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JANUARY 10, 2019 VOLUME 96 NO. 1

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GETTING PAID in 2019

- Private payers’ new requirements
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- Coding opportunities

EHR CONSOLIDATION CONSEQUENCES FOR DOCTORS
NEXPLANON is indicated for use by women to prevent pregnancy.

SELECTED SAFETY INFORMATION

Who is not appropriate for NEXPLANON
- NEXPLANON should not be used in women who have known or suspected pregnancy; current or past history of thrombosis or thromboembolic disorders; liver tumors, benign or malignant, or active liver disease; undiagnosed abnormal genital bleeding; known or suspected breast cancer, personal history of breast cancer, or other progestin-sensitive cancer, now or in the past; and/or allergic reaction to any of the components of NEXPLANON.

WARNINGS and PRECAUTIONS
Complications of insertion and removal
- NEXPLANON should be inserted subdermally and be palpable after insertion. Palpate immediately after insertion to ensure proper placement. Undetected failure to insert the implant may lead to unintended pregnancy. Failure to remove the implant may result in continued effects of etonogestrel, such as compromised fertility, ectopic pregnancy, or persistence or occurrence of a drug-related adverse event.
- Insertion and removal-related complications may include pain, paresthesias, bleeding, hematoma, scarring, or infection. If NEXPLANON is inserted too deeply (intramuscular or in the fascia), neural or vascular injury may occur. Implant removal may be difficult or impossible if the implant is not inserted correctly, inserted too deeply, not palpable, encased in fibrous tissue, or has migrated. If at any time the implant cannot be palpated, it should be localized and removal is recommended.
- There have been postmarketing reports of implants located within the vessels of the arm and the pulmonary artery, which may be related to deep insertions or intravascular insertion. Endovascular or surgical procedures may be needed for removal.

NEXPLANON and pregnancy
- Be alert to the possibility of an ectopic pregnancy in women using NEXPLANON who become pregnant or complain of lower abdominal pain.
- Rule out pregnancy before inserting NEXPLANON.

Educate her about the risk of serious vascular events
- The use of combination hormonal contraceptives increases the risk of vascular events, including arterial events [stroke and myocardial infarction (MI)] or deep venous thrombotic events (venous thromboembolism, deep venous thrombosis (DVT), retinal vein thrombosis, and pulmonary embolism). Women with risk factors known to increase the risk of these events should be carefully assessed. Postmarketing reports in women using the nonradiopaque etonogestrel implant have included pulmonary emboli (some fatal), DVT, MI, and stroke. NEXPLANON should be removed if thrombosis occurs.
SELECTED SAFETY INFORMATION (continued)

- Due to the risk of thromboembolism associated with pregnancy and immediately following delivery, NEXPLANON should not be used prior to 21 days postpartum.
- Women with a history of thromboembolic disorders should be made aware of the possibility of a recurrence. Consider removing the NEXPLANON implant in case of long-term immobilization due to surgery or illness.

**Counsel her about changes in bleeding patterns**
- Women are likely to have changes in their menstrual bleeding pattern with NEXPLANON, including changes in frequency, intensity, or duration. Abnormal bleeding should be evaluated as needed to exclude pathologic conditions or pregnancy. In clinical studies of the non-radiopaque etonogestrel implant, changes in bleeding pattern were the most common reason reported for stopping treatment (11.1%). Counsel women regarding potential changes they may experience.

**Be aware of other serious complications, adverse reactions, and drug interactions**
- Remove NEXPLANON if jaundice occurs.
- Remove NEXPLANON if blood pressure rises significantly and becomes uncontrolled.
- Prediabetic and diabetic women using NEXPLANON should be carefully monitored.
- Carefully observe women with a history of depressed mood. Consider removing NEXPLANON in patients who become significantly depressed.
- The most common adverse reactions (≥10%) reported in clinical trials were headache (24.9%), vaginitis (14.5%), weight increase (13.7%), acne (13.5%), breast pain (12.8%), abdominal pain (10.9%), and pharyngitis (10.5%).
- Drugs or herbal products that induce enzymes, including CYP3A4, may decrease the effectiveness of NEXPLANON or increase breakthrough bleeding.
- The efficacy of NEXPLANON in women weighing more than 130% of their ideal body weight has not been studied. Serum concentrations of etonogestrel are inversely related to body weight and decrease with time after implant insertion. Therefore, NEXPLANON may be less effective in overweight women.
- Counsel women to contact their health care provider immediately if, at any time, they are unable to palpate the implant.
- NEXPLANON does not protect against HIV or other STDs.

**Please read the adjacent Brief Summary of the Prescribing Information**

BRIEF SUMMARY (For full Prescribing Information, see package insert)  
Women should be informed that this product does not protect against HIV infection (the virus that causes AIDS) or other sexually transmitted diseases.

INDICATION AND USAGE  
NEXPLANON is indicated for use by women to prevent pregnancy.

CONTRAINDICATIONS  
NEXPLANON should not be used in women who have:  
• Known or suspected pregnancy  
• Current or past history of thrombosis or thromboembolic disorders  
• Liver disease, especially decompensated liver disease  
• Undiagnosed abnormal genital bleeding  
• Known or suspected breast cancer, personal history of breast cancer, or other progestin-sensitive tumors or in the family  
• Allergic reaction to any of the components of NEXPLANON [see Adverse Reactions]

WARNINGS AND PRECAUTIONS  
The following information is based on experience with the etonogestrel implants (IMPLANON® [etonogestrel implant] and NEXPLANON), other progestin-only contraceptives, or experience with combination (estrogen plus progestin) oral contraceptives.

1. Complications of Insertion and Removal  
NEXPLANON should be inserted subdermally so that it is palpable after insertion, and this should be confirmed by palpation immediately after insertion. Failure to insert NEXPLANON properly may go unnoticed during the initial palpation immediately after insertion. Undetected failure to insert the implant may lead to an unintended pregnancy. Complications related to insertion and removal procedures, such as pain, paresthesia, bleeding, hematoma, scarring, or infection, may occur.

If at any time after insertion NEXPLANON cannot be palpated, it should be localized and removal is recommended.

