainty, especially for physicians who are visionary and entrepreneurial in their leadership. “Luck favors the prepared,” says Werner. “Now is the time that will reward the more ambitious and the bolder-moving practices. Those that tend to be late adopters and more cautious—already finding themselves behind the curve—will find themselves more behind.”

In Hamburg, New Jersey, solo OB/GYN Fred Nichols, DO, is taking that approach. Three years ago, Nichols added weight loss services that were covered by insurance to his practice as an added revenue stream. Now, anticipating some financial uncertainty, he’s adding more ancillary services to keep his practice thriving.

“I have to think outside of the box,” says Nichols, who has operated independently for 15 years. “As an OB, I never thought I’d be doing facial rejuvenation, but it is a cash-paying service.”

Nichols has also taken on locum tenens work as a “little cushion” to help with the immediate future. “I used to be able to know, with some certainty, what patients and what revenue, were walking through the door,” he says. “I don’t feel that level of comfort anymore. If I see fewer patients, that means cutting staff and I don’t want to do that.”

Like Davis, he has dealt with the “huge cloud of uncertainty” dating back to before the election, but is a little more confident with a businessman running the country.

“No matter your political views, at the end of the day, [Trump] has run very successful businesses,” he says. “So in a business sense, things have to be cut and curtailed and I understand that. So I have a little wide-eyed optimism.”

GOING INTO ‘SURVIVAL MODE’

While Davis awaits the Trump Administration’s next move, she is also anxiously anticipating word from the Centers for Medicare & Medicaid Services (CMS) regarding her future reimbursement. Under the Medicare Access & CHIP Reauthorization Act (MACRA), practices like hers, with $30,000 or less in Medicare Part B charges, are exempt from data reporting provisions.

“I’m still awaiting my ‘golden letter’ from CMS regarding my MACRA exemption,” she says. “By my records, I should be exempt ... but what we have and what Medicare has for us is often incongruent.”

Davis has been on the phone with CMS frequently, starting in December 2016 when letters to qualifying providers were supposed to arrive. CMS then told her she’d find out in January, then that the letters were to come through Medicare Audit Contractors, so there...
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*Locum Tenens Awareness and Perception Survey Analysis, Prepared for CHG Healthcare Services, Inc. March 2016*
Dealing with uncertainty

Trends

Physicians should prepare for uncertainty coming out of Washington, D.C. because President Donald Trump is poised to shake up healthcare policy, says Robert Doherty, senior vice president for governmental affairs and public policy for the American College of Physicians (ACP).

In fact, Trump’s early executive orders, including a travel ban involving seven Middle Eastern countries and loosening of regulations in regards to the Affordable Care Act (ACA), have already created confusion for both physicians and patients, Doherty told Medical Economics.

“I think we are in an era of major disruption and it’s not entirely clear yet what policies the administration and Congress will pursue and in what order,” he says.

Trump’s unpredictability makes it difficult to gauge where healthcare policy will move under his leadership and that of the Republican-controlled Congress. Doherty says the ACP is working to provide clarity to physicians on some major issues, including Obamacare, Medicare payment reform, electronic health records (EHRs) and administrative burdens.

24 More recently, a CMS help desk attendant told her, “toward the beginning of February.” As of press date, Davis is still unaware if she needs to provide quality metrics or not. “For something that went into effect on January 1, this is quite a delay,” she says. “I have to pay salaries and there are other issues.”

Those other issues include replacing broken lab equipment and updating her practice’s electronic health record (EHR) system. Given the uncertainty of what’s ahead, both investments are on hold. Davis has also from third-party payers, including the government. Dr. Price did vote for MACRA, by the way.

I would expect as HHS secretary that Dr. Price would be receptive to potential changes to ensure there aren’t excessive burdens placed on physicians that don’t generate greater value, to try to make sure the transition is such that there are opportunities for physicians in all specialties to get on the value-based payment train.

I think there will be a hard look at the quality measures that are used: Are they meaningful, do they really help to improve patient care? … It’s not value-based payment if the measures you use to assess value aren’t good measures …

Q: Medical Economics: Is there any sense of what the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will be like under the Trump Administration? Are they committed to value-based care?

Doherty: I think they are committed. Remember, MACRA was passed by a huge bipartisan majority and passed by a Republican-controlled Congress. So this has the Republican brand all over it. In his confirmation hearings, Dr. Price [Tom Price, MD, secretary of the U.S. Department of Health & Human Services] indicated he remained supportive of the goals of that law, to move it toward value-based payment.

I do think Dr. Price comes at issues from the perspective of not wanting to put unnecessary burdens on doctors. He’s been very strong in his belief that the doctor-patient relationship needs to be protected from intrusions

Q: Medical Economics: Do you think this administration and Congress will continue to push doctors to use EHRs?

Doherty: I don’t think the push for EHRs will lessen. I don’t think anyone wants to go back to a world where almost everything is documented on paper. Interesting, as much as physicians are frustrated with EHRs—and
Dealing with uncertainty

called her bank to ensure her line of credit is secure and to indicate that she might have to use it in the near future.

Davis likens the current feeling to what used to be the annual uncertainty of whether Medicare’s Sustainable Growth Rate (SGR) would take effect—bringing double-digit reimbursement cuts to physicians—or Congress would delay the cuts for another year.

