DIY Telemedicine
Expert advice to get started

INCLUDING

Use e-visits to build a competitive edge

Overcome regulatory obstacles

Select the right vendor partner
Technology has the power to connect, but also the power to divide, as physicians well know.

One of the biggest barriers now in the physician-patient relationship lies in doctors' constant typing, clicking, and touching screens to get every detail of a visit documented. Many bemoan their lot as glorified EHR data-entry clerks, wasting their medical knowledge.

And then there’s telemedicine, a technology that promotes well-being by connecting physicians with patients even though they are in different locations. Some would call it “good” screen time vs. the EHR-fueled distraction that exists in an exam room.

Telemedicine is a tremendous tool to increase access to much-needed medical advice and intervention for rural patients, those with transportation issues, or any patient confronting a geographical obstacle to getting in front of a healthcare professional.

But I also worry about its misuse. I worry that telemedicine used as a tool to increase the quantity of patient visits will lead to the detriment of the quality of visits. I worry that in a hurry to meet millennials where they live—in their phones—practices and physicians will rush into the decision to implement e-visits whenever and wherever a patient wants in order to keep up with the times.

Today’s tech-enabled world gives us the power to demand immediacy and for things to revolve around our schedules: from food delivery to when we watch certain television shows. But patients shouldn’t dictate the process of a thorough examination for medical treatment due to their desires or convenience.

Telemedicine isn’t right for all practices either. Like any other evolving tech tool, jumping in too quickly can be costly for both the physician and practice.

In this issue, you’ll find information on how to set up a telemedicine program the right way—taking into account the long-term goals of your practice vs. just implementing it because other practices are doing so. We put this information together to help you separate the sales pitches from the true value of telemedicine.

In an era of tech-enabled patients and sometimes tech-encumbered physicians, there has to be a balance. Physicians know when a problem can be diagnosed on a hand-held screen and when something requires the physical touch and interaction with a physician in an office.

In the right hands, telemedicine can complement a physician’s mission to improve well-being. In the wrong circumstances, it can actually put lives in danger. So before using technology to improve patient connectivity, be cautious.

Keith L. Martin is editorial director for Medical Economics. Do you see telemedicine as more of a benefit or a detriment to healthcare? Tell us at medec@ubm.com.
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The AGA recommends PEG laxatives (like MiraLAX) as a first-line constipation treatment\(^1\)

- ✔ 96% patient satisfaction rate*
- ✔ #1 GI-recommended laxative for over 10 years

Start with MiraLAX for proven relief of occasional constipation.

Use as directed on product labeling or as directed by your doctor.

Bayer, the Bayer Cross, and MiraLAX are trademarks of Bayer.
Pharma companies don’t need your focus; your patients do

In response to "Drug innovation should be applauded, not used to shame physicians" and "Pharma accusations a 'slap in the face"' (Your Voice, February 10, 2018), the issue needs a dissenting response. Gilkison and Winiger make a case for the pharmaceutical-physician relationship as a mutually beneficial and educational one, even if profit oriented, I beg to disagree.

Let's look at the simplistic pro-pharma apologia in the light of cash. The alleged benevolence of PhRMA/pharmaceuticals evaporates when you see that pharmaceutical and health products spent $3.8 billion in congressional lobbying in 2017, way above that of oil and gas and health insurance. Why are the "nice" guys spending so much on Congress? They do it because that’s what they do, to cripple any chances of Medicare bargaining for better drug costs or any transparency on cost of production.

Why? Because common drugs like statins, Albuterol, and Insulin cost 50 percent to 80 percent less in Europe and Canada (often even less). Is this the trait of a real healthcare partner or a master of usury?

As for the educational benefit suggested by Gilkison, I am sure he is aware of scores or more of better sources to get his information. One of the most depressing moments in my career was watching a much-respected colleague at a pharmacy and therapeutics meeting in our community hospital presenting a new drug for consideration, straight off the laminated handout from Pharmaceutical Inc.

I will end with this: I don’t for a moment think it’s sheer malevolence when physicians get close to pharma, but it is a slippery slope from patient advocacy and that is our single duty.

Rohan Perera, MD
EAST SETAUKET, N.Y.

Physicians need to be wiser when dealing with drug reps

While I share many of my colleagues’ frustration about comments which suggest that physicians are merely “on the take” when meeting with pharma reps over a meal, the current era of transparency and autonomous patient-consumers requires that we do a better job managing our collective reputation. Optics matter.

As professionals entrusted to care for the sick and protect the privacy of the intimate stories of illness our patients share with us every day, it is hard to view ourselves as vulnerable to the psychology of the “sell.” But this is naive. Just ask anyone in pharma sales about their training, and you will hear about the well-honed techniques espoused on how to best influence their consumers—i.e., prescribers. Drawing on literature from psychology and behavioral economics, pharma sales forces have much more in mind than just providing product information.

The JAMA Internal Medicine study referenced in “Stop suggesting physicians are ‘bought’ through pharma gifts” (November 25, 2017) does provide evidence that these sales techniques are effective. The difference in branded prescribing patterns of physicians who received gifts was not extreme but was significant and is enough to create a perception of bias. For many patients who are struggling to pay for their medications, and whose trust in our profession has eroded through the years, this perception is reality.

I do feel there is value in limited interactions with sales reps, to find out about new products and receive demonstrations on proper storage and administration of medications, and device usage techniques. Lunches and pens are unnecessary. There are many objective ways to obtain information on biochemistry, dosing, efficacy, side effects, and patient selection.

Some pharma companies are exploring more patient-centered ways of collaborating with physicians, and this is refreshing. They provide education and contribute their resources to population health initiatives. Make no mistake: There is a sales effect at play here too, but it is transparent and win-win for patient, pharma, and health system alike.

Physicians are, at the core, humane professionals with our patients’ best interest top of mind. We are not, however, immune to the psychology of selling, and we must be wiser about activities that undermine our connection with those who have entrusted us to care for them.

Jeffrey Millstein, MD
WOODBURY HEIGHTS, N.J.
Healthcare is going gangbusters for the economy

The Dow is up. Unemployment is at an all-time low. The economy is going gangbusters. According to an American Medical Association report, that’s due in part to the healthcare industry. In fact, physicians are responsible for creating and supporting 12.6 million jobs and generating $2.3 trillion in economic activity.

Most people wouldn’t expect healthcare’s economic impact to be that great, says Richard C. Johnston, MD, FACP, chief executive officer and chief physician officer at USMD Healthcare in Dallas. Johnston says a busy internist might account for $1 million to $1.3 million dollars of a hospital’s revenue and some specialties, like orthopedics, are way higher. ”But to actually think about the number of employees, payroll, taxes, and other downstream revenue, this is the first time we’ve seen that presented,” says Johnston.

The study broke down data by region and measured the overall economic impact of physicians by four qualifiers:

- **17.1** - The number of jobs the average physician supports
- **$3.2 million** - Total economic output per physician
- **$1.4 million** - Dollar amount contributed to workers per physician
- **$129,000** - Tax revenue per physician

Johnston says the numbers first reflect how much healthcare means to the economy, and how cautious physicians should be when making dramatic changes in anything that affects healthcare economics. Also, that physicians, such as primary care doctors, account for so much revenue to the economy that they should be good stewards of how they handle that in terms of trying to lower the cost of healthcare.

**9 ways to combat physician suicide**

The physician suicide rate is 1.41 times greater than the general population, according to the American Foundation for Suicide Prevention.

**“Lack of autonomy, assembly-line medicine, blaming physicians with words like ‘burnout,’ and graduates who cannot find residencies are all factors in the high suicide rate.”**

Craig Wax, DO, a primary care physician in Mullica Hill, N.J., on the importance of physicians taking care of themselves to truly help others

**“Lower quality of training and clinical experience is beginning to become apparent.”**

Rebekah Bernard, MD, a primary care physician in Fort Myers, Fla., on the dangers of diploma mills in medicine
What’s causing the nurse shortage?

1. MORE PATIENTS

- **BABY BOOMERS**: 75 million
  - “Baby Boomers” who continue to drive demand for healthcare services. 80 percent have at least one chronic condition.

- **ACA COVERAGE**: 20 million
  - Americans with health insurance coverage through the Affordable Care Act.

- **OPIOID EPIDEMIC**: 1.3 million
  - Those hospitalized or treated in an ED due to opioid-related issues. (That’s 3,500 people each day.)

2. FEWER NURSES

- **70,000 nurses retiring annually**
  - By 2030, almost a million nurses will retire and leave the workforce, taking with the years of knowledge and experience they have accumulated.

- **64,000 turned away from nursing programs**
  - U.S. nursing schools turned away over 64,000 qualified applicants from nursing programs in 2016 due largely in part to an insufficient number of faculty and clinical preceptors.

- **17,000 nurse instructors needed**
  - According to the Bureau of Labor Statistics Employment projections for 2012-2022, over 3,400 nurse instructors will be needed each year through 2022. That’s over 17,00 in just the next five years.

3. OTHER FACTORS

- **Growing healthcare industry**
  - Employment in the healthcare and social assistance sector is projected to add nearly 4.0 million jobs by 2026, about one-third of all new jobs.

- **Challenges in recruitment**
  - 17.5% of newly-licensed RNs leave their first nursing job within the first year, and one-in-three (33.5%) leave within two years.

Source: Avant Healthcare Professionals (avanthealthcare.com)
**Practical Matters**

**Improve your claim denial management**

Denials continue to frustrate medical practices. That’s why focusing on the 90 percent that are avoidable is important. That’s where the hidden revenue lies.

**1st: Heal thyself**

The first step is to remove the physician from the day-to-day denials-management process. Physicians around the world are already spending too much time behind a computer screen. A study published in the *Annals of Internal Medicine* found physicians spend a significant part of their day not treating patients, but instead completing other tasks. These physicians spent approximately 27 percent of their time in face-to-face clinical contact with patients, while spending up to four hours on “desk work” for every one hour treating patients. This study had a somewhat small sample size, but it’s easy to see that as contracting and billing grows more complex, physicians may spend more time with a computer and less with patients.