2. Changes in Menstrual Bleeding Patterns  
After starting NEXPLANON, women are likely to have a change from their normal menstrual bleeding pattern. These may include changes in bleeding frequency (absent, less, more frequent or continuous), intensity (reduced or increased) or duration. In clinical trials of the non-radioopaque etonogestrel implant (IMPLANON), bleeding patterns ranged from amenorrhea (11 in 5 women) to frequent and/or prolonged bleeding (1 in 5 women). The bleeding pattern experienced during the first three months of NEXPLANON use is broadly predictive of the future bleeding pattern for many women. Should women be counseled regarding the bleeding changes they may experience so that they know what to expect. Abnormal bleeding should be evaluated as needed to exclude pathologic conditions or pregnancy. In clinical studies of the non-radioopaque etonogestrel implant, reports of changes in bleeding pattern were the main reason for stopping treatment (35%). Irregular bleeding (10.8%) was the most common reason women stopped treatment, while amenorrhea (22%) was cited less frequently. In these studies, women had an average of 17.7 days of bleeding or spotting every 90 days (based on 3.315 intervals of 90 days recorded by 780 patients). The percentages of patients having 0, 1-7, 8-21, or >21 days of spotting or bleeding over a 90-day interval while using the non-radioopaque etonogestrel implant are shown in Table 2.
14. Fluid Retention
Hormonal contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention. It is unknown if NEXPLANON causes fluid retention.

15. Contact Lenses
Contact lens wearers who develop visual changes or lens tolerance changes should be assessed by an ophthalmologist.

16. In Situ Broken or Bent Implant
There have been reports of broken or bent implants while in the patient’s arm. Based on in vitro data, when an implant is broken or bent, the release rate of etonogestrel may be slightly increased. When an implant is removed, it is important to remove it to its entirety (see Dosage and Administration).

17. Monitoring
A woman who is using NEXPLANON should have a yearly visit with her healthcare provider for a blood pressure check and for other indicated health care.

18. Drug-Laboratory Test Interactions
See hormone-binding globulin concentrations may be decreased for the first six months after NEXPLANON insertion followed by gradual recovery. Thyroxine concentrations may initially be slightly decreased followed by gradual recovery to baseline.

ADVERSE REACTIONS
In clinical trials involving 942 women who were evaluated for safety, change in menstrual bleeding patterns (irregular menses) was the most common adverse reaction causing discontinuation of use of the non-rodapioa etonogestrel implant (IMPLANON® [etonogestrel implant]) (11.1% of women).

Adverse reactions that resulted in a rate of discontinuation of 1% are shown in Table 3.

Table 3: Adverse Reactions Leading to Discontinuation of Treatment in 1% or More of Subjects in Clinical Trials of the Non-Rodapioa Etonogestrel Implant (IMPLANON)

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>All Studies N=942</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding irregularities*</td>
<td>11.1%</td>
</tr>
<tr>
<td>Emotional Lability†</td>
<td>2.3%</td>
</tr>
<tr>
<td>Weight Increase</td>
<td>2.3%</td>
</tr>
<tr>
<td>Headache</td>
<td>1.6%</td>
</tr>
<tr>
<td>Acne</td>
<td>1.3%</td>
</tr>
<tr>
<td>Depression†</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

*Includes "frequent", "heavy", "prolonged", "spotting", and other patterns of bleeding irregularity.
†Among US subjects (N=339), 6.1% experienced emotional lability that led to discontinuation.
‡Among US subjects (N=339), 2.4% experienced depression that led to discontinuation.

Other adverse reactions that were reported by at least 5% of subjects in the non-rodapioa etonogestrel implant clinical trials are listed in Table 4.

Table 4: Common Adverse Reactions Reported by ≥5% of Subjects in Clinical Trials With the Non-Rodapioa Etonogestrel Implant (IMPLANON)

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>All Studies N=942</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
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</tr>
<tr>
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<td>13.5%</td>
</tr>
<tr>
<td>Breast pain</td>
<td>12.8%</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>10.9%</td>
</tr>
<tr>
<td>Pharyngitis</td>
<td>10.5%</td>
</tr>
<tr>
<td>Leukorrhea</td>
<td>9.6%</td>
</tr>
<tr>
<td>Influenza-like symptoms</td>
<td>7.6%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>7.2%</td>
</tr>
<tr>
<td>Dysmenorrhea</td>
<td>7.2%</td>
</tr>
<tr>
<td>Back pain</td>
<td>6.8%</td>
</tr>
<tr>
<td>Emotional lability</td>
<td>6.5%</td>
</tr>
<tr>
<td>Nausea</td>
<td>6.4%</td>
</tr>
<tr>
<td>Pain</td>
<td>5.6%</td>
</tr>
<tr>
<td>Nervousness</td>
<td>5.6%</td>
</tr>
<tr>
<td>Depression</td>
<td>5.5%</td>
</tr>
<tr>
<td>Hypersensitivity</td>
<td>5.4%</td>
</tr>
<tr>
<td>Insertion site pain</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

In a clinical trial of NEXPLANON, in which investigators were asked to examine the implant site after insertion, implant site reactions were reported in 8.6% of women. Erythema was the most frequent implant site complication, reported during and/or shortly after insertion, occurring in 3.2% of subjects. Additionally, hematoma (1.0%), bruising (2.0%), pain (1.0%), and swelling (0.7%) were reported.

Effects of Other Drugs on Hormonal Contraceptives

Substances decreasing the plasma concentrations of hormonal contraceptives (HCs) and potentially diminishing the efficacy of HCs:

Substances decreasing the plasma concentrations of hormonal contraceptives (HCs) and potentially diminishing the efficacy of HCs:

- Enzyme inducer to ensure contraceptive reliability.
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  - Etonogestrel implant clinical trials are listed in Table 4.
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  - Etonogestrel implant clinical trials are listed in Table 4.

Effects of Other Drugs on Hormonal Contraceptives

Hormonal contraceptives may affect the metabolism of other drugs. Consequently, plasma concentrations may either increase (for example, cyclosporin) or decrease (for example, lamotrigine). Consult the labeling of all concurrently-used drugs to obtain further information about interactions with hormonal contraceptives or the potential for enzyme alternations.

USE IN GERIATRIC POPULATIONS

1. Pregnancy

Risk Summary
NEXPLANON is contraindicated during pregnancy because there is no need for pregnancy prevention in a woman who is already pregnant (see Contraindications). Epidemiologic studies and meta-analyses have not shown any increased risk of genital or non-genital birth defects (including cardiac anomalies and limb-reduction defects) following maternal exposure to low dose CHCs prior to conception or during early pregnancy. No adverse development outcomes were observed in pregnant rats and rabbits with the administration of etonogestrel during organogenesis at doses of 315 or 781 times the anticipated human dose (60 μg/day) of NEXPLANON should be removed if maintaining a pregnancy.