“You have to go into protection mode, like we did pre-Obamacare and with the SGR,” she says. “You go back into that survival mode.”

that’s not all because of the government—very few that have adopted EHRs would ever go back to paper charts. So I don’t think the push to get EHRs universally adopted is going to go away, I don’t think the push to achieve true interoperability is going to go away — it’s one of physicians’ main frustrations.

There may be some efforts to look at the penalties. A very large number of physicians are getting Meaningful Use penalties this year. I wouldn’t be surprised to see some interest in easing those penalties. When you have very large numbers of physicians failing to meet the requirements of a regulatory program, you have to ask the question: Is it the regulatory program’s fault or is it the docs’? The numbers are so big, there are reasons to suggest it’s the program itself that’s problematic.

Now remember, MACRA is transitioning away from meaningful use (MU) to advancing care information (ACI). Congress really wanted to ease the burden with complying with what had been MU before, and making the goal to promote use of EHR systems that truly are shown to improve patient care.

There’s still too much of a pass-fail philosophy in the ACI program. That was an area in the final rule that the ACP and others felt they didn’t go far enough under the previous administration. So I think that’s an area ripe for improvement as well.

I still think you’re going to see carrots and sticks, though. MACRA is a carrot-and-sticks system, but even that’s an improvement over MU, because MU right now is only sticks. … I do think there’s a lot that can be done under the ACI program to work with the vendors to make EHRs more relevant and useful, to avoid unnecessary clicks and pop-up reminders that drive doctors crazy, and improve patient safety.

Q: Medical Economics: What are some ways ACP and other physician organizations can advocate in Washington on behalf of small practice physicians?

Doherty: The administrative burden is the number one thing I hear when I go around the country and talk to doctors. … While administrative burden affects all physicians, primary care physicians get the brunt of it. Everything in healthcare comes down on them, whether its pre-authorizations or second-guessing everything they do.

At ACP, we have an initiative called “patients before paperwork” where we are really going to challenge administrative requirements, tasks and regulations that are imposed upon physicians and detract from the physician-patient relationship. We all recognize that some regulation is necessary and appropriate, but in many cases it’s either a requirement that has no justification or has been shown to not really achieve the results it was intended to achieve, or maybe there’s just a better way of doing it.

We’re going to be coming up with some comprehensive recommendations over the next several months to address some of that. Some will be taken to Congress and HHS, because some of it is the government, but I can also tell you the private sector and private insurance industry is a big part of that as well.

For small practices under MACRA, the ability for them to participate in alternative payment models (APMs) is huge. You can get bonus payments and incentives for being an APM. So far, most of the APMs are more suitable for larger systems, so we need to find APMs that work for small practices. We need to find ways for small practices to virtually group together as an APM to achieve economies of scale.

If you can eliminate red tape and regulations and create more opportunities for small practices to participate in APMs, I think that would be a huge help to physicians in small practices.
8 ways to make adult vaccinations profitable

New CDC guidelines suggest greater immunization rates, so practices should review programs

by JENNIFER NELSON Contributing author

Physicians know the health value of vaccinations and want to provide patients with this important service. But historically, there’s been a gap between vaccine costs and the reimbursement practices receive for administering them. Though some physicians still feel vaccinations are cost-neutral or even a financial drain, many practices have taken steps to create robust vaccination programs that actually contribute to their bottom line.

“One of my biggest challenges is getting physicians to understand that vaccinations are simple, easy and economically they make sense, and we’re doing the right thing for patients,” says Jason Goldman, MD, an internal medicine practitioner in Coral Springs, Florida, and governor of the Florida chapter of the American College of Physicians.

With the Centers for Disease Control and Prevention’s recent update to adult vaccination guidelines urging more immunizations, now is a good time for physicians to review their programs.

THE REALITY OF VACCINATIONS IN PRACTICE

Physicians agree that vaccinating patients is medically essential, but it takes some understanding of the business of vaccines to do it in a way that makes financial sense.

Since vaccines are expensive to purchase and reimbursement often was not robust or timely in the past, practices were left paying out-of-pocket for a service on which they often lost money.

That needn’t happen today. Goldman attributes some of the problems physicians have now to poor business decisions and a lack of knowledge about reimbursement practices.

In fact, practices can actually make a profit based on billing for the vaccination itself, in addition to the administration codes. But to do so, physicians have to understand supply and demand, vaccination recommendations, the reimbursement procedures and they must stay on top of the business of vaccines.

Here are eight ways physicians can make vaccinations more cost-effective:

1 Practice good inventory management

If vaccines sit in the refrigerator unused, the practice has incurred an expense it may not recoup.

While vaccines have long shelf lives, practices that inventory well know how much they have on hand, how much they need and when to purchase more. In addition, they needn’t pay for the vaccine until long after the payer reimburses them for vaccinating the patient. With deferred billing and timely reimbursements today, there’s no reason to lose money on vaccine purchases.
But someone must track fluctuations in the demand for vaccines by reviewing previous vaccination records and scheduled appointments, then use that data to assess how many vaccinations may be needed in the next 90 days. That way, a practice can keep enough inventory on hand to meet demand. Practice staff should order every two to four weeks to best keep supply in line with expected demand.

2 Consider a vaccine purchasing group
Buying vaccines through a purchasing group, which takes many independent practices together and negotiates the lowest possible fee for bulk purchases, is the most cost-effective way to buy vaccines. A practice that doesn’t belong to a vaccine pur-

CDC revises guidelines for adult vaccinations

As physicians find ways to make vaccinations economically viable for their practices, new federal immunization guidelines urge greater coverage for adults.