Whether the billing experts are members of the practice or external experts, physicians who hand off the denials management process increase the time they can spend with patients, and can improve productivity and boost revenue by allowing experts to take control of the process.

**The denial dilemma**

- 50-65 percent of denials are never reworked
- 200 million claims are rejected every year
- 90 percent of denials are avoidable

**2nd: Automate**

Artificial intelligence (AI) is all over the news today, often classified as a savior to business or the end of the workplace as we know it. The truth, like anything, is somewhere in between. AI, like other technologies, is a tool that can be used to increase productivity and efficiency. For providers, AI’s older sibling, automation, can be used to decrease, or even eliminate, denials.

As a business practice, automation can be used to enhance the provider’s office staff. An automated denials management solution can increase efficiency by allowing staff to focus on other issues that require resolution.

A well-thought-out automated denials management solution actually starts long before any claim is denied. To whittle away at the 90 percent of denials that are avoidable, the process should begin early.

**3rd: Bring it together**

Attacking denied claims in advance, before they happen, is the objective. This allows providers the opportunity to chip away at that 90 percent. While there are many ways to affect this number, here are three important tactics to start with:

- Patient eligibility should be high on the provider checklist. Checking patient eligibility in advance ensures that patients have insurance to cover the treatment.
- The claim itself must be clean: treatment codes, which change over time, must be kept up-to-date.
- No matter how much effort is expended verifying eligibility and checking claims, some will be denied. But even this event has a positive outcome: Practices can understand and identify the common reasons for denials, which will help prevent them in the future.

Automating this portion of the revenue cycle management process can provide exceptional value to providers as the process also influences the more than 50 percent of denied claims that are never resubmitted to payers. The best solutions examine current and retroactive denials to ensure the practice receives all the reimbursement it deserves, which helps ensures providers get on the right side of that 90 percent.

**Kevin Lathrop** is president of TriZetto Providers Solutions. Send your practice management questions to medec@ubm.com.

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MedicalEconomics.com
Michael Tracy, MD, received an urgent phone call from a patient who had cut his hand and was bleeding; his patient wanted to know if he should visit Tracy’s office or go straight to the emergency department.

Tracy, a primary care physician in Powell, Wyo., was working to quickly get information about the injury when the patient suggested they use their iPhone’s FaceTime function so Tracy could see the cut for himself. Tracy saw right away that the patient had an arterial bleed and immediately sent him to the nearest ED.

Tracy says the experience showed him how valuable video visits can be for his three-physician direct care practice, 307Health. “My biggest hope is we can use telemedicine to improve the delivery of care,” he says.

Technology advances over the past decade have made telemedicine much easier to implement and integrate with other computer apps, according to health IT experts, physicians, and practice consultants.

However, establishing telemedicine within a primary care practice—especially...
Telemedicine as a competitive edge, not a competitor’s advantage

By Keith L. Martin

Last year, Cleveland Clinic announced it was expanding its telemedicine program to 24 states outside its Ohio headquarters, signifying a growing trend. More hospitals and health systems are expanding their online patient visits into other markets.

But experts note that just because a patient living outside Ohio can see a physician from the Cleveland Clinic, doesn’t mean they will. Rather than presenting a challenge to small medical practices, it can present an opportunity.

“I, personally, would prefer to see my own primary care physician via telemedicine rather than meeting a new physician and working with them via telemedicine,” says Kristi Fahy, manager of informatics, information governance and standards at the American Health Information Management Association. “Fostering ongoing patient loyalty can be seen as a driver to encourage small physician groups to consider implementing telemedicine.”

Fahy adds that telemedicine extends to connecting patients with specialists. Some patients may have to travel long distances for a referral or don’t have the option of choosing preferred specialists based on where they live. Through their primary care provider’s telemedicine connection, however, they can visit a familiar, nearby office and have a customized telemedicine consultation encounter with a specialist of choice and with their trusted primary care doctor in the room.

“That small practice physician continues to stay involved in the patient care path through telemedicine,” she says. “These patients can more easily keep up with follow-up visits and hopefully keep up with their medication needs through the physician they are loyal to already.”

Providing telehealth access not only makes a smaller practice more competitive, Fahy says, it can also increase revenue. This can include seeing more patients online and in the practice as well as taking advantage of numerous reimbursement opportunities from government and private payers. This year, Fahy notes, Medicare has 96 codes for telehealth-related payments.

However, like any technological tool available to practices, telehealth must have a focus for the medical practice before implementation, including identifying ways to integrate its use into the practice.

Neha Sachdeva, a director at consultancy KPMG’s advisory healthcare and life sciences practice, says physicians need to first “identify the ‘why’” when implementing telehealth services. This includes the purposes for adoption, asking if it makes sense for the business, and how it can benefit both patients and the practice.

A thorough analysis of how telehealth will keep the practice competitive is critical. This includes taking a hard look at costs to implement the program and what reimbursement opportunities it opens up.

“Telemedicine isn’t a silver bullet to solve all physician problems,” Sachdeva says. “It shouldn’t be the only option to help remediate all the challenges to [patient] access or financial challenges.”

Like Fahy, Sachdeva sees a well-implemented telehealth program as a competitive edge for small practices. As regulatory and reimbursement challenges are reduced, telemedicine will have the opportunity to become more of the norm than the exception in care delivery.

“You also have an evolving patient population, used to doing everything on a smart device or online in all other aspects of their day-to-day activities,” she says. “Patients will start to shop around … so I think telemedicine helps organizations remain competitive and provides a service to help them not only retain patients, but acquire new patients as well.”

New telehealth services in the 2018 Medicare Physician Fee Schedule

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APRIL 10, 2018
various private insurers, do cover telemedicine. Because reimbursements for such services aren’t universal, though, physicians need to assess their payer mix and calculate whether offering telemedicine services makes financial sense, says Ashutosh Goel, MD, chief information officer, chief medical informatics officer, and senior vice president of IT for Bronson Healthcare, a health system based in Kalamazoo, Mich.

“They should look at their total patient volume, understand which of their patients are under some type of capitation model, which percentage of the panel is looking for these visits as a ‘retail’ service that they are willing to pay out of pocket for,” he says, adding that there’s no standard calculation for evaluating these factors to determine fiscal viability for telemedicine.

Goel says physicians might also consider researching whether any employers in their region are willing to pay for telemedicine visits for their employees and then partnering with those companies to provide them.

He also suggests using patient surveys and any related market data (generally compiled and sold by research firms) to help determine whether demand can support telemedicine in a practice.

Steven E. Waldren, MD, MS, director of the Alliance for eHealth Innovation, suggests that in addition to patient surveys, physicians log telephone calls of conditions that could be addressed with telemedicine.

Waldren advises physicians to calculate their monthly cost for providing telemedicine and then estimate how many visits per month would be required to see a return on investment.

Goel, a member of the physician committee at the Healthcare Information and Management Systems Society (HIMSS), a nonprofit organization promoting the use of health IT, says telemedicine makes the most financial sense for concierge-type practices or those with a large patient population covered under a capitation model (under which there aren’t reimbursements for individual visits, so there’s no difference financially whether the physician sees patients via telemedicine or in person).

John Sharp, MSSA, FHIMSS, senior manager of consumer health IT with Personal Connected Health Alliance, a nonprofit arm of HIMSS, says practices could also forgo seeking insurance payments for their telemedicine services and instead charge patients directly.

“That might still be worthwhile for patients who see it as better than taking off a half day from work to come in,” Sharp adds.

**DETERMINE PARAMETERS**

Telemedicine has particular appeal for patients who can’t easily make it into an office: disabled patients; patients with chronic conditions who need frequent visits to stay on track; those with transportation challenges; and patients with compromised immune systems, experts say. So practices starting telemedicine need to establish guidelines on which patients and what conditions are good candidates for telemedicine services.

Tracy says he recently scheduled a video visit with a patient who was snowbound, for example, but he and others agree patients with certain conditions or symptoms need to be seen in person. Those include any exam where the doctor needs to physically touch the patient, as well as exams that require the use of specialized medical equipment such as stethoscopes.

On the other hand, patients with chronic conditions who need more frequent visits could invest in mobile apps, such as an otoscope app and attachment, as well as home devices, such as a connected blood pressure cuff or glucometer, and thereby make themselves good candidates for telemedicine visits.

Sharp recommends physicians select a particular set of patients from that list and conditions compatible with telemedicine visits to use for a pilot program. (Patients with hypertension or diabetes who already come in for regular checkups to help stay on track make good candidates for a pilot program, for example.)

Know the rules of telemedicine and learn about how the tech works

*Continued on page 48*
The recent shooting deaths of 17 students and adults at a Florida high school has sparked a new round of debate over ways to curb gun violence. Following the shootings, five physician organizations issued a joint statement calling gun violence “a public health epidemic that is growing in frequency and lethality and... is taking a toll on our patients.” The statement urges lawmakers to treat gun violence as “a pervasive threat to public health” and to take evidence-based measures to prevent future suffering due to guns.

To learn more about the movement to treat gun violence as a public health issue, and how individual physicians can address the problem, Medical Economics spoke with Jack Ende, MD, MACP, president of the American College of Physicians (ACP), one of the signatories to the joint statement.

Q: In your view, would approaching gun violence and gun control as public health issues actually help to reduce gun violence?

Jack Ende: While we don’t have all the data yet, there are data that suggest that when physicians bring this up in their practice, when they screen for both patients at risk for gun violence—either harming others or themselves—that they can make a difference. And certainly it just makes sense for doctors to take a public stance on this, but also to build this into their day-to-day practice.

One can really draw the analogy between gun violence and other public health issues, public health issues that at first glance were never considered within the purview of physicians, like wearing seatbelts. And now we’re very much involved in [the campaign of] don’t text while you drive.

Tobacco use is another public health issue. Physicians including this in their general history and physical and providing counseling have been shown to make a real difference. I think it has to be a multi-pronged effort on gun violence, but the medical profession really does have a very important role to play. Not exclusively, of course. We need policymakers at the state and national level, but physicians also have a real role to play here.

Q: Why do you think Congress and state legislatures have been slow to...
**Policy**

**Gun violence**

“...We were not speaking out against guns, but rather firearm violence. And it’s very difficult to find a doctor that would be opposed to that position.”