2. Nursing Mothers

Lactation

Risk Summary
Small amounts of contraceptive steroids and/or metabolites, including etonogestrel are present in human milk. No significant adverse effects have been observed in the production or quality of breast milk, or on the physical and psychomotor development of breastfed infants. Hormonal contraceptives, including etonogestrel, can reduce milk production in breastfeeding mothers. This is less likely to occur if breastfeeding is established; however, it can occur at any time in some women. When possible, advise the nursing mother about both hormonal and non-hormonal contraceptive options, as steroids may not be the initial choice for these patients. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for NEXPLANON and any potential adverse effects on the breastfed child from NEXPLANON or from the underlying maternal condition.

3. Pediatric Use

Safety and efficacy of NEXPLANON have been established in women of reproductive age. Safety and efficacy of NEXPLANON are not appropriate for postpubertal adolescents. However, no clinical studies have been conducted in women less than 18 years of age. Use of this product before menarche is not indicated.

4. Geriatric Use

This product has not been studied in women over 65 years of age and is not indicated in this population.

5. Hepatic Impairment

No studies were conducted to evaluate the effect of hepatic disease on the disposition of NEXPLANON. The use of NEXPLANON in women with active liver disease is contraindicated (see Contraindications).

6. Overweight Women

The effectiveness of the etonogestrel implant in women who weighed more than 130% of their ideal body weight has not been defined because such women were not studied in clinical trials. Serum concentrations of etonogestrel are inversely related to body weight; therefore, the decrease with time after implant insertion. It is therefore possible that NEXPLANON may be less effective in overweight women, especially in the presence of other factors that decrease serum etonogestrel concentrations such as concomitant use of hepatic enzyme inducers.

OVERDOSE

Overdose may result if more than one implant is inserted. In case of suspected overdose, the implant should be removed.

NONCLINICAL TOXICOLOGY

In a 24-month carcinogenicity study in rats with subdermal implants releasing 10 and 20 mcg etonogestrel per day (equal to approximately 1.6-3.6 times the systemic steady state exposure in women using NEXPLANON), no drug-related carcinogenic potential was observed. Etonogestrel was not genotoxic in the in vitro Ames/Salmonella reverse mutation assay, the chromosomal aberration assay in Chinese hamster ovary cells or in the in vivo mouse micronucleus test. Fertility in males returned after withdrawal from treatment.

PATIENT COUNSELING INFORMATION

See FDA-Approved Patient Labeling.

• Counsel women about the insertion of NEXPLANON implant. Provide the woman with a copy of the Patient Labeling and ensure that she understands the information in the Patient Labeling before insertion and removal. A USER CARD and consent form are included in the insert. Have the woman complete a copy of the USER CARD and retain it in your records. The USER CARD should be filled out and given to the woman after insertion of the NEXPLANON implant so that she will have a record of the location of the implant in the upper arm and when it should be removed.

• Counsel women to contact their healthcare provider immediately if, at any time, they are unable to palpate the implant.

• Counsel women that NEXPLANON does not protect against HIV or other STDs.

• Counsel women about their use of NEXPLANON. Provide the woman with a copy of the Patient Labeling and ensure that she understands the information on the Patient Labeling before insertion and removal. A USER CARD and consent form are included in the insert. Have the woman complete a copy of the USER CARD and retain it in your records. The USER CARD should be filled out and given to the woman after insertion of the NEXPLANON implant so that she will have a record of the location of the implant in the upper arm and when it should be removed.

• Counsel women that NEXPLANON does not protect against HIV or other STDs.

• Counsel women that the use of NEXPLANON may be associated with changes in their normal menstrual bleeding patterns so that they know what to expect.

Manufactured for: Merck Sharp & Dohme Corp., a subsidiary of MERCK & CO., INC., Whitehouse Station, NJ 08889, USA.

For more detailed information, please read the Prescribing Information. USP; MXBS415-IPTX-1705/019 Revised: 05/17

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WOMN-1267530-0000 05/18
Time for physicians to answer the call on telemedicine

With office visits jammed with complex patients and underserved communities aching from lack of access, physicians need to think outside of the box. Or at least outside of the 10 x 10 exam room. Expansion of telemedicine is one solution.

Telemedicine often imparts thoughts of a futuristic technology, yet teleconsultation is ingrained in our American medical identity. Some of the first telephone lines were strung to connect rural physicians with patients and to bypass the late night horseback ride to the bedside. Physicians have been teleconsulting with patients for generations.

We must expand our current expectations for telemedicine and meaningfully embed this tool into our daily practice. State of the art virtual care software platforms can be used to harness online and asynchronous patient interviews to transform the way patients can access their physician. Based upon condition and symptoms, patients are guided through a branching algorithm of detailed questions.

For example, a young and healthy female with dysuria may answer a chain of questions about the duration of symptoms, history, allergies, and acknowledgement of any red flags. Following this structured framework of questioning (which mirrors that performed during an in-person interview), a templated document is generated and forwarded to their physician for review. For dermatologic concerns, pictures can be uploaded as well. The physician can review documents and choose to treat or to refer for the appropriate level of evaluation.

If treatment is provided, a few clicks generate sufficient documentation to meet billing requirements in the 38 states that permit telemedicine reimbursement, or patients may pay directly. Such platforms streamline evaluation and offer efficient treatment for simple, acute conditions. As digital monitoring capabilities continue to improve and artificial intelligence progresses, these capabilities will only become more valuable.

It is essential that telemedicine complement and expand our current healthcare delivery—not hinder our day-to-day activity. I personally provide patient portal messaging answers to over 100 medical inquiries a day in my practice without reimbursement. A balance must be struck between the futuristic technology and billing models expanded on above, and the reality of the in-the-trench physician.

Continuity of care still matters. Virtual care interactions are best performed in the context of an established patient-physician relationship. The key is that technology and telemedicine should be used to enhance our healthcare system, not overturn it.

Our patients are eager for new ways to connect with their physicians and to better understand their own health. There are currently over 165,000 health-related smartphone apps available, and these were downloaded over 1.7 billion times in 2017. Over 87 percent of patients report they have used at least one digital health tool this year. Other industries are taking notice, with over $5 billion in venture capital funding for telehealth in just 2017 alone. I truly believe that telehealth has the potential to transform delivery, improve access, and decrease costs. Our patients are increasingly eager for such transformation and want us to guide them. As physicians we just have to be willing to answer the call.

Aaron George, DO, is a family physician practicing in his hometown of Chambersburg, Penn. He was named one of the 40 under 40.
LAST WORD

Physician moonlighting
Working a second gig doesn’t always mean heavy travel burdens, writes Suneel Dhand, MD.