The national advisory panel of the U.S. Centers for Disease Control and Prevention (CDC) recently released its 2017 advisory for recommended shots in conjunction with several medical groups, including the American College of Physicians.

Guidance on seasonal flu shots has been revised by eliminating nasal flu vaccines and modifying flu shot advice for patients with egg allergies. Adjustments were also made to recommendations for vaccines against hepatitis B and meningococcal disease.

“All adults need immunizations to help them prevent getting and spreading serious disease that could result in poor health, missed work, medical bills, and not being able to care for family,” the report’s lead author, David Kim, MD, said in a statement. Kim is deputy associate director for adult immunizations in the CDC’s Immunization Services Division.

Here are the major changes physicians need to know:

- Elimination of nasal flu vaccine, because studies have found it to be largely ineffective.
- Egg-allergic people, whether they have mild or more serious allergy, can receive any age-appropriate flu vaccine. The new guidance states even people who develop symptoms like swelling, lightheadedness or breathing difficulties may get a flu shot, however they should get the shot under supervision of a healthcare provider who is able to recognize and manage severe allergic conditions.
- Adults with HIV should receive a two-dose series of MenACWY, a combination meningococcal vaccine.
- A new vaccine schedule has added people infected with hepatitis C virus to the list of those with chronic liver disease who could benefit from a hepatitis B vaccine series.

In addition to these changes, researchers noted that U.S. adult immunization rates fall short of recommended levels.

Furthermore, the report found that only 20% of adults 19 years of age and older have had a Tdap vaccine, which protects against tetanus, diphtheria and pertussis.

ONLINE
For a chart on the CDC’s new vaccination schedule by age, visit bit.ly/17-adult-vax
chasing group is missing an opportunity to save money, say experts.

Purchasing directly from manufacturers is the next-best option for obtaining a good price. The most expensive method is to buy vaccines through a third-party reseller or vendor. Its costs and associated fees are going to be higher than going through the manufacturers directly. Goldman advises avoiding these vendors or resellers who sell the vaccine at a marked-up price.

Goldman always looks for the most economical way to purchase vaccines. “If I pay promptly I get another discount, and if I buy multiple vaccines, I get another discount,” he says.

3 Manage billing

New ICD-10 codes make billing for vaccines easier.

“If you don’t know the codes, you’re not going to get the reimbursement,” says Goldman. Only one diagnosis code—Z23—accounts for immunizations, whereas previously each vaccine needed its own diagnosis code. Each type of vaccine then has an administration code—whether pneumonia, flu, tetanus or hepatitis.

Federal law mandates that insurance companies reimburse for the cost of all vaccines recommended from the American College of Immunology and the Advisory Committee for Immunization Practices. These groups, along with the CDC, determine the recommendations for patients under 65. But administration of the immunizations is left to payer negotiations for reimbursement.

Goldman explains that Medicare has specific billing guidelines: The pneumonia, hepatitis B and flu vaccines all are reimbursable under part B. As long as physicians follow the guidelines, they will receive reimbursement.

Other vaccines, including those for shingles, hepatitis A and tetanus, fall under Medicare part D. Many physicians mistakenly refer patients to a pharmacy for these vaccinations because they didn’t realize they were reimbursable. There is computer software available that will allow a physician’s office to submit claims under a pharmacy billing code to receive reimbursement for these vaccines. That software, TransactRx, is available for free, will also check if the patient is not covered or if their coverage doesn’t include vaccines.

Software is available from Merck that will check vaccination coverage for Medicare patients and allow physicians to receive reimbursement for vaccinating those patients.

4 Defer payment

Most vaccine manufacturers, along with vaccine purchasing groups, have a 60-day payment term, at the end of which a practice could pay, and do so with a credit card. Since credit card statements come back 30 days later, a practice could wait nearly 90 days before having to pay for its vaccines.

Even better, some manufacturers and most vaccine purchasing groups offer a deferred invoice so practices don’t have to pay for three months. “So you get the vaccine, you administer it, you get the reimbursement and they don’t...”

One of my biggest challenges is getting physicians to understand that vaccinations are simple, easy and economically they make sense, and we’re doing the right thing for patients.”

—JASON GOLDMAN, MD, INTERNIST, CORAL SPRINGS, FLORIDA

CODING FOR ADULT VACCINES

ICD-10 diagnosis code: Z23

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<tr>
<th>Vaccine</th>
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<td>Shingles zoster</td>
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Source: U.S. Centers for Disease Control and Prevention; Priority Health
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Adult vaccinations

“Physicians need to figure out a way to do [vaccinations] in the most economical way for them.”

—AARON E. GLATT, MD, CHAIRMAN, THE DEPARTMENT OF MEDICINE, SOUTH NASSAU COMMUNITIES HOSPITAL, OCEANSIDE, NEW YORK

5 Get a handle on reimbursement
While physicians often experienced long delays and inadequate reimbursements in the past, these should not be problems today.

Typically, it takes about seven to 10 days to get reimbursed for vaccines if physicians are using an electronic system and submit clean claims. Practices that are having problems with reimbursement are either not using their billing software correctly or filing claims incorrectly. The most common billing problems include entering incorrect information, inputting the wrong codes and mismatching treatment and diagnosis codes.

6 Look for pricing deals
Practices can receive email alerts announcing when manufacturers raise their vaccine prices. Before manufacturers raise their prices, they typically offer a grace period.