**treat gun violence as a public health issue?**

Ende: I think the whole issue unfortunately reflects how we make policy at the national level, oftentimes influenced by specific interest groups rather than national welfare. I’m not a politician, but in certain districts, in certain states, the gun lobby has undue influence over the legislative process.

The College is not opposed to owning guns. Our policy really is focused on firearm violence. There is within the Second Amendment still so much that can be done to limit the amount of guns, particularly these guns that are more suitable for war than for recreation.

**Q: Does the ACP have an official position regarding the use of guns, or guns in the home?**

Ende: Absolutely. It’s a very important issue for the College. We’ve taken a stance on this going back several years. In 2015 we issued a paper that was jointly written with other physician groups like the American Academy of Pediatrics and American College of Surgeons, and even the American Bar Association signed on to that paper. It’s one of the few times when doctors and lawyers have joined forces to put together real policy.

There’s a link (bit.ly/ACP-pledge) and the pledge says, “When risk factors for harm to my patients or others are present, I will ask my patients about firearm ownership and safety.” And hundreds of doctors have signed onto that. It’s encouraging physicians to include questions about firearms in their routine history and physical. For new patients it’s a very simple question, ‘Do you have firearms?’ If they answer “yes,” there are some follow-up questions.

But also for patients at risk. Those with substance abuse, those with alcohol problems, certain mental illnesses—not all—certain patients who are depressed or at suicide risk, we really need to ask questions about guns.

Houses that have children should be included as well. And if they do have guns, the follow-up questions would be [if] the gun is safely stored and locked and the ammunition is kept separate from the guns. We think the data will show that does make a difference.

**Q: In the 1990s Congress put limits on the CDC’s ability to research gun violence. Have the ACP and other medical organizations lobbied to get that lifted?**

Ende: Absolutely. We need more research on this, but there are limits to the kinds of research that’s being done by the CDC and other public health institutions and that really is one of the problems. So that is a point that’s clearly made in all our position statements, that we need more data. We need governmental agencies to do the research on this.

It’s like any other public health problem. Ebola, for example. You really need to get in, do the research, find out what the risk factors are, and find out what the pathophysiology is. That is the way to go about addressing issues of public health.

**Q: What sense do you get from ACP members as to the importance of reducing gun violence?**

Ende: When we came out with our 2015 joint position paper, there was a bit of pushback because so many of our members own and enjoy having guns as part of their hobbies. But as members looked into this further, they came to realize we were not speaking out against guns, but rather firearm violence. And it’s very difficult to find a doctor that would be opposed to that position.

And College members, like I believe the public in general, have reached a point where there’s just greater concern about firearm violence. Not necessarily owning guns, but firearm violence. And in whose hands should those guns be? People with substance abuse, alcohol, serious depression—they should not be allowed to have guns.

One of the points the College makes is that these mass shootings, as horrific as they are, are really just a part of the problem. There are 33,000 deaths per year and twice that number of injuries.
Balancing the joy of locum tenens with the joy of home

LeaAnn Schroeter, MD would be the first to tell you that a physician working locum tenens is presented with a variety of challenges and even downsides.

Dr. Schroeter was drawn to locum tenens work for the same reason most physicians are — the freedom that comes from its inherent flexibility. A pediatrician married to another physician practicing full-time, she wanted the ability to better accommodate her schedule to his. She also wanted more time with her four daughters, two of whom live abroad; one in Turkey, the other in Nepal. When she received one daughter’s “Mom, we should hang out in Europe together” invitation, she was free to accept, taking a summer off to “wander around Germany doing local people stuff” with her daughter. “It was great fun.”

Seek out friends

“Our roots are very deep in our community,” she explained. “I really do love being at home. When I’m working [a locums job], I am engaged and I am fine. I don’t get homesick. When I come home, I realize, oh, I missed that little party or this person had this and that." Keeping engaged with her friends takes more effort now, but it is effort she doesn’t mind expending because she understands their dilemma. “They always assume you’re away so they don’t call you. When you’re home, you have to be super intensive about finding your friends.”

Dr. Schroeter minimizes the effect of her absences by taking shorter assignments, those that get her home on weekends or that keep her geographically close to home.

What about feeling like a stranger among unfamiliar people and places when she is at a job? Isn’t that a downside of locums? Her solution is natural for her: she engages the community she’s visiting like it were her own. She makes the people she meets her new circle of friends.

Making personal connections

A nurse at one job was complaining that she hadn’t the time or the skills to make curtains before an imminent visit by her in-laws. Dr. Schroeter occasionally brings a sewing machine when working locums, and she just happened to have it this time. “Seriously, I’ve sewn curtains a ton,” she told the nurse, “and I have my sewing machine with me. I’ll make them for you.” Word spread among the staff, and soon the hospital had a new hero.

She too has been the recipient of kind acts by her new friends. Staff she’d grown close to created a collage of exotic waterfalls with multiple pictures of her in a kayak, one of her favorite pastimes. They posted it on one of their walls and sent her a note saying, “Now, you are with us always.”

To learn more about locum tenens and read about other physicians’ experiences visit locumstory.com
Prior authorization bill seeks to address ‘cumbersome’ process

A bipartisan bill introduced in Congress in January could help improve patient care while saving doctors time by allowing for electronic prior authorizations of Medicare Part D prescriptions. Passage of the bill also could have a ripple effect in speeding the use of electronic prior authorizations for non-Medicare prescriptions, observers say.

“The current prescription authorization process for Medicare enrollees can be lengthy, confusing and frustrating,” Rep. Ben Ray Lujan, a Democratic Congressman from New Mexico, told Medical Economics via a written statement. “But it is often even more cumbersome and frustrating for doctors and other providers, relying on outdated technology like faxed notifications in an age when many offices have evolved to digital/paperless recordkeeping.”

Lujan is a sponsor of the bill, the Standardizing Electronic Prior Authorization for Safe Prescribing Act of 2018 (H.R. 4841), which requires Medicare Part D plans to electronically transmit and receive prior authorization approvals for prescriptions. Such electronic requests would be required beginning Jan. 1, 2020. It also calls on HHS to create standards for defining electronic transmissions of prior authorization requests.

Physicians and their staffs spend an average of 16.4 hours a week on prior authorizations of all kinds, according to a 2016 survey by the American Medical Association. In the same study, 75 percent of physicians answered “high or extremely high” when asked “How would you describe the burden associated with PA [prior authorization] for the physicians and staff in your practice?”

“There is a lot of prior authorization that is still occurring on paper,” notes Samantha Burch, senior director of congressional affairs with the Healthcare Information and Management Systems Society (HIMSS). While HIMSS was still examining the specifics of the bill and had not taken a position on it at press time, it has generally supported electronic prior authorization in the past, Burch notes.

“The issue of automation and reducing manual paper work is mutually beneficial” for doctors and patients, she says.

Steve Green, MD, chief medical officer at Sharp Rees-Stealy Medical Group in San Diego, and a board member of the American Medical Group Association, agrees that electronic prior authorization can improve patient care. With electronic authorization, a physician can know before a patient leaves his or her office whether that patient will be able to get coverage for a new drug.

If authorization is denied, the physician can then quickly prescribe an alternative, he explains. With paper-based authorization, a patient can leave and not know until they arrive at their pharmacy that the prescribed drug is not covered by their insurance plan. They may simply not fill the prescription at that point and their doctor may not know they are not taking the new medication until their next visit.

The requirement for HHS to establish standards could spur other insurance plans to move to electronic pre-authorizations. “In general, the trend is Medicare does something and not too long after that, the other plans start going along with that,” notes Green.

Given the bill’s bipartisan support in the House—it has two Democratic and two Republican co-sponsors—it could see passage this session.

John Frank is a contributing author. Do you think the bill would ease the prior auth burden? Tell us at medec@ubm.com.
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Medicare abuse and home healthcare

Set policies to protect your practice

In 2017, a Dallas physician and three home health agency owners were found guilty for their roles in a $375 million home health care fraud scheme. This is just one example out of hundreds of criminal and civil actions investigated by the Office of Inspector General.

Medicare paid an estimated $41.1 billion (11 percent of Medicare dollars) incorrectly in 2016, including $7.7 billion in improper payment for home health services and supplies. The majority ($7.4 billion) of these improper payments for home health services and supplies were due to insufficient documentation to support home health services.

Fraud vs. abuse

Medicare fraud is when someone intentionally deceives Medicare or falsifies information when billing Medicare. Although cases of Medicare fraud do occur, few physicians will intentionally commit Medicare fraud in their careers. More commonly, physicians unintentionally commit Medicare abuse because of gaps in education and training.

Medicare abuse is when systemically poor medical practices and procedures result in unnecessary costs to Medicare. Examples of abuse include repeated duplication of services, failing to discontinue services even when they are no longer necessary and providing unnecessary medical services or equipment. Referral to home health care services when it is not medically necessary is an example of Medicare abuse. Penalties of Medicare abuse include exclusion from participation in federally funded health-care programs, fines and possible imprisonment.

Appropriate documentation

Appropriate documentation is critical when billing Medicare for home health services. There are several criteria that must be met and clearly documented.

Providers eligible to certify the necessity of home health services must be Medicare enrolled Doctors of Medicine, Doctors of Osteopathic Medicine, and Doctors of Podiatric Medicine (for claims relative to their scope of practice).

Face-to-face encounter

The patient and provider must have a face-to-face encounter related to the primary reason the patient requires home health services. This encounter must take place within 90 days prior or 30 days following the start of home health services. The face-to-face encounter may be performed by:

- The certifying physician who is establishing and reviewing the plan of care that requires home health services.
- The physician who cared for the patient if a patient is admitted to home health services directly from an acute or post-acute care facility.
- Nurse or nurse practitioner that collaborates with the certifying physician or doctor from the acute or post-acute care facility.
- Certified nurse midwife or physician assistant under the supervision of the certifying physician or physician from the acute or post-acute care facility.

The patient must be confined to the home, such that leaving the home is infrequent and requires considerable effort. This includes individuals who need the aid of a supportive device or another individual to leave their residence, or have a condition that prohibits them from leaving their home.