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Do you have physician career regret?

As far back as early medical school, Sylvie Stacy, MD, MPH, a primary care physician, realized she probably wasn’t going to be happy spending her whole career in an outpatient setting churning through patients. “I went to medical school because it was a childhood dream of mine; I always wanted to be a doctor. But I don’t think I ever really took the time to think about whether that was a good fit for me,” says Stacy.

An introvert, Stacy was surprised to find patient care exhausting and that she needed a good amount of quiet time to be able to recover after making rounds. “I just never thought about how exhausting seeing patients in a clinic or hospital as a full-time job would be for me until I was actually in the weeds doing it during medical school, and then it hit me hard. ‘Oh no, this does not fit with my personality; what are my options here?’”

Today Stacy runs an online community focused on helping physicians have fulfilling careers in medicine. Called Look for Zebras after the saying in medicine, “If you hear hoof beats, look for horses, not for zebras.” I tell other physicians that, when it comes to our professional lives, we need to look for zebras.”

A recent cohort JAMA study on physician burnout and regret found that 45.2 percent of second-year residents reported burnout, while 14 percent had career choice regret, (defined as whether, if able to revisit career choice, the resident would choose to become a physician again).

Characteristics associated with a higher risk of reported regret included being female and having a high level of anxiety in medical school, while those associated with a lower risk of career regret reported lower overall levels of empathy during medical school.

Maiysha Clairborne, MD, an integrative family physician and the founder of the website Stress Free Mom MD, has transitioned out of clinical medicine after 14 years.

“Influenza

The promise of a new intranasal flu vaccine: Better protection, less side effects
New antiviral approved just in time for flu season
FDA, Chains Fight for Flu Vaccines
For more, visit bit.ly/ME-influenza

Slideshow spotlight
Explaining the benefits and limitations of fitness trackers to patients
Here are pros and cons primary care physicians should keep in mind while discussing fitness trackers with their patients.
To view, visit bit.ly/pro-cons-fitness-trackers

MedicalEconomics.com
Nurse practitioners are critical providers of patient care

Your article (“The value of nurse practitioners to medical practices”, August 8th) correctly cited the number of nurse practitioners (NPs) is on the rise. While more patients are choosing NPs as their provider, conducting over a billion visits annually, the article misses the mark on a handful of key points.

NPs have been providing primary, acute and specialty care to patients of all ages and walks of life for nearly half a century. NPs’ abilities to assess patients, order and interpret diagnostic tests, make diagnoses, and initiate and manage treatment plans, including prescribing medications, make us neither mid-level nor an extension of our physician colleagues, rather a critical provider of patient-centered care.

Second, the assertion that NPs merely exist to free up time for doctors undermines the value that NPs bring to health care cost management. Numerous studies have documented that patients seen by NPs have lower readmission rates and are more likely to adhere to plans of care—two important factors in bending the cost curve and improving the quality of life for patients.

Lastly, there was no mention of the prevailing trend of states which have modernized their scope of practice laws to allow NPs to practice to the fullest extent of their licensure and training. As evidenced in recent analysis, nine of the top 10 best states for health care (as measured by outcomes, costs, and accessibility) have enacted such laws, known as full practice authority (FPA). Interestingly, nine of the bottom 10 still limit patient access to NPs by keeping collaborative agreements and other restrictive measures in place.

While we appreciate the interest in gaining perspective on the value of NPs to medical practices, it is these facts which matter most to your audience and patients alike—especially when considering choosing an NP for primary care.

Joyce M. Knestrick, Ph.D., C-FNP, APRN, FAANP
PRESIDENT, AMERICAN ASSOCIATION OF NURSE PRACTITIONERS

Editor’s note: This was first published in the December 10, 2018, issue of Medical Economics. It contained errors and this is the corrected version.

Lowering the cost of a medical education

Few would disagree that the cost of medical school is high as Aaron George, DO, explains in “We must address the rising cost of medical school” (The Last Word, November 10, 2018 issue).

But, as an alternative, why not combine medical school and college into a five-year program instead of the traditional eight? After all, much of what is learned in college is of questionable value for practicing physicians, especially those in primary care.

I remember sitting in my organic chemistry class and wondering what organic chemistry had to do with being a doctor. Not to mention calculus and physics; and trying to understand the Krebs Citric Acid cycle.

While browsing in a bookstore recently, I pulled an MCAT prep book off the shelves and paged through it. The questions about osmosis, semi-permeable membranes, osmolality and the Krebs Citric Acid Cycle were still there.

Now after 43 years of practicing primary care I wonder even more.

In 1910 the Carnegie Institute commissioned Abraham Flexner to investigate medical school education. He was appalled at the lack of full time teachers with any scientific knowledge.

His report sparked a revolution in medical education. The result was an over-emphasis on basic science and full-time professors. But, years later Flexner lamented that medical schools had gone too far in their focus on science. Which may explain the why so many students take residencies in specialties and so few in primary care.

If the costs of medical education are worrisome, the overemphasis on science is just as worrisome. It’s not a matter of education, it’s a matter of common sense.

Edward Volpintesta, MD
BETHEL, CONN.
A new study found that there was a growing demand for physicians in 2018, especially primary care specialists. The report, by healthcare social media company Doximity, analyzed physician job advertisements nationally to find where in the United States physicians are most needed and what specialties have the highest demand. Below are some of the key findings.

"Other research has shown that there are a number of factors driving physician demand, including an aging population that requires more medical services and increased administrative tasks for doctors."

—Christopher Whaley, Ph.D., lead author of the report, adjunct assistant professor, University of California, Berkeley School of Public Health

"The demand growth we're finding seems to be outpacing the strong economy, and it's possible that this represents an early warning of demand outstripping the available supply of medical talent."

—Amit Phull, MD, vice president of strategy and insights, Doximity
Eliminate claim denials for medical necessity

There are numerous reasons for claims denials but most of them come down to some form of documentation error, according to Karen Meador, MD, MBA, Senior Physician Executive and Managing Director at the BDO Center for Healthcare Excellence in New York, NY.

Furthermore, most of the claims she has seen that “rise to the level of dispute” have some sort of issue around medical necessity, she says.

Medical necessity, as defined by the American Medical Association (AMA), refers to healthcare services or products provided to a patient “for the purpose of preventing, diagnosing or treating an illness, injury, disease, or its symptoms.” This is in keeping with generally accepted standards of medical practice, that are clinically appropriate, and “not primarily for the economic benefit of the health plans and purchasers.”