To buy vaccines prior to a manufacturer’s price increase, practices should look at when the vaccine’s price is going up, how much the practice has in storage, how many patients are scheduled to receive it during the next 30 to 60 days before deciding whether it’s cost-effective to purchase an additional lot before the price increases.

Manufacturers’ representatives are also usually good about bringing price sheets to the office in advance of increases. If Goldman sees there is going to be a price increase in the next 90 days, his medical assistant orders more product. “Because if you are vaccinating routinely, you are not going to have expired stock,” he says. If, however, practices have expired vaccines, many manufacturers will take them back and give credit for it.

7 Form an immunization team
Running a profitable vaccination program may take a team—someone to order vaccines and be alert for price increases, someone to monitor inventory and a biller who understands the codes, the software and all the billing systems and stays on top of fee schedules and raises them accordingly.

Goldman does it all himself, but many practices prefer their office staff to handle these tasks. Office personnel involved in any aspect of the vaccine program may need additional training.

8 Alert patients when they are due for vaccinations
William Schaffner, MD, MACP, professor of preventive medicine and infectious diseases at Vanderbilt University School of Medicine in Nashville and an infectious disease physician, urges physicians to implement electronic health record systems that include prompts to alert them when a patient needs a vaccination.

Goldman’s office routinely phones patients to remind them of their vaccination needs. “Flu and pneumonia are probably the most widely-given vaccines, but we also give a number of shingles, hepatitis and tetanus as well,” he says.

To compete with pharmacies or “minute clinics,” physicians should try to bring patients into their practice for vaccinations, even if it means temporarily adjusting practice operations.

“We run flu shot clinics where patients can just drop in to get their shot and not have to make an appointment or fill out paperwork,” says Jeffrey Kagan, MD, an internist in Newington, Connecticut and member of the Medical Economics editorial advisory board. “That’s one way to become more financially viable.”

Many patients would rather get vaccinated at their doctor’s office if it’s quick and easy, knowing it is being administered by a medical office versus someone at a retail clinic. Kagan gives about half his patient flu shots this way.

“You can make a profit anywhere from $10 to $50 per vaccine, depending on which vaccine it is,” says Goldman. “But more importantly than that, it is good patient care. It keeps the patient healthy, and prevents them from getting infections and keeps them out of the hospital.”

This should be the standard offering of every practice—to make sure adult patients are vaccinated appropriately as per published guidelines, and as per their individual case when it may differ from guidelines, says Aaron E. Glatt, MD, FACP, chairman of the department of medicine and hospital epidemiologist at South Nassau Communities Hospital in Oceanside, New York.

“Physicians need to figure out a way to do this in the most economical way for them.”
Navigating each day requires us to make thousands of decisions, and our brain’s default setting is to ignore conflicting information. When doing so, we often overlook valuable information that completes the picture. While mental shortcuts help in some facets of life, falling victim to confirmation bias in matters of personal finance can lead to subpar results.

Some of my physician clients came to me with portfolios they had managed themselves. When I analyze these portfolios and dig deeper about how investments were selected, I find confirmation bias is often at work.

For example, many investors utilize Morningstar (a publication providing mutual fund research) when picking funds. “I only pick four- or five-star rated funds,” is a common refrain during initial meetings with prospective clients.

However, when I ask if they did any research to determine correlations between Morningstar’s highly rated funds and superior performance, I get a quizzical look. (Hint: the most meaningful correlation between a fund’s future performance isn’t the number of stars; it’s cost).

Also, investors should not overlook negative stories about an investment in a sea of otherwise positive press. What’s the track record of the “experts” you are using? Finally, if working with a financial adviser, be sure to ask what process they use to overcome confirmation bias. Doctors are especially prone to confirmation bias for the simple reason that most work in demanding environments under intense time pressures—not the optimal environment for contemplative decision-making.

Financial decisions are often easy to enter but harder to exit, making the stakes involved with an error that much higher.

The saying “two heads are better than one” has merit. It’s helpful to have an unbiased friend or colleague vet your analysis. One famous psychologist uses an interesting twist on this idea by presenting his friends the opposing view of his intended course of action to see if they endorse it, and if so, why.
The digital disconnect in post-acute care

Health IT change is coming to nursing facilities and home health agencies, fixing a problem for physicians

by KEN TERRY Contributing author

HIGHLIGHTS

Besides improving quality, the increasing digitization of post-acute care (PAC) providers could help reduce the burden of repetitive daily tasks involved in the oversight of PAC, such as signing orders and care plans and reviewing patient information.

AS THE MEDICAL director of a nursing home, Kenneth Kubitschek, MD, an internist in Asheville, North Carolina, gets called occasionally about patients he’s never seen. Perhaps a patient has just been transferred in, and he’s asked to sign off on the orders written by the hospitalists.

The problem, he says, is that without an electronic link with the hospital, all the nurse in the skilled nursing facility can do is fax him the orders – without any context for the cases.

“I’ll go through the medicines and hope that the discharging physicians had it all correct,” he says. “It’s like any pass-off, you have to hope that the person passing the baton is doing a good job.”

The quality of care would improve, he argues, if there were better online communications between hospitals and skilled nursing facilities.

Most nursing homes and other post-acute-care (PAC) providers, including rehab facilities and home health agencies, are still in the stone age of information technology, experts say. But health care reform is forcing PAC providers to computerize and compelling hospitals to prioritize information exchange with nursing homes and home care agencies.

When physicians are able to access vital data across these care settings much faster than they do now, they will find it easier to care for patients recovering from hospital stays and dealing with complex illnesses, observers say.