The patient must need a skilled service such as skilled nursing, physical therapy, speech therapy, or occupational therapy.

The provider must certify that the patient is eligible by signing and dating the certification.

Review the care plan

After 60 days, the provider must review the plan of care and determine whether home health services are still required. An estimate of the continued duration of skilled services is required.

How to protect yourself

At this time, Medicare does not have a policy that requires providers submit a specific form to Medicare for home health services. Providers and institutions may choose to develop policies that ensure all the criteria for ordering home health services are fulfilled. The creation of such guidelines will help medical practices protect themselves from partaking in Medicare abuse.
in Medicare fraud, waste, and abuse.

The first step in policy development is education of healthcare providers and staff. It is recommended to start with an overview of healthcare fraud and broader program integrity (PI) issues including fraud and abuse laws and how various organizations are responding to PI issues. Next, preventative strategies to improve PI including protecting medical identities should be discussed. Finally, education should be aimed at documentation and billing best practices. Healthcare providers and staff must also be aware of how and when to report inappropriate activities, and the consequences of not complying with Medicare fraud and abuse laws.

Providers and schedulers must create a policy that all home health service referrals must be initiated at a face-to-face encounter with an appropriate provider. At that encounter, a plan for reviewing the plan of care within 60 days must be solidified. These encounters may be a second face-to-face encounter, or a discussion via phone or e-mail.

A standardized form should be developed to ensure all components are included when billing for home health services. This form should include:

- **Encounter Date**
- **A brief narrative describing why the patient is homebound**
- **A brief narrative describing why skilled services are necessary**
- **Signature of the certifying physician, including date of signature**

The policy should be publicly posted for patients to review, along with information for patients so they may report policy violations. Finally, a system must be in place to continuously enforce and review the policy. A compliance committee may be tasked with enforcing disciplinary guidelines for not complying to the policy, as well as conducting continuous internal monitoring and periodic review of the policy.

### Establish a policy

Medicare fraud is a widespread problem in the United States and includes improper billing and documentation when ordering home health services. In order to ensure claims are appropriate, physicians should be aware of which patients are eligible for home health services and the associated documentation that should be submitted to support the claim. Establish a policy to ensure providers are adequately informed on appropriate Medicare billing for home health services would be beneficial. Developing a form for the policy that states the minimum required documentation for Medicare home health services and is available to all providers would ensure that each claim meets the requirements for Medicare billing. An established policy is a crucial step toward protecting your medical practice from unintentionally partaking in Medicare fraud and abuse.

**Janis Coffin, DO** (pictured) is assistant dean, and **Megan McMurray, OMS IV, Mianna Armstrong, MS, OMS IV, and Seth Bires, MS, OMS IV**, are medical students in the College of Osteopathic Medicine at Kansas City University in Joplin, Missouri. Send your legal questions to medec@ubm.com.

**$77 BILLION**

how much Medicare spent on improper payment for home health services and supplies in 2016
Financial Strategies

How physicians can stretch their college dollars

Saving for college is one thing, but making the most out of those savings is something else entirely. Fortunately, there are concrete steps physicians can take to make sure they stretch those education dollars.

How early should you develop a plan? Ideally, start making financial adjustments when your child enters middle school. But even if your college-bound child is already in their senior year of high school, there are still strategies to reduce their college costs and decrease their Estimated Family Contribution (EFC).

Let’s start with some of the short-term strategies that everyone can take advantage of—like what funds to use to pay for college costs.

529s are great but...

One mistake parents sometimes make is to pay all of their college costs out of their 529s. Why is this bad? Because doing this may make some parents ineligible for the American Opportunity Tax credit, which taxpayers can claim for the first four years of higher education tuition, course materials (such as books), and required fees. The credit is worth up to $2,500 per year based on adjusted gross income.

Since you’ve already received a tax benefit with the tax-free distribution from your 529, the government says you can’t “double-dip” and also claim the $2,500 American Opportunity Tax credit. You can use one or the other, but not both. Your tax adviser can work with you to figure out how to use your 529 funds in a way that will help you take advantage of this credit.

Beware generous grandparents

If a grandparent gives your child money for college, even if it’s under the $14,000 cap of what the IRS considers a tax-free gift, that money can still cost you and your child. That’s because of how FAFSA (Free Application for Federal Student Aid) rules determine income. Any money a grandparent gives a student over the income protection allowance of $6,570 is assessed as untaxed student income at 50 cents on the dollar. That’s regardless of whether the grandparent gives the money directly to the child or sends a payment to the school to cover tuition.

How much could that cost you? A $16,300 gift from grandma for the benefit of the child raises the family’s EFC by $5,000 to $8,000, depending on whether the student has already reached their income protection allowance. That doesn’t mean grandparents shouldn’t help out at all. Some experts suggest waiting until after students are upperclassmen and have filed their last FAFSA before withdrawing money from 529s.

In the clear with the IRS, but not FAFSA

Thinking of dipping into your retirement fund to pay for college? Think again. Yes, the IRS waives the 10 percent early withdrawal penalty on funds a parent withdraws for college. The FAFSA, on the other hand, calculates that money as added income, usually assessing it at a rate of 47 percent.

Not all calculations are equal

Don’t be fooled into thinking that all schools calculate income in the same way. Federal methodology does not use home equity to determine EFC but institutional methodology does. Know which methods the schools being considered use before applying can avoid disappointment when those awards letters arrive.

Remember, no award is final

Just because your child receives a financial aid award letter from a college doesn’t mean that’s the end of the story. Research how to write an effective appeals letter or consult an experienced college coach, and then appeal that award. The reasons you might appeal an award include changes in family income, unexpected medical expenses, or simply if...
one school offers your child a more generous financial aid package than another school with a similar program and selectivity.

**The longer view**

As for long-term strategies, look first at where you hold your savings. Saving in your child’s name is never a good idea. A child’s income is assessed at a higher rate than their parents—roughly 15 percent to 20 percent higher.

**Asset awareness**

Where parents hold their own assets makes a difference as well. Physicians will want to hold their assets in their business during the college years. That’s because business assets aren’t used to determine the EFC under the federal methodology as long as your business has fewer than 100 employees. This is not true, however, under the institutional methodology and you will need to talk to a financial expert who understands the rules to sort through everything if you are considering one of those colleges. On the other hand, personal assets are assessed at a rate of 5.64 percent.

**Business restructuring**

Physicians also should consider restructuring their business. Converting a sole proprietorship to an S Corp or converting a “pass-through income” S Corp into a C Corp will reduce adjusted gross income and increase potential for financial aid. Both an S Corp and a C Corp will provide protection from personal liability. In general, corporations prefer C Corps because they provide more flexibility, including allowing them to have global investors, more than 100 shareholders, and diversity in classes of stock. Small businesses tend to prefer S Corps because profits are taxed only at the shareholder level. C Corps, on the other hand, are taxed at the corporate and again at the shareholder level. Both an S Corp and a C Corp will help reduce adjusted gross income, which FAFSA calculates at up to 47 percent. If you’re concerned about limiting your access to cash, remember that FAFSA rules allow business owners to take personal loans from their businesses without penalty. Of course, you’ll want to consult legal and tax professionals before making any changes.

**Family matters**

Finally, don’t discount nepotism. Hiring a spouse or child can help save on your family’s medical costs when you set up a medical reimbursement plan (under IRS Section 105). And your child can earn up to $6,570 per year without having that income assessed under FAFSA rules.

Of course, rules are often changing. To ensure you make the most of your money, it’s best to consult with a CPA and a college planning expert who will give you the most up-to-date advice on how to stretch your college dollars.

“Don’t be fooled into thinking that all schools calculate income in the same way. ... Know which methods the schools use before applying can avoid disappointment when those award letters arrive.”

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Jim Slowik is the chief college funding strategist of www.MyCollegePlanningTeam.com. Send your financial questions to medec@ubm.com.
The eroding trust between patients and physicians

Why the relationship is strained and what doctors can do to strengthen the connection

by BY JAMES F. SWEENEY Contributing author

or decades, physicians were among the most respected professionals in the United States. But that’s changing.

Patients’ trust in their doctors and healthcare in general is declining and the consequences go beyond physicians’ lowered status. A lack of trust can lead to decreased patient compliance, worse outcomes, corrosive physician-patient interactions, and physician burnout.

“The physician-patient relationship has taken a major hit over the years and the connection is much less than it used to be,” says Andrew Morris-Singer, MD, an internist and president of Primary Care Progress, an organization working to improve primary care. “We have to reimagine the relationship. It has to evolve because the current relationship isn’t working.”

ERODING TRUST

In 1966, 73 percent of Americans said they had great confidence in the leaders of the medical profession. In 2012, only 34 percent felt the same way, according to a 2014 study published in the New England Journal of Medicine. Similarly, in a 2017 SERMO survey, 87 percent of U.S. physicians said patients trust their doctors less than they did 10 years ago.

Healthcare is not the only institution suffering from an erosion of trust. Organized religion, government, media, law enforcement, the financial system, higher education, and almost every other pillar of society is as well. Social scientists have attributed this to everything from higher levels of education, the spread of the internet, and failures of the institutions themselves.

Healthcare, once regarded as a bastion of altruism and incorruptibility, has been revealed to be as imperfect as any other institution. Thanks to the fights over the Affordable Care Act, proposals to cut Medicare and Medicaid and the push for universal coverage, healthcare has become a highly controversial issue for providers and patients alike. Healthcare systems, insurers and professional organizations like the American Medical Association have all been accused of acting out of self-interest, rather than in the best interest of patients.

In addition, patients now have access to information that makes it easier for them to second-guess their physicians. The internet allows them to do their own research and arrive at their own diagnoses and treatments, correct or not. As a result, fewer patients defer to physicians without question and, if their information conflicts with their doctors’ views, they might...
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58% of U.S. adults who said doctors can be trusted, which ranks the U.S. at 24 out of 29 industrialized countries.

Source: International Social Survey Programme

医师信任

38% of U.S. adults who said doctors can be trusted, ranking the U.S. at 24 out of 29 industrialized countries.