Get specific

One of the common problems contributing to poor documentation, Meador says, is a byproduct of EHRs. In a bid to save time, certain functions, such as copy and paste features and generic templates, can lead to a lack of specificity as physicians copy notes into claims.

“Notes can look very similar not only one day to the next for the same patient, but often among different patients,” Meador says.

She says physicians must take care to make sure that each note is “specific and unique to that patient” even when using templates.

“Physicians should routinely ask themselves ‘have I put uniquely identifying information regarding this patient, regarding his or her history, review of systems, exams, and the plan?’” she says.

In addition, the check-one-box function of many templates isn’t always enough to make the case for medical necessity; more complex notes are often required. “I can often review medical records and see that based on the vital signs, certain labs and the overall exam, this patient needed to be admitted, but the physician wrote a very brief plan, often following a template,” Meador says.

Don’t forget the signature

Another byproduct of EHR systems is that they allow for a physician to make an electronic signature instead of a physical signature. However, Meador says, some statements include language that says “signature not required.” An unsigned claim will cause a rejection from the payer.

In newer EHRs, “that language has since been changed to instead say ‘electronic signature,’” she points out. But not all EHRs are up to date.

The timeliness of a physician’s signature is also important, she says. “We do still see problems where the signature happens too long after the note was entered.” She says that can be problematic if a nurse practitioner or other mid-level practitioner wrote the note and then the physician signed it later.

“If that’s not done timely, that can be a potential opportunity for the payer to challenge,” she says.

Obtain oversight

To save a physician hassles in claims denials and appeals around medical necessity, Meador recommends they involve a third-party, either to do the coding, or to double check a physician’s coding.

Having a third party check the information that supports the documentation can avoid what Meador calls a common pitfall, which is where the physician, crunched for time, relies upon information in their mind from the physical exam and visit rather than confirming that it matches what was documented.

Having a coding expert or a coding team on board can also provide feedback to ensure that the code was appropriate for what was documented, she says. Such feedback might help physicians code appropriately to a higher level, as well.

She recommends physicians hire an outside group to come in annually and do a preventative audit of the records. “It can be very helpful pulling a random selection of records for each of the physicians and then getting an assessment of the accuracy of the coding, billing and thoroughness of the documentation.”

Oversight can only improve billing for medical necessity. “Physicians need to be reminded that one really has to think about how one communicates with the payer,” Meador says.

Jordan Rosenfeld is a contributing author. Send your financial questions to medec@ubm.com.
Russell Libby, MD, selected his EHR system because it has the features and functions that best fit the needs of his practice.

He worries, though, that the features that make this EHR work so well for him and his practice colleagues could be eliminated if his EHR vendor merges with another—as so many other vendors have done.

“Not enough doctors pay attention to what’s happening with healthcare technology. But there are some who are worried, and they’re worried because they’re aware of the ramifications,” says Libby, president of the Virginia Pediatric Group and a board member of the Physicians Foundation.

Libby’s concerns are well-placed. The number of EHR vendors has dwindled in recent years following numerous mergers and acquisitions, dropping from 1,000-plus 10 years ago to approximately 400 now, according to KLAS Research, an Orem, Utah-based health IT review firm.

Libby and others say they expect more vendor consolidation in the future, a fact that could leave physicians with a host of problems, such as reduced levels of tech support, increased fees, and the need to migrate to a new system.

Health IT experts say physicians should keep an eye on EHR industry news and take steps to safeguard themselves to ensure practice continuity should their vendor merge with another.

“There’s only so much a practice can do about vendor consolidations, but physicians can be vigilant and make sure they do all they can to protect themselves and their practice. What they don’t want as a practice is to be unprepared and not know what their options are,” says Robert Tennant, MA, director of health information technology policy at the Medical Group Management Association.

MARKET DYNAMICS FAVOR CONSOLIDATION

The EHR market expanded rapidly in the past 20 years, with technology advances and government incentives spurring physicians and healthcare institutions to move from paper-based to electronic records. The percentage of physicians using EHRs jumped from 18 percent in 2001 to 57 percent in 2011 to 87 percent in 2015, according to the Office of the National Coordinator for Health Information Technology (ONC).

ONC figures from 2017 show that most physicians—or 64%—use one of seven major vendors; Epic Systems Corp. and Allscripts lead the way with about 33% of the physicians as customers.

But tens of thousands of physicians use EHRs from other vendors, from well-known makers such as Practice Fusion and eMDs to dozens of niche companies that cater to the unique needs of medical specialists or small independent practices.

However, consolidations in recent years have shaken up the market, as various vendors bought up others to gain market share, break into specialty practice areas or bolster their financial prospects, says Aaron Gleave, director of research for the ambulatory market at KLAS Research.

Many of the acquisition activity has involved small EHR vendors being bought up.
but plenty of mid-size and larger vendors were acquired as well. For example, health IT vendor eMDs bought several tech assets, including EHRs, from McKesson Business Performance Services in 2016. And in 2018 Allscripts acquired Practice Fusion for $100 million.

Joel White, executive director of Health IT Now, a nonprofit group promoting the use of information technology in healthcare, predicts more consolidation in the future. He says EHR vendors are seeing fewer customers needing new implementations, as most physicians and healthcare institutions have EHRs by this point.

As a result, vendors are looking for other ways to grow their customer base and revenue streams while positioning themselves to compete. White says vendors are looking at acquisitions as one strategy to reach those objectives.

Gleave, White and others say small EHR vendors and those servicing niche markets are most likely to be targeted for acquisition, as they typically are weaker financially than the larger players in this market. But industry experts say even major EHR vendors could be bought by even larger companies within the health IT space as well as by large companies outside it.

"Everyone is making acquisitions of some kind, whether they’re adding additional EHR players to their portfolios or acquiring companies that would be considered ancillary products as a complement," Gleave adds, explaining that an EHR vendor may see a strategic advantage to buying a company that makes patient outreach systems or a revenue management software vendor may want to buy an EHR vendor as a way to grow marketshare.

IMPLICATIONS FOR PHYSICIANS
Many physicians are nervous about these market dynamics because they fear that consolidations could negatively impact their practice.

Physicians could see changes to the monthly fees charged by their vendors and tech support levels, Gleave says. Worse, they could see their EHR system phased out, forcing them to migrate to another product.

Libby says some physicians worry that the functions they like in their existing EHR could change and that the niche offerings within their existing EHR might disappear. "That could really impact [the practice] and create some significant long-term problems," he says.