“If physicians have improved access to [PAC] data, hopefully they can make better decisions and can provide more efficient care for the patient and can improve transitions and outcomes,” says Mike Seiser, director of the healthcare practice at Chicago-based Huron Consulting Group. “As they move to value-based care and population health, they will need that kind of data.”

WHY PAC PROVIDERS LAG

Experts agree that PAC providers trail acute and ambulatory care providers in health IT by a wide margin.

One reason PAC providers lag is their lack of resources, says
"I couldn’t do this job without the knowledge and skills I learned in the Kelley Physician MBA."

Michelle Fenoughty, MD, MBA’16
Chief Medical Officer and OB/GYN
Hendricks Regional Health

NOT JUST ANY MBA.
ONE DESIGNED FOR PHYSICIANS.

Physicians are the catalysts for driving healthcare change. That’s why we created the Kelley Business of Medicine Physician MBA. Built from specialized, contemporary courses at the intersection of medicine and business, our 21-month, physician-only MBA allows you to learn and apply business skills in a healthcare context.

For physicians like Michelle Fenoughty, MD, MBA’16, learning business made all the difference. “You’ll be much better at making business decisions and giving advice to administrative colleagues, especially when an issue impacts physicians’ roles,” says Dr. Fenoughty. “But just as important, learning business will make you a better clinician—because you’ll see medicine differently.”

Watch Dr. Fenoughty’s story and explore the program. kelley.iupui.edu/med-econ
Jonathan Baker, FACHE, managing director of the healthcare solutions practice at consulting firm KPMG. He assigns part of the blame to the exclusion of PAC providers from the government’s EHR incentive program, which has deprived these providers of funding to upgrade their health IT systems.

There are signs of change, however. The Meaningful Use program has provided an incentive for hospitals to send electronic care summaries to skilled nursing facilities and home care agencies. In addition, cooperation with PAC providers can help reduce readmissions, for which the Centers for Medicare & Medicaid Services (CMS) financially penalizes hospitals. And some healthcare systems recognize that post-acute care holds the key to controlling costs under bundled-payment arrangements.

“In areas like mandatory bundled payment pilots, hospitals are making meaningful attempts to enable bidirectional exchange of data with post-acute facilities,” notes Greg Kuhnen, director of research for Advisory Board, a Washington, D.C.-based consulting firm.

Studies show that most of the variability in cost for bundled procedures stems from post-acute care, notes Kuhnen. Therefore, he says, it makes sense for hospitals in bundled payment arrangements to exert tighter control over what nursing homes are doing. To do that, they need data to make the nursing homes’ activities visible.

In some cases, he adds, PAC facilities owned by or closely affiliated with a healthcare system will piggyback on the health IT infrastructure of that system. That gives nurses in skilled nursing facilities, for instance, the ability to view hospital information online.

Seiser thinks that some healthcare organizations might start to subsidize health IT purchases by PAC providers. He doesn’t believe, however, that the government will cough up any more EHR incentive funds.

Meanwhile, PAC facilities are consolidating into larger entities, and hospitals are acquiring skilled nursing facilities and home care agencies, Seiser points out. As a result, more PAC providers will gain the resources to invest in health IT. At the same time, independent PAC organizations will have to computerize so they can compete for referrals from hospitals.

“If they want to be a good partner as we move toward population health management, they’re going to have to improve their ability to communicate online with hospitals, or they won’t be chosen as a partner,” Seiser says.

**EHR VENDORS EXPAND**

As hospital interest in PAC grows, the leading suppliers of acute-care EHRs are also expanding their products into that market, says Kuhnen. Epic, for example, is giving PAC providers some ability to view data and to document in the EHRs of hospitals and ambulatory care clinics.

Similarly, Healthy Planet, Epic’s population health management software, can be used by home health aides or someone else who would not otherwise have access to a clinical record, he notes. Healthy Planet allows such users to assign tasks to people electronically and to do clinical documentation. A hospital could use that data to trigger an intervention if a patient’s condition deteriorates.

Baker also sees growing integration between hospital and nursing home systems. “Epic, Cerner and Meditech have the ability to aggregate [acute care] data in the ancillary areas like radiology, lab and pharmacy. When they have an enclosed system with a skilled nursing facility inside it, they can provide those physicians access so they can look up the latest data on the patient.”

When hospitals and nursing homes are online with each other, and physicians can see what’s happening with their patients, the improved visibility should lead to higher quality and lower cost, Kuhnen says.

“Reducing length of stay is a clinical win if a patient is ready to move on to a less-acute setting. And we know that post-acute-care facilities have at times held patients longer than necessary. So closer scrutiny of what’s happening in these settings should benefit patients clinically, and there’s a financial incentive to reduce wasteful care.”

Home health agencies’ ability to ex-

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“I’ll go through the medicines and hope that the discharging physicians had it all correct. It’s like any pass-off, you have to hope that the person passing the baton is doing a good job.”

— KENNETH KUBITSCHEK, MD, INTERNIST, ASHEVILLE, NORTH CAROLINA
change data with hospitals is rudimentary, Seiser says, but most can send and receive a limited amount of information fairly well.

Some home care agencies have also improved their ability to communicate with physicians, he says. For example, he has seen advanced systems in agencies that allow physicians to view home care data online. But those capabilities are not being widely used.

**REDUCING OVERSIGHT BURDEN**

Besides improving quality, the increasing digitization of PAC providers could help reduce the burden of repetitive daily tasks involved in the oversight of post-acute care, such as signing orders and care plans and reviewing patient information. But that relief has not yet arrived for most physicians.