WHY TRUST MATTERS
Patients who mistrust medicine or physicians to the point that they avoid healthcare altogether obviously put themselves at great risk, but those are the most extreme cases. Primary care physicians are more likely to encounter distrustful patients who are disinclined to seek healthcare, unforthcoming in conversation, and suspicious of diagnoses and treatments.

All of those can damage the doctor-patient relationship.

Numerous studies have shown trust is important to an effective doctor-patient relationship. A meta-analysis published last year in *PLoS ONE* found a “small to moderate correlation” between patient trust in their healthcare professionals and health outcomes. Patients who trust their physician are more likely to follow prescribed courses of treatment.

Trust is an important factor in patients’ decisions whether to enroll in clinical trials and research projects, according to a study in the *Journal of Clinical Oncology*. And trusting patients are more likely to stay with the same providers of care, which can have positive results, such as fewer emergency department visits.

If there’s a silver lining amid all the discouraging data, it’s that even patients who distrust the healthcare system tend to like their own doctors, just as voters despise Congress but keep re-electing their own representatives. A 2013 Gallup poll found that 69 percent of the public rated the honesty and ethical standards of physicians as a profession as “very high” or “high.” That can be a foundation from which physicians can build trusting relationships.

Patients want to trust their physicians, Morris-Singer says, it’s just that the modern healthcare system gets in the way. Doctors should be aware of why patients might not trust them, but keep working toward building a more productive relationship, he says.

NO TIME FOR TRUST
While many factors contribute to the erosion of trust, experts blame a lack of time with patients more than anything else. Trust tends to build over time and through repeated interactions, which can be difficult to provide in primary healthcare.

"In these impersonal medical systems, there is very little time for clinicians to establish meaningful rapport with patients," says Stephen Post, Ph.D., director of the Center for Medical Humanities, Compassionate Care, and Bioethics at State University of New York at Stony Brook. "They’ve got to see eight patients in 30 minutes. Given that kind of a pace, it’s extremely difficult to build trust and to create meaningful, healing relationships."

Physicians can no longer expect patients to trust them just because they’re doctors; it must be earned. “Clinicians are not factory workers, though oftentimes they feel they are,” Post says. EHRs can make abbreviated appointments even worse for patients if their doctor is too busy typing on a laptop to make eye contact or engage in conversation, he says.

Sometimes, patients aren’t with the same physician long enough to build trust. As employers shop for the lowest health insurance rates, they can change carriers and contracts as frequently as every year. That can force patients to switch doctors, which means their existing patient-physician relationship is erased and a new one has to be built from scratch.

HOW TO BUILD TRUST
Some physicians have built their practices around models that allow them to form the kind of relationships with patients that the doctors think is crucial. For example, after years in various group practices, Pamela Wible, MD, created her ideal family practice in Eugene, Ore., 13 years ago. It’s just her, no providers or staff. Thirty- to 60-minute appointments are the norm and she takes the time to get to know her patients.

“I actually get to develop a relationship with my patients and that leads to better care and better outcomes and an ability to determine what’s really going on underneath a patient’s initial complaint,” she says.

The ability to spend more time with patients is crucial to successful diagnoses and treatment, she says. "If they don’t trust you,
they may not tell you that they’re a sex worker; they may not tell you that they’re doing illicit drugs; they may not tell you what’s really concerning them for fear of being judged by you,” Wible says.

A desire for a closer relationship with their patients is one of the reasons Matthew and Janelle Pfieger, husband-and-wife osteopaths, left a busy clinic in Denver in 2016 to open a direct-pay family practice in rural Huntington, Ind. Matthew says he builds trust with patients through longer appointments and genuine expressions of interest: “It’s about asking questions and showing you care for people and it’s asking about their family and their kids and other things.”

As the first direct primary care practice in the area, the Pfiegeres have had to educate patients about how they operate, but the response to the model has been positive, says Matthew. “Patients are really looking for someone they can have a relationship with,” as opposed to a harried physician with an eye on the clock, he says.

Of course, building an independent practice with 30-minute appointments is not an option for most physicians. In fact, more doctors are joining large group practices and healthcare systems that come with performance metrics, productivity reviews, and third-party scheduling, all of which can increase pressure on doctors to see more patients in less time. So what can a physician do to build patient trust within the constraints of a system not conducive to doing so?

Fight for time with patients, says Wible. Show administrators the research that time leads to trust which can lead to better outcomes. Use staff to perform duties that take away from interaction with patients. And use that time to listen.

“Doctors are famous for interrupting (patients) within 15 seconds,” says Post. “Let people have a little bit of time to talk about the personal aspects of their illness and then add an affirming comment, like ‘That must be very difficult.’”

Answer patients’ questions honestly, adds Pfieger. “When (doctors) don’t answer or give answers that aren’t helpful, that’s when the distrust happens.”

Take advantage of the five to 10 minutes patients typically spend in the exam room waiting for the physician, Wible says. Hang a whiteboard on the wall and ask patients to write down questions, concerns and goals for the visit while they wait for the doctor. This provides the physician with a quick summary of patients’ priorities.

Dhruv Khullar, MD, MPP, an internist in New York City who wrote a New York Times column on trust, says clear and open communications with patients is crucial. “Always tell the patient what you’re doing, why you’re doing it and reassure them about the fact you’ve done this before or maybe you haven’t done it before. All that needs to be very transparent,” he told Medical Economics.

Doctors also should disclose conflicts of interest to dispel any suspicions about their motives; and do what they can to level the imbalance of power in their relationships with patients, Khullar says.

One way doctors can level the relationship, according to an article in the AMA Journal of Ethics, is to explain to patients why they make the decisions they do and employ shared decision making, which invites patients to become partners in their treatment.

And remember, Khullar says, trust doesn’t come automatically; it takes time and commitment. “If we work hard to demonstrate that we’re trustworthy,” he says, “patients will trust us over time.”

How physicians suffer from a lack of patient trust

While a great deal of research has focused on how a lack of trust hurts patients, it can also take a toll on healthcare providers.

Pamela Wible, MD, a primary care physician in Eugene, Ore., who has written a book about doctor suicide and leads wellness retreats for healthcare providers, says a trusting relationship with patients is crucial to physicians’ happiness and job satisfaction.

“If you do not have that relationship it’s just going through the motions. You have less joy, fewer breakthroughs, less connection with your patients,” she says. “It’s the moments of awe with other human beings [such as between physician and patient] that keep us fulfilled and wanting to go the extra mile for people.”

Rushed and superficial relationships with patients conflict with the reasons most physicians entered medicine, says Stephen Post, Ph.D., director of the Center for Medical Humanities, Compassionate Care, and Bioethics at State University of New York at Stony Brook. “Physicians are so caught up now in administrative tasks that aren’t at the core of who they want to be. They’re just under so much pressure bureaucratically that they get disconnected from why they went into medicine in the first place,” he says.
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Managing physician risk in a costly world

by JANET KIDD STEWART Contributing author

A mid speculation that malpractice insurance rates will rise, maintaining an air-tight risk management plan should be on doctors’ agenda this year.

Malpractice insurance rates declined over the last decade as tort reform and industry safety measures led to fewer claims, but the size of the largest claims is growing. This could lead to higher rates in the future, experts say.

“It’s not widespread, but we’re finally beginning to see some upward pressure on [malpractice insurance] rates,” says Chad Karls, FCAS, principal and consulting actuary for Milliman, a Brookfield, Wis.-based actuarial and consulting firm. The examples are spotty geographically, but primary care practices are among those at higher risk, he says.

A 2017 study of hospital professional liability by consulting firm Aon and the American Society for Healthcare Risk Management projects no increase in the number of claims below $2 million for 2018, but a 2 percent rise in claim severity. The study also noted “early signs” of a rise in the number of claims above $5 million, but the data wasn’t conclusive enough to quantify the increase.

Also on the rise, the report found, are so-called batch claims, or multiple claims resulting from a repeated behavior. One example: improperly sterilized equipment.

Karls expects liability insurance rates to stay favorable for another couple of years, but there are some signs of change ahead. Increasing demand for electronic records and safeguarding patient privacy could spur a rising number of claims.

Internal medicine providers, in particular, could see higher rates as claims centered on failure to diagnose rise, Karls says. These types of claims can often take an extended time to surface as more is learned about how a disease progressed, so he urges doctors to be sure they are working with a highly-rated carrier.

Beyond taking care when choosing a carrier, practice owners should stay vigilant in maintaining their risk mitigation strategies, he says. And that involves protecting a doctor’s personal finances from excess professional liability as well as those of the practice.

“Large hospital systems today have whole risk management teams to do investigations and implement policies,” says Craig Brodsky, JD, a partner with the law firm Goodell DeVries in Baltimore, Md. “The question is how to put that type of system in place at a smaller practice without breaking the bank.”

PHYSICIAN, AUDIT THYSELF

Physicians should start by taking advantage of the resources available through vendors, Brodsky says. Liability insurers typically offer some risk mitigation reviews as part of their contracts or provide more comprehensive services for a fee, and many offer discounts if physicians attend risk-mitigation seminars.

HIGHLIGHTS

- It’s essential to understand the professional liability implications of any agreement your practice signs.
- Go beyond the chart. Physicians must remember to incorporate phone and email conversations into the record as well.
Primary care doctors, in particular, need to be aware of some newer types of risks, he says. Mandatory use of EHRs elevates their exposure to possible security and data breaches. Increased use of telemedicine raises the possibility of more diagnostic errors. Practice mergers and rising numbers of non-physician providers can chip away at the close personal relationship doctors used to have with their patients, and studies show patients are more likely to sue providers they don’t know well.

The renewed focus on sexual harassment in the workplace also poses a risk, one the practice’s attorney should address through written policies and procedures, says Brodsky.

“Large hospital systems today have whole risk management teams. ... The question is how to put that type of system in place at a smaller practice without breaking the bank.”

—CRAIG BRODSKY, JD, PARTNER, GOODELL DEVRIES, BALTIMORE, MD.

As more primary care physicians have become employed by or affiliated with hospitals, a possible outcome could be higher numbers of large claims as plaintiffs’ attorneys seek deeper pockets, says Erik Johnson, regional director for Aon Global Risk Consulting and author of the report.