Gleave says mergers among EHR vendors do not always lead to problems for the physicians using those systems; he says many vendors work hard to take care of their customers before, during and after the consolidations. However, he adds, even if a transition between vendors goes smoothly for a physician, such mergers still generally result in some changes to the EHRs, service level agreements, and fees.

PHYSICIAN PREPARATION
Although physicians can’t stop consolidations, they can take steps to limit the potential for negative impacts to their own practices.

Gleave says physicians should have a good handle on their data —where it is and how to transfer it. "Make sure your data is ready to grab and go. Know very specifically what the process is to migrate your data from your existing vendor to another—what’s the timeframe for the work, what’s the cost, and what format is the database in," he says, noting that each vendor has its own procedure and associated costs for transferring the data.

He says EHR vendor contracts typically spell out this information, so physicians should start by reviewing their contracts (on their own or with a lawyer) and then discuss with their vendor any details that remain unclear.

White says the federal 21st Century Cures Act, passed in 2016, could provide some help. He says the law incented vendors to make it as easy as possible for physicians to be vigilant and make sure they do all they can to protect themselves and their practice.

What they don’t want as a practice is to be unprepared and not know what their options are.”

—ROBERT TENNANT, MA, DIRECTOR OF HEALTH INFORMATION TECHNOLOGY POLICY, MGMA

Athenahealth latest EHR vendor to be purchased
Two private equity firms, Veritas Capital and Elliott Management Corp., acquired athenahealth, the Waterton, Massachusetts-based company, for nearly $5.7 billion. The firms announced that athenahealth will be combined with Virence Health, Veritas’ healthcare services company, after the sale is completed.
to export their data out of the vendors’ systems—although other health IT experts say they’re not sure this new law will do much to reduce the challenges or costs of transferring data.

Gleave says physicians should have a list of a few vendors with products that could fit their needs so they can move quickly if they must find a replacement.

Meanwhile, physicians who find themselves with a vendor being bought by or merging with another should contact their vendor immediately to ask several key questions, Tennant says. These include how the merger will proceed, the timeline for consolidation, and what support the vendor will provide during any transition from one EHR version to another.

In addition, they should ask how fees, service and support will change as well as what features, functions, templates and other user interfaces could change and when. And physicians should work with their existing and new vendor representatives to determine whether changes resulting from the merger would impact any of the new EHR’s integration with other systems.

MARKET CONSOLIDATION PROS AND CONS

White says mergers among EHR makers could bring many positives to physicians. “When I think about vendor consolidation, I’m thinking about products becoming more usable, more functional and more customer friendly,” he says.

He says the consolidations could yield economies of scale for vendors, giving them more capital to invest in developing innovative capabilities. He predicts vendors will want to focus more on developing additional functions and more user-friendly features to better compete in the marketplace moving ahead.

“The vendors will need to compete in delivering value,” he adds, noting that as EHR vendors have seen a drop in the number of new customers implementing EHRs for the first time they now must compete on better usability to retain and attract customers.

Libby, too, says market consolidation could yield benefits such as increased interoperability among physician office systems as there will be fewer systems with unique integration requirements.

But Libby says consolidations could bring challenges for physicians. Physicians who have to switch to a new EHR as a result of a consolidation may face unexpected costs as well as lost productivity as they learn to navigate a new system—both of which are particularly hard blows to small practices struggling to survive financially. And physicians could lose the strong relationships that they built with their vendors, should they be acquired by bigger companies.

Those negative impacts could hurt practices, Libby says. “Those ripples [from EHR consolidation] can become waves that overwhelm practices,” he adds.

Gleave likewise says market consolidation could hurt practices, as acquiring EHR vendors could raise fees, change service levels and eliminate features that individual physicians rely on.

“Support is a big concern, particularly for small practices. They don’t have deep pockets and they feel vulnerable in the marketplace,” he says.

Libby also says there’s the possibility that market consolidation could lead to near monopolies, which have traditionally meant lower levels of innovations and higher rates charged to customers.

“That’s a fear that many of us have,” he says. White, too, says he sees potential for consolidations to create difficulties for physicians, such as when their EHRs are discontinued following mergers. White says the government entities should oversee consolidations to ensure such scenarios are kept in check and to ensure a near monopoly doesn’t emerge in the EHR market.

“There’s no guarantee that this will all be positive; I think there’s risk of harm to the consumer with consolidation. That’s why we need oversight,” White says. “But my expectation is we’ll see a lot more innovation as a result and that’s good for doctors and, more importantly, it’s good for patients.”
**INDICATION**

- GARDASIL 9 is a vaccine indicated in females 9 through 45 years of age for the prevention of cervical, vulvar, vaginal, and anal cancers caused by human papillomavirus (HPV) Types 16, 18, 31, 33, 45, 52, and 58; precancerous or dysplastic lesions caused by HPV Types 6, 11, 16, 18, 31, 33, 45, 52, and 58; and genital warts caused by HPV Types 6 and 11.

- GARDASIL 9 is indicated in males 9 through 45 years of age for the prevention of anal cancer caused by HPV Types 16, 18, 31, 33, 45, 52, and 58; precancerous or dysplastic lesions caused by HPV Types 6, 11, 16, 18, 31, 33, 45, 52, and 58; and genital warts caused by HPV Types 6 and 11.

- GARDASIL 9 does not eliminate the necessity for women to continue to undergo recommended cervical cancer screening.

- Recipients of GARDASIL 9 should not discontinue anal cancer screening if it has been recommended by a health care professional.

- GARDASIL 9 has not been demonstrated to provide protection against diseases from vaccine HPV types to which a person has previously been exposed through sexual activity.

- GARDASIL 9 is not a treatment for external genital lesions; cervical, vulvar, vaginal, and anal cancers; or cervical intraepithelial neoplasia (CIN), vulvar intraepithelial neoplasia (VIN), vaginal intraepithelial neoplasia (VaIN), or anal intraepithelial neoplasia (AIN).

**INDICATION (continued)**

- Not all vulvar, vaginal, and anal cancers are caused by HPV, and GARDASIL 9 protects only against those vulvar, vaginal, and anal cancers caused by HPV Types 16, 18, 31, 33, 45, 52, and 58.

- Vaccination with GARDASIL 9 may not result in protection in all vaccine recipients.

**SELECT SAFETY INFORMATION**

- GARDASIL 9 is contraindicated in individuals with hypersensitivity, including severe allergic reactions to yeast, or after a previous dose of GARDASIL 9 or GARDASIL® (Human Papillomavirus Quadrivalent [Types 6, 11, 16, and 18] Vaccine, Recombinant).