For example, internist Jeffrey Kagan, MD, of Newington, Connecticut, derives 15% of practice revenue from his work in seven nursing homes. Six of them send him orders to sign. The one that doesn’t requires him to pick up them up in person.

Some of the others fax orders to him, some use email, and a couple skilled nursing facilities allow him to go to a website and digitally sign orders there. Home health agencies send orders by fax, snail mail or courier.

Kagan, a member of the *Medical Economics* editorial advisory board, would like them all to go online. “It would make my life much easier,” he says.

Kagan also complains about the information overload that he constantly encounters in nursing homes. In the past, he recalls, patients would arrive at a nursing facility with a one-page clinical summary that would include basic data. It would be followed by a two- or three-page discharge summary that included history highlights and physical.

But nowadays, with hospitals easily able to print out sections of the patient’s EHR or the whole chart, they send the entire H&P, he says.

“For a quick little admission where the patient had a knee replacement, you’ll get 20-25 pages of documentation,” he says.

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**SPECIALIST MODEL**

Kubitschek has some of the same frustrations as Kagan. But Asheville, North Carolina, has much better IT integration between PAC providers and physicians than most of the country.

One reason is that most of the specialized physicians who staff the 29 local nursing homes belong to a single group owned by Team Health. All the internists and other specialists in the group use the same EHR (Geri-Med), and local primary care doctors can view that record online.

Team Health recently interfaced Geri-Med with PointClickCare, the most commonly used EHR in nursing homes. Now nurses in skilled nursing facilities can enter certain kinds of notes into Geri-Med, says Kubitschek.

This model improves both communications and the quality of care, says Kubitschek, a *Medical Economics* editorial advisory board member, partly because the geriatric specialists who follow patients in the nursing facility can see them more often than primary care doctors did.

Also, his access to the specialists’ Geri-Med EHR gives him a birds-eye view of the relevant portions of the patient’s hospital record as well as their nursing home encounter notes. Moreover, his EHR can exchange secure messages with Geri-Med, including attachments of clinical summaries.

**SLOW IMPROVEMENT**

Physicians should not expect PAC providers to improve their digital capabilities significantly in the near future.

There’s still a lot of paper in PAC facilities, and document scanning is state-of-the-art in many facilities, Seiser points out. Even skilled nursing facilities and home care agencies with EHRs are not yet exchanging much data electronically with hospitals or ambulatory-care providers.

“The ability to do discrete two-way integration of data is not there yet,” he says. “But the vendors are getting a little better at it, and so are the hospitals. It will continue to ramp up in sophistication.”

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*JEFFREY KAGAN, MD, INTERNIST, NEWINGTON, CONNECTICUT*
in one office won’t do well at [the practice] next door,” Borglum says. “It typically comes down to the salesmanship of the staff.”

Physicians have to put time into building a service and training staff to communicate it to patients, says David Zetter, PHR, CHBC, principal of Zetter Healthcare, a consulting firm in Mechanicsburg, Pennsylvania.

Zetter and Borglum both say they have taken on new clients, only to hear stories of failed ancillary businesses when practices ignored the need to market the new service. Sometimes they even see unused equipment gathering dust in conference rooms because a partner who spearheaded an idea for a service left the practice before getting it up and running and the other partners weren’t committed to the idea. Sometimes partners get excited about a new service but are too distracted by daily practice demands to give it the required attention.

Time and money costs associated with ancillaries vary dramatically, Zetter says, not only among different services but within them. Two practices opening radiology suites, for example, will have different cost and revenue structures depending on factors such as whether they lease or buy equipment, whether the equipment is new or refurbished and how they charge for a radiologist’s time to read images, not to mention local labor costs involved in building out the suite around the equipment and transportation costs for the X-ray machine. Consider all the options when estimating costs and revenues, he suggests.

“You may find it’s more economical to bill payers just for the technical component,” or it may make economic sense to absorb the entire procedure, pay fees to the radiologist, and seek reimbursement for both the equipment and physician time, he says.

**RUN THE NUMBERS**

Another common mistake, accepting a vendor’s revenue and return-on-investment projections, can be avoided by asking for details on the vendor’s underlying assumptions and then comparing the practice demographics used in those assumptions to the practice’s own patients, Zetter says. For leased or rented equipment, he also recommends asking vendors for actual invoices and how often they have increased prices in recent years.

Physicians should estimate what the patient demand will be for any given venture, then determine the current reimbursement rate for the service from each payer, he says. If Medicare accounts for 60% of the practice and two insurers account for the remaining 40% of patients, for example, the practice should calculate a weighted average reimbursement rate that mirrors this mix, Zetter says.

Practices finding it difficult to get a straight answer on reimbursement should insist payers provide the information, Zetter says. “Every payer’s fee schedule is proprietary, and even as a consultant, I have to sign non-disclosure agreements keeping me from using the data for other clients. But if you are under contract with them, they have to provide it,” he says.

Practices should also remember to factor in the costs of devoting physician and staff time to these efforts, experts say. The accompanying chart shows how to calculate physician and staff labor costs on a per-minute basis.

And physicians should consider the im-
pact on the practice’s cash flow of any large ancillary equipment lease, Gans says. A vendor might present enticing returns that are based on the ability to depreciate the equipment, but the practice still has to make those monthly payments.