As a result, it’s essential to understand the professional liability implications of the agreements, experts say. Often, a large network will move to settle claims quickly, for example, when an individual doctor might be better off fighting them to clear their professional record.

“Doctors still have an individual interest and they need to be aware that a business entity is not going to look out for their interests,” says John Lyddane, JD, a partner with law firm Dorf & Nelson LLP in New York. Negotiating for an independent attorney or liability insurer as part of an employment agreement is the best way to avoid those conflicts ahead of time, he says.

Frequently, joint practice agreements will spell out how legal claims will be handled, and the arrangements typically are meant to serve the organization, not necessarily to get the best outcome for an individual doctor.

“In a sense, [physicians] really can’t just go hire their own representation because the contract itself says you are agreeing to their risk management system,” Lyddane said.

If a practice decides to settle a malpractice case instead of going to trial, for example, the physician named in the suit has to live with the repercussions of having his or her name and the incident (along with whether a monetary settlement was involved) in the National Practitioner Data Bank.

This, in turn, can lead to denials for participation in certain healthcare plans, Lyddane says. It could also affect a physician’s employability and likelihood of receiving hospital admitting privileges, he says.

GO BEYOND THE CHART

Practice consultants routinely chide physicians for not documenting courses of action that they recommend to patients. This lack of documentation can be problematic in lawsuits, but limiting it to a chart entry isn’t always sufficient, either.

For example, if a primary care physician refers a patient to a specialist but the patient doesn’t go, the PCP can be held responsible...
in a lawsuit if there was no follow-up with the patient or the specialist, Lyddane says. Often, he says, he recommends that referring physicians make a follow-up call directly to the specialist to confirm that the patient was actually seen and the results of the visit were added to the primary care physician’s record.

And physicians must remember to incorporate phone and email conversations into the record as well, he says. An electronic message trail is better than no trail at all to document a physician’s orders, but if the order never makes it into the official record it can be a problem, he says.

Copying and pasting previous notes in the EHR when seeing a patient with a recurring problem is another mistake from a liability standpoint, he says. That’s because any inaccurate information in those notes gets repeated in newly-created notes. For each visit, physicians should create a new electronic record, he says.

**CONSIDER THE WHOLE TEAM**

The use of ancillary services, physician assistants, and nurse practitioners is yet another factor to consider when it comes to managing risks, experts say.

Vicarious liability, or the responsibility of a physician for the actions of subordinate providers of care, is an important part of assessing a practice’s overall risk profile, says Ingrid Hubbard Reidy, vice president of risk management for ISMIE Mutual Insurance Company, a Chicago-based medical liability insurer.

Some states require written collaborative practice agreements covering the scope of work performed by non-physicians, she says, and all providers should have documentation of staff members’ credentials and continuing training. And be aware that state laws covering these arrangements are changing frequently, she says.

Even among physicians, other types of documentation are crucial, she says. For example, when practices don’t have access to their patients’ data from admitting hospitals, it creates a significant liability risk, she says.

Many physicians today are so accustomed to EHRs that they don’t think about picking up a phone to inform a colleague about a development with a patient, she says. So if a specialist is not connected to the primary care provider via the EHR, the primary physician can be left completely unaware of a patient’s progress.

Care coordination poses another potential risk, particularly for primary care physicians, Reidy says.

“It’s in the handoffs of care that we’re missing a lot of things,” she says. “Many of the large health systems are doing a good job within the confines of their own system with this, but it’s a real challenge for [doctors] not in the system. Sometimes, [primary care providers] don’t even know their patient is in the hospital. They’re really struggling with that and it provides a lot of risk for them” because they don’t know to ask questions about their patients’ last medical encounters.

**“It’s not widespread, but we’re finally beginning to see some upward pressure on [malpractice insurance] rates.”**

—CHAD KARLS, FCAS, PRINCIPAL AND CONSULTING ACTUARY, MILLIMAN, BROOKFIELD, WIS.

Often, simply asking a patient if they’ve seen any other physicians since their last office visit is an effective way of catching errors of omission in the information trail, she says.

Another important risk mitigation tool is simply the human element, experts say. As medical groups get bigger and more corporate, the deep personal relationships formed between patients and doctors are under siege, Reidy says.

One way providers can mitigate this trend is by sharpening their communication skills. Be very clear with patients about the diagnosis and treatment plan, she says. Making sure to educate patients and getting them to acknowledge that they understand what they need to do to comply with the plan is crucial, she says.

**SHIELDING PERSONAL SAVINGS**

While relatively few malpractice awards exceed physicians’ insurance limits, it’s important to consider personal assets when thinking about protection against liability claims.

Employer-sponsored retirement accounts generally are protected from claims and a
workplace 401(k) or 403(b) plan carries the most asset protection from creditors because they are protected by federal labor law. IRAs have fewer protections than employer plans in non-bankruptcy liability cases, though state laws vary regarding these accounts.

Some states offer strong protections for IRAs against creditor claims, says Richard Naegle, JD, an employee benefits attorney with Wickens, Herzer, Panza, Cook & Batis-ta Co. in Avon, Ohio. California, on the other hand, leaves wide discretion to judges as to how much money in an IRA can be included in a malpractice award.

And in some states, SEP-IRAs (designed for the self-employed) are not protected from claims, he says. Physicians with funds in these accounts may want to discuss with a financial adviser the idea of converting them to Rollover IRAs, which are designed to house funds moved from other types of accounts, says Naegle, who studied state laws governing IRA claims.

The takeaway, he says, is to plow as much savings into a practice’s 401(k) plan as possible, but be aware how vulnerable funds in IRAs could be in the event of a creditor issue. They carry more protections than a non-retirement taxable account does, but depending on the state the protections could still be weak.

To be sure, Brodsky adds, the need to maintain robust risk management principles isn’t going away.

“HIPAA compliance and general data breaches is a massive issue right now, bigger than any exam-related issues,” says Brodsky. “As the government continues to add regulations, it becomes harder to keep the system secure.”

MORE TIPS ON MANAGING RISK
In addition to malpractice, physicians must consider a host of other risks to their practice.

Protect the 401(k)
If you’re overseeing the practice’s 401(k) plan, make sure the plan isn’t running the risk of losing its tax-deferred status by failing to comply with rules such as making timely deposits of employee contributions, says Jan Jacobson, retirement policy senior counsel for the American Benefits Council in Washington, D.C.

Even very small plans with just a dozen or so participants are beginning to hire outside administrators as fiduciaries to ensure the plan complies with all applicable laws, she says.

“You can get sued for virtually anything, from having excessive fees to the wrong investments,” she says. “So, you need a good process for plan design, and that means getting a fiduciary to hold your hand through it all.”

Know your home rules
Just as states vary on how retirement accounts are protected from creditors, they also differ on how home equity is treated. Most states offer some kind of protection for primary residences, but many put caps on the amount of home value that can be shielded, so be aware that some home equity could be at risk in a lawsuit.

Put up some umbrella protection
Umbrella insurance is designed as a catch-all liability policy that sits on top of other personal policies and provides for coverage of major claims that exceed standard coverage. Financial advisers typically recommend buying coverage for at least the amount of a client’s net worth. Policies with $3 million in coverage generally cost around $400 a year, though terms vary by region.

Trust in trusts?
Beyond these measures, doctors are often pitched on spending thousands of dollars on trusts designed to keep assets away from creditors. While every person’s risk tolerance is different, John Lydane, JD, a partner with law firm Dorf & Nelson LLP in New York, reminds clients that awards in excess of coverage limits are relatively rare.

“I’ve been doing this for 40 years and our firm has probably handled 10,000 cases in that time. I only know of five or six times when someone had to pay an award above their [malpractice] policy,” he says. “And the largest excess payment I ever heard of was for $50,000 over a physician’s malpractice limit of $3 million.”

Lydane advises physicians to buy enough liability coverage to let you sleep at night, but do no more.
The grass is greener on our side.

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This allows the practice to evaluate its telemedicine plans and adjust its technology, policies, and procedures—such as how the physician's camera is positioned to how patients submit data before the telemedicine visit—before rolling it out more broadly.

“Similar to in-person practice, when using telemedicine, a physician should ensure that patients retain their rights concerning privacy and secured health information, access to their medical records, and information about benefits, risks, and alternatives to proposed treatments or procedures,” says Latoya S. Thomas, director of the State Policy Resource Center at the American Telemedicine Association (ATA).

SELECT A BUSINESS MODEL

Physicians have a choice as to how they want to practice telemedicine. They can integrate it into their existing practice or they can partner with companies that offer such services.

Those who decide to integrate telemedicine into their existing practices to treat their own patients will have to select and then implement the technology, policies, and processes to make it work for them, Tennant says.

Although that’s the route many physicians take, practices can work with companies that provide all the infrastructure to enable video visits, Sharp says.

“The company either takes a larger portion of the reimbursement or requires a monthly fee or something like that. But the advantage is they provide everything out of the box for you. And they [tailor the site’s branding], so you put your own practice logo on it,” Sharp explains.

Health IT experts say these services allow physicians to treat both their own practice’s patients and possibly non-practice patients who seek services through the company’s own network.

Goel says he sees companies structure their payments based simply on per-patient visits. The prices under this model range from $50 to $100; companies may charge a technical fee on top of this. Goel says practices can establish a fee schedule to charge patients higher amounts, to ensure they make a profit, but he notes reimbursement models don’t support such pricing. As a result, such telemedicine services are used primarily in concierge practices.

Thomas says practices should:

- Evaluate the company’s reputation as well as its business and/or clinical model.
- Consider the platform’s ease of use, set up and training/education for the platform; software features such as security, e-prescribing, billing, mobile app capabilities, EHR integration.
- Weigh the costs associated with it, including marketing, training, technical assistance, maintenance, professional licensure or malpractice fees against the expected income derived from it.

Similar to advice usually offered for other new business arrangements, health IT experts say, physicians should ask if a company will allow the practice to pilot a program before signing a long-term contract.

DETERMINE OBJECTIVES

Practices need to know why they want to offer telemedicine services and articulate how and where they want this to work within their practice, Waldren says.