- Because vaccinees may develop syncope, sometimes resulting in falling with injury, observation for 15 minutes after administration is recommended. Syncope, sometimes associated with tonic-clonic movements and other seizure-like activity, has been reported following HPV vaccination. When syncope is associated with tonic-clonic movements, the activity is usually transient and typically responds to restoring cerebral perfusion.

- Safety and effectiveness of GARDASIL 9 have not been established in pregnant women.

- The most common (≥10%) local and systemic adverse reactions in females were injection-site pain, swelling, erythema, and headache.

- The duration of immunity of GARDASIL 9 has not been established.

**DOSAGE AND ADMINISTRATION**

- GARDASIL 9 should be administered intramuscularly in the deltoid region of the upper arm or in the higher anterolateral area of the thigh.
  - For individuals 9 through 14 years of age, GARDASIL 9 can be administered using a 2-dose or 3-dose schedule. For the 2-dose schedule, the second dose should be administered 6–12 months after the first dose. If the second dose is administered less than 5 months after the first dose, a third dose should be given at least 4 months after the second dose. For the 3-dose schedule, GARDASIL 9 should be administered at 0, 2 months, and 6 months.
  - For individuals 15 through 45 years of age, GARDASIL 9 is administered using a 3-dose schedule at 0, 2 months, and 6 months.
**GWADASIL**

**Human Papillomavirus 9-valent Vaccine, Recombinant**

**BRIEF SUMMARY OF PRESCRIBING INFORMATION**

**Indications and Usage**

**Girls and Women**

GWADASIL® is a vaccine indicated in girls and women 9 through 45 years of age for the prevention of the following diseases:

- Cervical, vulvar, vaginal, and anal cancer caused by Human Papillomavirus (HPV) types 16, 18, 31, 33, 45, 52, and 58.
- Genital warts (condyloma acuminata) caused by HPV types 6 and 11.
- And the following precancerous or dysplastic lesions caused by HPV types 6, 11, 16, 18, 31, 33, 45, 52, and 58:
  - Cervical intraepithelial neoplasia (CIN) grade 2/3 and cervical adenocarcinoma *in situ* (AIS).
  - Cervical intraepithelial neoplasia (CIN) grade 1.
  - Vulvar intraepithelial neoplasia (VIN) grade 2 and grade 3.
  - Vaginal intraepithelial neoplasia (VaIN) grade 2 and grade 3.
  - Anal intraepithelial neoplasia (AIN) grades 1, 2, and 3.

**Boys and Men**

GWADASIL 9 is indicated in boys and men 9 through 45 years of age for the prevention of the following diseases:

- Anal cancer caused by HPV types 16, 18, 31, 33, 45, 52, and 58.
- Genital warts (condyloma acuminata) caused by HPV types 6 and 11.
- And the following precancerous or dysplastic lesions caused by HPV types 6, 11, 16, 18, 31, 33, 45, 52, and 58:
  - Cervical intraepithelial neoplasia (CIN) grades 1, 2, and 3.

**Limitations of Use and Effectiveness**

The health care provider should inform the patient, parent, or guardian that vaccination does not eliminate the necessity for women to continue to undergo recommended cervical cancer screening. Women who receive GWADASIL 9 should continue to undergo cervical cancer screening per standard of care.

**Method of Administration**

- **If the second dose is administered earlier than 5 months after the first dose, administer a third dose at least 4 months after the second dose.**

**INJECTION-SITE REACTIONS**

<table>
<thead>
<tr>
<th>Post-dose 1</th>
<th>Post-dose 2</th>
<th>Post-dose 3</th>
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<td>70.3</td>
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<td>12.9</td>
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<td>28.3</td>
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<td>0.6</td>
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<td>2.5</td>
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**ADVERSE REACTIONS**

**Clinical Trials Experience:** Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a vaccine cannot be directly compared to rates in the clinical trials of another vaccine and may not reflect the rates observed in practice.

**WARNINGS AND PRECAUTIONS**

**Syncpe:** Because vaccines may develop syncpe, sometimes resulting in falling with injury, observation for 15 minutes after administration is recommended. Syncpe, sometimes associated with tonic-clonic movements and other seiunelike activities, has been reported following HPV vaccination. When syncpe is associated with tonic-clonic movements, the activity is usually transient and typically responds to restoring cerebral perfusion by maintaining a supine or Trendelenburg position.

**Managing Allergic Reactions:** Appropriate medical treatment and supervision must be readily available in case of anaphylactic reactions following the administration of GWADASIL 9.

**Table 1: Rates (%) and Severity of Solicited Injection-Site and Systemic Adverse Reactions Occurring Within Five Days of Each Vaccination with GWADASIL 9 Compared with GWADASIL (Studies 1 and 3)**

**Girls and Women 16 through 26 Years of Age**

**Injection-Site Adverse Reactions**

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<tr>
<th></th>
<th>N= 7069</th>
<th>N= 6997</th>
<th>N= 6909</th>
<th>N= 6971</th>
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<td>1.0</td>
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<td>23.3</td>
<td>28.3</td>
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<td>22.6</td>
<td>34.0</td>
<td>8.1</td>
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**Systemic Adverse Reactions**

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<tbody>
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<tr>
<td>Temperature ≥102°F</td>
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<td>0.3</td>
<td>0.4</td>
<td>1.0</td>
<td>0.2</td>
<td>0.3</td>
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**Girls 9 through 15 Years of Age**

**Injection-Site Adverse Reactions**

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<td>Erythema, Severe</td>
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<td>0.3</td>
<td>1.7</td>
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**CONTRAINDICATIONS**

Hypersensitivity, including severe allergic reactions to yeast (a vaccine component), or after a previous dose of GWADASIL 9 or GWADASIL®.
GARDASIL® Human Papillomavirus, 9-valent Vaccine, Recombinant

Table 1 (continued)

<table>
<thead>
<tr>
<th>Systemic Adverse Reactions</th>
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<th>GARDASIL</th>
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<tr>
<td>Temperature ≥100°F</td>
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<td>3.0</td>
<td>6.7</td>
</tr>
<tr>
<td>Temperature ≥102°F</td>
<td>0</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
</tbody>
</table>

The data for girls and women 16 through 26 years of age are from Study 1 (NCT00543543), and the data for girls 9 through 15 years of age are from Study 3 (NCT01304498). N=number of subjects vaccinated with safety follow-up. n=number of subjects with temperature data. Pain, Any=mild, moderate, severe or unknown intensity Pain, Severe=incapacitating with inability to work or do usual activity Swelling, Any=any size or size unknown Swelling, Severe=maximum size greater than 2 inches Erythema, Any=any size or size unknown Erythema, Severe=maximum size greater than 2 inches

Unsolicited injection-site and systemic adverse reactions (assessed as vaccine-related by the investigator) observed among recipients of either GARDASIL 9 or GARDASIL in Studies 1 and 3 at a frequency of at least 1% are shown in Table 2. Few individuals discontinued study participation due to adverse experiences after receiving either vaccine (GARDASIL 9 = 0.1% vs. GARDASIL <0.1%).