**CONSIDER TOTAL VALUE**

Sometimes an ancillary doesn’t provide much return at all, but helps patient care run smoothly or saves administrative time.

John Bender, MD, FAAFP, chief executive officer of a 25-provider, multi-location primary care practice in Fort Collins, Colorado says he still offers lab services, but also provides services with higher reimbursement rates or margins, such as mammography, aesthetics, dietician and other services.

Even though he might not be reimbursed fully for blood draws, he calculates that when labor savings are factored in, he’s better off doing the draws in-house. Moreover, he says, the quick turnaround is better for patients.

“If a person comes in and 15 minutes later I have lipid results, now it’s a more effective conversation to talk with him about getting serious” about improving his health, says Bender.

“As a business owner, my biggest overhead is not supplies and equipment but staff,” Bender adds. “We found that if we just ran the cell count in-house, now it took us literally five minutes to get the blood and look at the result and we’re done.”

**GET GOING**

If the numbers look good, don’t waste too much time debating, Zetter says.

“Chronic care management is a big thing right now, where you get a fee for each patient you are monitoring, but you have to be first in your market to get in there and do it,” he says, noting that specialists can offer these services and sign up patients for these programs.

“There’s so much more revenue there if you really want it, but it takes work and planning.” Generally, chronic care management programs will generate $40 per enrolled patient per month, experts say.

Whichever service physicians decide to add, don’t commit to overly burdensome supply costs, experts advise. Most equipment and services can be rented, where a technician comes with the required device.

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**Internal medicine & ancillaries**

Here’s how internal medicine physicians replied in our 88th Physician Report (coming April 25) on the use of ancillary services at their practices and the financial benefit.

**Q:** What ancillary services does your practice offer?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>79%</td>
<td>Lab services</td>
</tr>
<tr>
<td>51%</td>
<td>ECG</td>
</tr>
<tr>
<td>49%</td>
<td>Spirometry</td>
</tr>
<tr>
<td>29%</td>
<td>Radiology / imaging services</td>
</tr>
<tr>
<td>21%</td>
<td>Nutritional counseling / weight loss</td>
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<tr>
<td>18%</td>
<td>Holter monitoring</td>
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<tr>
<td>17%</td>
<td>Bone densitometry</td>
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<tr>
<td>12%</td>
<td>Urodynamics</td>
</tr>
<tr>
<td>12%</td>
<td>Cosmetic / aesthetic procedures</td>
</tr>
<tr>
<td>6%</td>
<td>Stress tests</td>
</tr>
<tr>
<td>5%</td>
<td>Drug dispensing</td>
</tr>
<tr>
<td>6%</td>
<td>Sleep medicine</td>
</tr>
<tr>
<td>5%</td>
<td>Optical services / sales</td>
</tr>
<tr>
<td>8%</td>
<td>Other</td>
</tr>
</tbody>
</table>

**Q:** What percentage of your practice’s revenue is generated by these ancillary services?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Revenue Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>56%</td>
<td>0%-10%</td>
</tr>
<tr>
<td>20%</td>
<td>11%-20%</td>
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<tr>
<td>13%</td>
<td>21%-30%</td>
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<tr>
<td>8%</td>
<td>31%-40%</td>
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<tr>
<td>3%</td>
<td>41%-50%</td>
</tr>
<tr>
<td>1%</td>
<td>51%-70%</td>
</tr>
</tbody>
</table>
Ancillary services

Money

on a schedule that conforms to the level of the practice’s demand, rather than leasing a product 24/7 for a given period. There will be finance charges in the lease, but depending on patient volume, leasing may make sense, particularly in the startup phase.

Testing the waters in this way will allow a practice to experiment with an array of services, Berg says.

Above all, stay flexible, experts say. “Pay attention, because it’s all subject to change,” Fabrizio says. “Whatever is gravy today might be out of favor next year. You might have a reimbursement commitment for a year or two, but nobody is bound to cover a service forever.”

BEAUTY RUSH

Aesthetics services are hot, but consider competition and legal issues

More primary care physicians are adding aesthetics to their traditional practices, driven by declining reimbursements for non-aesthetics from insurers and the proliferation of non-invasive techniques that appeal to aging baby boomers, says Alex Thiersch, JD, founder of the American Med Spa Association and a Chicago-based partner with the law firm ByrdAdatto.

Consumers spend around $11 billion annually on non-surgical cosmetic procedures, according to the American Society for Aesthetic Plastic Surgery. The most common include Botox, hyaluronic acid, hair removal, chemical peels and microdermabrasion.

It’s critical to understand the needs of a practice’s patient base and to study the competition in the local market before diving in to any ancillary service and to hire advisers who understand the legal requirements governing physician self-referrals, experts say.

When Wendy Goodwin, MD, quit her physical medicine practice at a Texas university in 2015, she had a three-year, non-compete agreement to deal with and a strong desire to blend her fitness passion into a wellness-based practice.

She’s been covering her living expenses partly through expert witness testimony while she builds out an aesthetics practice at a Dallas fitness center that will offer onabotulinumtoxinA (Botox) hormone replacement therapy and other anti-aging services, some administered by others under her MD license supervision.

Already familiar with Botox from her years working with muscle issues of brain and spinal injury patients, her comfort level was high and retraining time for cosmetic procedures relatively low and, thus, fairly inexpensive, she says. She chose not to invest in costly laser equipment.

“I had to go with the skills I had, and will build from there,” she says. “There are so many things that can be done today that are minimally invasive.”