“Are you going to use it for off-hour calls? To offload some regular visits? To make it convenient for patients?” he asks.

Determining these objectives helps practices make smarter decisions when it comes to choosing the technology and building the policies and procedures for telemedicine, he says. For instance, a practice that wants to use telemedicine to connect patients with their own physicians might require just a secure video connection.

On the other hand, a practice using telemedicine to treat patients with chronic conditions might want a more robust system with functions such as dashboards for managing patient data that the entire care team can use.

REVIEW REGULATIONS

Regulatory requirements for telemedicine vary from state to state, according to Waldren. For example, some states require physicians to have an existing relationship with patients they treat via video visits, while others don’t. Meanwhile, some states require parity between telemedicine and equivalent face-to-face visits to ensure the medical services physicians offer virtually mirror the quality they offer in person.

Similarly, physicians should review their malpractice policies to ensure their coverage extends to telemedicine services. Telemedicine service coverage can vary from payer to payer and from state to state.

The Center for Connected Health Policy offers resources to help physicians sort through rules and regulations as well as the state-by-state variations among them. (Find them at bit.ly/CCHPCA-policies.) There are also state and regional telemedicine groups that offer guidance on such issues.

Similarly, practices need to work with payers to ensure they use the right codes for reimbursement, as billing codes for telemedicine can vary...
Telemedicine licensure and related challenges for physicians
By Marcie M. Damisch, JD, LLM

While the availability and use of telemedicine services is increasing annually, healthcare providers engaged in providing telemedicine services must carefully navigate numerous regulatory obstacles. Failure to abide by applicable laws may jeopardize the licensure of the healthcare provider, result in monetary fines and penalties, and increase potential exposure to medical malpractice claims.

FOLLOWING STATE RULES
Licensure presents the most obvious obstacle to the growth of telemedicine services, as state laws governing the provision of telemedicine services differ widely. Generally, healthcare providers are required to be licensed in the state in which the patient receiving the services is located. Certain states, like Texas, offer a special license for the provision of certain types of telemedicine services. Other states, such as California, allow for limited consultations by out-of-state practitioners without licensure. In evaluating the licensure requirements for the provision of telemedicine services in any state, healthcare providers need to carefully consider the nature and frequency of the services they will provide. For clinicians rendering telemedicine services in multiple states, this can be a time-consuming and costly endeavor.

Obtaining multi-state licensure is only part of the challenge for providers, however. Healthcare providers practicing telemedicine in multiple states are also required to adhere to the standards of medical practice in each state, and state standards of practice vary considerably. For example, in Colorado, the practice of medicine is defined broadly and encompasses telemedicine. To guide physicians, the Colorado Medical Board has issued a rule for the appropriate use of telehealth technologies in the practice of medicine. However, other states have considerably less guidance available or have not issued any unique laws or regulations concerning telemedicine services.

Adding to the complexity, there is no one location for a provider to find the applicable rules. In some states, these rules are found in statutes and regulations. In other states, they may be found in the rules, policies, and procedures of the state licensing boards.

AWARENESS OF OTHER LAWS
Healthcare providers also need to be aware of federal and state laws governing the privacy and security of medical information and ensure the technology they are using complies with applicable laws. In addition, the availability of reimbursement for telemedicine services varies widely from state to state and should be considered when structuring any arrangement for the provision of telemedicine services. The Medicare Anti-Kickback Statute and the Physician Self-Referral law (also known as the Stark law) and similar state laws may also apply to arrangements for telemedicine services. Lastly, the prohibition on the corporate practice of medicine in certain states may also impact what type of entity may provide telemedicine services.

While telemedicine services have the potential to offer significant benefits to the general population, the government, and the healthcare industry through reduced costs and increased access to care, the technology is advancing at a faster pace than the law.

Marcie M. Damisch, JD, LLM, is a shareholder in Stradling’s Corporate practice group. Her practice is focused on the representation of healthcare providers and related entities.
How will the practice capture and process payment for the visit?
How does the software capture information from the patient?
How easy is it for the practice to incorporate clinical guidelines and recommendations?
Does the system support the requirements for telemedicine that are specific to the state in which the practice resides?
How easy is it for the practice to document the visit using the platform, and how is that documentation integrated into the patient EHR?
What ancillary services, such as marketing materials to give to patients, does the platform provide to ensure success?

They also advise selecting platforms that are HIPAA-compliant instead of using consumer services (such as Skype) or technologies offered to businesses that don’t have the same level of security requirements as healthcare. Waldren reminds practices to ask vendors for verification that they’re HIPAA-compliant.

Tennant advises physicians to seek out colleagues in similar-sized practices who have implemented telemedicine to ask about their experiences and the technologies they use. He suggests visiting the practice to observe telemedicine in action.

**HARDWARE REQUIREMENTS**

The good news is, most physicians won’t need significant hardware investments.

“For the vast majority of telemedicine, the commercial consumer-level products are more than adequate,” Waldren says, noting that the cameras in desktops and laptops offer sufficiently high resolution.

Physicians also should have headsets to ensure adequate sound quality and more privacy than the speaker functions embedded in laptops and desktops generally offer, health IT experts say.

Additionally, “you want to make sure your internet connection is fast enough to support video,” Sharp says, adding that physicians can test their connection using a free consumer platform (such as Skype) to see if their system works smoothly or if the video snags or crashes their computers (thus indicating the need for an upgrade).

**ADJUST PRACTICE WORKFLOW**

Practices need to consider how telemedicine will fit into their services. That includes:

- Determining whether the procedures for checking in and treating patients for telemedicine visits will mirror the workflow of in-office visits or whether the workflow needs to be tweaked; for example, practices might opt to have their non-physician staff gather needed information from patients at the start of the telemedicine visit as they do for in-office visits. Or practices could decide to have patients electronically enter information prior to their appointment.
- Determining whether, and where, they can add automation and patient-entered information into the process.
- Determining whether physicians will be the only ones to conduct telemedicine visits, and if not, under what circumstances other team members may conduct those visits.

Bush recommends training at least one point person for telehealth, with responsibilities for scheduling the appointments and sending out the appointment notices with the links or details on how to join the video visit. Related to that, physicians need to determine whether they’ll use telemedicine to handle urgent calls.

Experts also advise practices to consider how telemedicine will fit into the practice schedule. Sharp says some practices carve out blocks of time during their schedules for telehealth visits rather than having telemedicine services available at all times.

Practices need to consider their typical office rhythms and patient demands, such as whether they get a flood of appointment requests on Monday morning that could be handled more efficiently via telemedicine.

Sharp adds that practices piloting telehealth might consider planning only for a few hours weekly to test how well it works rather than starting with large blocks of time. They also need to determine, based on their patients’ needs and practice experience, how much time to allot for these visits.

**MARKET & MEASURE SUCCESS**

A practice can work through all these questions before implementing telemedicine only to find that it isn’t well-received by patients. A practice might not see a return on its investment—at least not in the short run.

But physicians shouldn’t abandon telemedicine in such circumstances, experts say, but rather use the experience to evaluate how to better promote the service to patients and to refine their pricing.

Telemedicine can help practices be more efficient, and thus more profitable, as well as provide supplemental income to physicians. However, health IT experts don’t see it as a lucrative endeavor.

Still, practices offering telemedicine should seek to maximize the value of their investments, and that means letting patients know that it’s available, Waldren says.

“You’re going to have to market it to your patients and explain what they can and can’t do, so think about a marketing campaign,” he says.

The campaign should do more than simply say the service is available, Waldren adds. It should let patients know why it’s available, when it’s offered, and for what conditions.

At the same time, physicians should determine from the start what a successful telemedicine program should look like for their practice so they can establish metrics to judge their efforts as they get under way.

Physicians could establish objectives around improved financials, patient convenience, provider satisfaction rates, and/or patient outcomes. Whatever the anticipated benefits, Waldren says physicians should set how and when to measure progress in each area to determine if they’re succeeding with their telemedicine program.

He adds, “You want to check in frequently enough to make sure you’re making progress.”
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How to select the right telemedicine vendor

by CHERYL ALKON Contributing author

HEN patients contacted her via social media Tisha Rowe, MD, MBA, used to respond to them. But when the Houston, Texas-based primary care physician found that the messages kept coming, she knew something had to change. "A lot of people would reach out to me and say, "Can you answer this question?'" she says. "I thought, "Wait a minute. I’m working, and I’m not getting paid for it."

In 2014, no one was really discussing telemedicine, she says. So she looked into implementing it not just for her own patients, but for others. Today, Rowe is the founder and CEO of RoweDocs, an online network of 75 physicians who offer telemedicine visits to their current patients.

But even with Rowe's business background, finding the right vendor wasn't easy. Vendors would make promises they ultimately couldn't deliver on.

The first company had problems in following HIPAA. The second couldn't bill an insurance company, or verify a patient's insurance coverage. The third said it was a telemedicine company, but only offered chat communications without video conferencing, Rowe says.

As Rowe's experience indicates, finding the right telemedicine vendor can be a challenge. As more practices consider offering telemedicine, both the big picture and the small details matter. Taking a thoughtful approach can help physicians determine which vendor will provide the best fit for their practices and their patients.

ASK THE RIGHT QUESTIONS

Asif Shah, MBA, associate principal at ECG Management Consultants, a healthcare management consulting firm, first worked with Greensboro, N.C.-based Cone Health, a six-hospital healthcare system, two years ago. Cone Health contacted ECG after seeing a competitor’s highway billboards offering $50 telemedicine visits. Cone Health wanted to do something similar.

According to John Jenkins, MD, Cone Health's senior vice president and chief clinical office for connected care, Cone had three objectives for implementing telemedicine: positioning the company as innovative and transformative, remaining competitive in a market where other companies advertised frequently about their own telemedicine capabilities, and creating a multi-year strategy for entering the digital health world.

"Spend as much time as possible defining the problem before you look for solutions—that is absolutely critical," Jenkins advises. "People tend to jump into virtual health, as a way to check the box, rather than thinking about why they need it."

Shah says practices need to think about telemedicine as a concept. Know the answers to questions such as "Why do this?", "How to do it?", and "How will it affect your brand?" Don't consider vendors solely by what technology they offer, but instead know what problems the practice is trying to solve with telemedicine integration, such as patient convenience, or staying competitive in the market.

Once a practice understands why it wants...
to implement telemedicine, Shah notes that finding a third-party planner can help a practice select potential vendors, though it’s certainly possible for a practice to make the decision on its own. The potential to get bogged down by the number of vendors and what they offer, however, can be minimized by using an outside consultant.

**PROS AND CONS OFBRANDING**
Shah also cites branding as a consideration when implementing telemedicine. “It’s common to have something indicating that the system is ‘powered by XYZ vendor,’” says Shah. Is it important for the practice to offer its own telemedicine technology directly on its own website, for example, or would the practice prefer to send its patients to a third-party website or vendor app? And if the vendor’s website or app is what the practice will use, would the patient be able to tell the difference, or will it appear as if the software comes from the practice itself?

Using its own branded telemedicine site has its advantages, notes Shah. “From a patient perspective, they will continue to stay within the practice’s ecosystem,” which helps keep the patient connected to the practice, indicates that the practice is innovative, and maintains the patient’s familiarity with the practice they already know, he says. It also keeps patients from potentially leaving the practice’s website and not returning.

The disadvantages of a branded site are that if the patient has a bad experience with the platform, even if it is a vendor issue, the patient will associate that experience with the practice itself, Shah says. Other critical questions include:

- If the practice is relying on smartphone apps to connect with patients, will the vendor be able to support patients who use both iPhones and Android devices?
- Can the vendor work with the practice to individualize what it offers for each practice, or is it a more universal system?
- How does the vendor provide training so that the practice physicians understand how the telemedicine system operates? How quickly will they offer patients access to the provider?

**GET THE PATIENT PERSPECTIVE**
Without implementing feedback from patients on how telemedicine should work, it’s possible patients won’t stick around long enough to use the system for an extended period, says Shah. His client, Cone Health, used patient feedback it obtained through surveys and follow-up phone calls to improve the process.

Ultimately, Cone Health saw more growth than all its competitors saw in the prior three years because their telemedicine vendor provided the whole experience, he says. “As a result, repeat patients would say, ‘If I hadn’t been able to do this video visit, I would have gone to the ER,’” he says.

**MAKING THE RIGHT CHOICE**
Rowe says practices should ask vendors for a 30-day trial period, to ensure that the vendor can actually provide the services it says it can offer. Also, when a vendor offers customer support, ensure it is available during extended hours or over the weekend, “not during the time you plan on seeing patients,” she says.

Other points to consider: use a vendor with a physician support line that is separate from what patients use for support, and confirm that a vendor’s software can verify insurance, as well as send and receive prescriptions and labs directly, Rowe says.

The experience helped Rowe develop RoweDocs to serve as an implementation manager for practices who want to incorporate telemedicine.

“Don’t just try to put the tech in and think it will magically work without doing the work. ... it’s what you do with the technology that is important.”

— TISHA ROWE, MD, MBA, PRIMARY CARE PHYSICIAN, HOUSTON, TEXAS
Coding Insights

CODING CASE STUDY  Hypertension and obesity

Getting paid requires accurate documentation and selecting the correct codes. In our Coding Case Studies, we will explore the correct coding for a specific condition based on a hypothetical clinical scenario.

Clinical scenario

Chief Complaint: Mr. Jones is a 64-year-old male, who presents with hypertension and morbid obesity.

History: Patient states he is less active now due to change in employment and has been eating more fast food lately due to his busy work schedule.

Review of Systems

Constitutional: Negative for fever, chills, fatigue.

Respiratory: Negative for cough and shortness of breath.

Cardiovascular: Negative for chest pain, palpitations, and leg swelling.

Physical Exam

BP: 152/106  Pulse: 64
Temp: 99.6°F (37.6°C)  BMI: 50.49 kg/m²
Height: 5’ 11.73”  Weight: 369 lb 8 oz

Constitutional: He is oriented to person, place, and time. He appears well-developed. No distress. Obese male seated in chair, pleasant, looks comfortable.


Cardiovascular: Normal rate, regular rhythm and normal heart sounds.

Pulmonary/Chest: Effort normal and breath sounds normal.

Abdominal: Soft. Bowel sounds are normal. There is no tenderness.

Musculoskeletal: Normal range of motion. He exhibits no tenderness.

Assessment and Plan

- Hypertension, unstable, amlodipine (NORVASC) 5 MG tablet; Take 1 tablet (5 mg total) by mouth daily. Dispense: 30 tablet; Refill: 11

- Morbid obesity, BMI, 50.49 - Reinforced need to lose 10 to 20 percent of his current body weight through proper nutrition and increased physical activity

Documentation Coding Requirements

Hypertension

When documenting, include the following:

- Type  e.g. essential, secondary, etc.
- Causal relationship  e.g. Renal, pulmonary, etc.

Overweight and Obesity

When documenting, include the following:

- Cause  Due to excess calories, drug-induced
- Severity  Choose one of the three options below
  ➢ Overweight
  ➢ Obesity
  ➢ Morbid (severe) obesity

Complication  With alveolar hypoventilation

ICD-10 Codes

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<th>Description</th>
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<tr>
<td>I10</td>
<td>Essential (primary) hypertension</td>
</tr>
<tr>
<td>I11.9</td>
<td>Hypertensive heart disease without heart failure</td>
</tr>
<tr>
<td>I15.0</td>
<td>Renovascular hypertension</td>
</tr>
<tr>
<td>E66.01</td>
<td>Morbid (severe) obesity due to excess calories</td>
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<td>E66.09</td>
<td>Other obesity due to excess calories</td>
</tr>
<tr>
<td>E66.1</td>
<td>Drug-induced obesity</td>
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<td>E66.2</td>
<td>Morbid (severe) obesity with alveolar hypoventilation</td>
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<tr>
<td>E66.3</td>
<td>Overweight</td>
</tr>
<tr>
<td>E66.8</td>
<td>Other obesity</td>
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<tr>
<td>E66.9</td>
<td>Obesity, unspecified</td>
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Use additional code to identify body mass index (BMI), if known

Z68.1—Z68.45  Body mass index (BMI), adult

Diagnosis codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I10</td>
<td>Essential (primary) hypertension</td>
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<tr>
<td>E66.01</td>
<td>Morbid (severe) obesity due to excess calories</td>
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<tr>
<td>Z68.43</td>
<td>Body mass index (BMI) 50.0-59.9, adult</td>
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</table>

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Indiana. Send your coding questions to medec@ubm.com.
The best of intentions from payers often hurt physicians

“The best of intentions from payers often hurt physicians.”

By Jennifer Frank, MD

Editor’s note: This article was first published in our partner publication, Physicians Practice.

Today was the closest I’ve come in a long time to hanging up my corporate stethoscope and entering the field of direct primary care. There is tremendous appeal to me in simply providing medical care for a reasonable fee without going through insurance or having to jump through the endless hoops Medicare requires. However, there are many reasons holding me back, not the least of which is the security of being an employed physician.

However, two events pushed me to the edge this afternoon. The first is a “premium quality” rating by one of our insurers. Through a complex formula which may involve Newtonian physics, physicians are rated into tiers—a reflection of their quality and cost of care. Not only did I not qualify for tier 1, but I didn’t qualify for tier 2 either. I was put in the category of “did not meet quality care and is essentially a quack physician” (I added that last part for emphasis).

This perplexes me. While I can accept that I may not be among the best physicians in terms of the cost of care/quality mix, I have to protest that I’m in the low quality category.

No one wants to be told that they are a subpar performer. I suspect that my ranking is an error based on the fact that, as medical director for our urgent care, claims are submitted under my name thereby making my cost of care seem quite high. However, the lack of transparency in how the math was done, the extreme difficulty in getting information, and really, the idea that the entirety of my medical practice can be fit into a tier is offensive.

The second insult came when we were informed of a new requirement by another health plan that our physicians would need to go through an extensive process for opioid prescribing that involved completing their own online training (I’ve already completed more than the requirement for my state license for opioid prescribing), obtaining all past medical records (yes, this is good medical practice but can be challenging in reality), preferentially prescribing at specific pharmacies, and so on.

Our organization has a thought-out process and policy for controlled substance prescribing. We practice in a state with robust regulations governing how controlled substances are prescribed. This is an additional layer of complexity added to an already high-risk and complicated process.

I am all for safe opioid prescribing, but sometimes these types of regulations and hoop-jumping result in physicians refusing to prescribe. Those who continue to prescribe will end up with an increasingly burdensome workload as patients transfer care to them.

The care we provide should be evaluated for both quality and cost. Opioids should be prescribed responsibly and safely. However, physicians are getting burned out or are already so.

One of the main contributors is when our work becomes more difficult to complete while we are simultaneously scrutinized against a wide range of rating systems and scales that may fail to convey the entire picture. I may be ready to turn in my NPI number and start bartering my services for chickens and free oil changes.

Jennifer Frank, MD, is a primary care physician in private practice in northeastern Wisconsin.
“I love medicine because ...”

Maria Young Chandler, MD, MBA
Business of Medicine / Pediatrics
Irvine, Calif.

“as a leader you can affect larger populations of patients in need.”

George G. Ellis, Jr., MD
Internal Medicine
Boardman, Ohio

“I love helping people.”

Antonio Gamboa, MD, MBA
Internal Medicine / Hospice and Palliative Care
Austin, Texas

“I am able to make an impactful difference in someone’s life on a daily basis.”

Jeffrey M. Kagan, MD
Internal Medicine / Hospice
Newington, Conn.

“of the rewards of helping so many patients while getting personal thrills playing medical detective.”

Melissa E. Lucarelli MD, FAAFP
Family Medicine
Randolph, Wis.

“taking care of patients is the best job in the world. It’s the ever-increasing regulations and the EHR clicks and the administrative burden which get me down.”

Joseph E. Scherger, MD
Family Medicine
La Quinta, Calif.

“I get to help people.”

Salvatore Volpe, MD
Pediatrics/Internal Medicine / Pediatrics
Staten Island, N.Y.

“of the connection with others while helping them.”

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