Legal barriers for primary care doctors to start up aesthetic practices on the side are relatively low, Thiersch says, but significant problems can occur later, particularly for doctors who are overseeing the work of others.

The med spa industry is growing so quickly that entrepreneurs are searching for doctors to lease their licenses to spas and serve as medical directors, sometimes without adhering to state laws regarding supervision of activities, Thiersch says. Patients need to be seen face-to-face by the doctor, he says, so a doctor simply popping into an office once a month won’t be sufficient for compliance.

“What I always tell my clients is, if they want to get into aesthetics, they need to … prove to a medical board they can perform these functions. A weekend course is not enough, but you don’t necessarily need to precept with a plastic surgeon for a year, either.”

It comes down to medical judgment. “Can you justify your involvement to a medical board if somebody got injured or filed a complaint?” he says.
Calculating ROI

**Equipment Cost Analysis**
To calculate if an instrument will pay for itself use the following formula:

**Formula**

\[
\text{Cost per day/time used} = \frac{\text{Purchase price} + \text{Annual cost of supplies and maintenance}}{\text{Estimated useful life in years}} + \frac{\text{New instrument’s annual cost}}{\text{Days/times used per year}}
\]

**Staff labor**

\[
\text{Staff labor cost per minute} = \frac{\text{Wage per hour} + \text{Benefits per hour}}{60}
\]

**Doctor labor**

\[
\text{Doctor labor cost per minute} = \frac{\text{Annual receipts}}{\text{Hours worked per year}} \div \frac{\text{Gross receipts per hour}}{60}
\]

**Time savings needed**

\[
\text{Minimum # of minutes needed to be saved per day/times used to justify cost} = \frac{\text{Cost per day} \div \text{Labor cost per minute}}{\text{Cost per day} \div \text{Labor cost per minute}}
\]

**To calculate additional profit potential use this formula**

\[
\text{Profit per procedure} = (\text{Reimbursement for service} - \text{Reimbursement w/o new equipment}) - \text{Increased reimbursement per procedure} - \text{Additional labor per procedure} - \text{Other (remodel, training, space used)} - \text{Cost per time used (above)} \times \text{Estimated procedures per year}
\]

Are you liable for retirement plan malpractice?

Most physicians in America know all about medical malpractice risks, but many are unaware of another type of liability exposure: retirement plan malpractice.

As a physician offering a retirement plan such as a 401(k) to employees, you are a plan sponsor and fiduciary to your plan participants. Per the Employment Retirement Income Security Act of 1974 (ERISA), a fiduciary has important responsibilities:

- Acting solely in the interest of plan participants and their beneficiaries
- Carrying out duties prudently
- Following the plan documents
- Diversifying plan investments
- Paying only reasonable plan expenses

As a fiduciary, your personal assets could be at risk and could be used to compensate for fiduciary losses. Proper administration of a retirement plan will result in liability exposure reduction and an optimized plan.

1. Create an investment policy statement (IPS) that is easy to follow. ERISA states that a plan must create a clear, prudent, documented procedure and process for investment-related decision-making in relation to the plan’s goals and objectives for plan investment. This statement would include the processes for selecting and monitoring the plan's investments. The IPS helps to reduce liability exposure by providing evidence of a prudent investment decision-making process.

2. Eliminate revenue sharing. Reduce liability exposure and save on fees by working with a record keeper who uses a fixed, per-participant, fee model and is not being compensated by revenue sharing.

   These fees can start out at a reasonable level, but over time, as the plan assets grow, the fees may become excessive, thus increasing liability exposure. Fixed per-participant fees help to ensure that costs do not become exorbitant as the plan’s assets grow and the plan sponsor’s liability exposure is reduced.

3. Get a second opinion from a fee-only registered investment adviser (RIA) who specializes in retirement plans. An RIA is a fiduciary and must put his or her client’s best interests before their own. Because they cannot participate in revenue sharing, they should tend to recommend investments and funds that have lower expense ratios.

   Benchmarking your plan with what is currently available and possible is the best way to determine if your plan is paying excessive fees. Fees are relative and you can only know if you are overpaying if you shop around.

4. Maintain the required ERISA Fidelity Bond of no less than 10% of the plan’s assets as of the beginning of the year. ERISA’s minimum required bond is $1,000 and the maximum is set at $500,000. A fidelity bond will help to insure the plan’s assets against fraud or dishonesty on the part of anyone handling the plan’s assets. By not having this fidelity bond, it could signal to the Department of Labor (DOL) and others that fiduciary duties are not being met.

5. Obtain fiduciary liability insurance. Insurance goes beyond the fidelity bond and covers plan sponsors and their legal expenses if a breach of fiduciary duty occurs.

Seth Svenson, MBA, is a retirement plan advisor and president of Orchid Wealth Management in Palo Alto, California. Send your legal questions to medec@ubm.com.
IN CASE YOU MISSED IT

“It often perplexes me that what sells well in one office won’t do well at [the practice] next door.”
KEITH BORGLUM, CHBC, HEALTHCARE CONSULTANT AND BROKER
PAGE 14

“Luck favors the prepared. Now is the time that will reward the more ambitious ... practices.”
MARK WENER, MD, CHARTIS GROUP
PAGE 22

“Physicians need to figure out a way to do vaccinations in the most economical way for them.”
AARON E. GLATT, MD, SOUTH NASSAU COMMUNITIES HOSPITAL
PAGE 28
The board members and consultants contribute expertise and analysis that help shape the content of Medical Economics.
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