Table 2: Rates (%) of Unsolicited Injection-Site and Systemic Adverse Reactions Occurring among ≥1% of Individuals after Any Vaccination with GARDASIL 9 Compared with GARDASIL (Studies 1 and 3)

<table>
<thead>
<tr>
<th>Reactions</th>
<th>GARDASIL 9</th>
<th>GARDASIL</th>
<th>GARDASIL 9</th>
<th>GARDASIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection-Site Adverse Reactions (1 to 5 Days Post-Vaccination, Any Dose)</td>
<td>N=7071</td>
<td>N=7078</td>
<td>N=299</td>
<td>N=300</td>
</tr>
<tr>
<td>Pruritus</td>
<td>5.5</td>
<td>4.0</td>
<td>4.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Bruising</td>
<td>1.9</td>
<td>1.5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hematoma</td>
<td>0.9</td>
<td>0.6</td>
<td>3.7</td>
<td>4.7</td>
</tr>
<tr>
<td>Mass</td>
<td>1.3</td>
<td>0.6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>1.0</td>
<td>0.7</td>
<td>1.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Induration</td>
<td>0.8</td>
<td>0.2</td>
<td>2.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Warmth</td>
<td>0.8</td>
<td>0.5</td>
<td>0.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Reaction</td>
<td>0.6</td>
<td>0.6</td>
<td>0.3</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Systemic Adverse Reactions (1 to 15 Days Post-Vaccination, Any Dose)

<table>
<thead>
<tr>
<th>Reactions</th>
<th>GARDASIL 9</th>
<th>GARDASIL</th>
<th>GARDASIL 9</th>
<th>GARDASIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>14.6</td>
<td>13.7</td>
<td>11.4</td>
<td>11.3</td>
</tr>
<tr>
<td>pyrexia</td>
<td>5.0</td>
<td>4.3</td>
<td>5.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Nausea</td>
<td>4.4</td>
<td>3.7</td>
<td>3.0</td>
<td>3.7</td>
</tr>
<tr>
<td>Dizziness</td>
<td>3.0</td>
<td>2.8</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Fatigue</td>
<td>2.3</td>
<td>2.1</td>
<td>0</td>
<td>2.7</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>3.3</td>
<td>1.0</td>
<td>0.3</td>
<td>0</td>
</tr>
<tr>
<td>Myalgia</td>
<td>1.0</td>
<td>0.6</td>
<td>2.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Myalgia</td>
<td>1.0</td>
<td>0.7</td>
<td>0.7</td>
<td>0</td>
</tr>
<tr>
<td>Abdominal pain, upper</td>
<td>0.7</td>
<td>0.8</td>
<td>1.7</td>
<td>1.3</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>0.1</td>
<td>0.1</td>
<td>0.3</td>
<td>1.0</td>
</tr>
</tbody>
</table>

The data for girls and women 16 through 25 years of age are from Study 1 (NCT00543543), and the data for girls 9 through 15 years of age are from Study 3 (NCT01304498). N=number of subjects vaccinated with safety follow-up. In an uncontrolled clinical trial with 1,394 boys and 1,075 girls and women 16 through 26 years of age N=637; for boys and men 16 through 26 years of age N=1,399. Pain, Any=mild, moderate, severe or unknown intensity Pain, Severe=incapacitating with inability to work or do usual activity Swelling, Any=any size or size unknown Swelling, Severe=maximum size greater than 2 inches Erythema, Any=any size or size unknown Erythema, Severe=maximum size greater than 2 inches

Table 3 (continued)

<table>
<thead>
<tr>
<th>Unsolicited Injection-Site Adverse Reactions (1-5 Days Post-Vaccination, Any Dose)</th>
<th>GARDASIL 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection-Site Hypersensitivity</td>
<td>1.0</td>
</tr>
<tr>
<td>Injection-Site Pruritus</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Unsolicited Systemic Adverse Reactions (1-15 Days Post-Vaccination, Any Dose)

<table>
<thead>
<tr>
<th>Reactions</th>
<th>GARDASIL 9</th>
<th>GARDASIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Pyrexia</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>1.0</td>
<td></td>
</tr>
</tbody>
</table>

Boys 9 through 15 Years of Age N=639

Table 4: Rates (%) of Unsolicited Injection-Site and Systemic Adverse Reactions Occurring among ≥1% of Individuals after Any Vaccination with GARDASIL 9 Compared with GARDASIL (Studies 1 and 3)

<table>
<thead>
<tr>
<th>Reactions</th>
<th>GARDASIL 9</th>
<th>GARDASIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection-Site Pain, Any</td>
<td>71.5</td>
<td></td>
</tr>
<tr>
<td>Injection-Site Severe</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Injection-Site Erythema, Any</td>
<td>24.9</td>
<td></td>
</tr>
<tr>
<td>Injection-Site Erythema, Severe</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Injection-Site Swelling, Any</td>
<td>26.9</td>
<td></td>
</tr>
<tr>
<td>Injection-Site Swelling, Severe</td>
<td>5.2</td>
<td></td>
</tr>
<tr>
<td>Oral Temperature ≥100.0°F†</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>Oral Temperature ≥102°F</td>
<td>1.4</td>
<td></td>
</tr>
</tbody>
</table>

Systemic Adverse Reactions (1 to 15 Days Post-Vaccination, Any Dose)

<table>
<thead>
<tr>
<th>Reactions</th>
<th>GARDASIL 9</th>
<th>GARDASIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>9.4</td>
<td></td>
</tr>
<tr>
<td>Pyrexia</td>
<td>8.9</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>1.3</td>
<td></td>
</tr>
</tbody>
</table>

The data for GARDASIL 9 boys 9 through 15 years of age are from Study 2 (NCT00943722). The data for boys and men 16 through 26 years of age for GARDASIL 9 are from Study 7 (NCT01651949). *Unsolicited adverse reactions reported by ≥1% of individuals n=number of subjects vaccinated with safety follow-up For oral temperature: number of subjects with temperature data for boys 9 through 15 years of age N=637; for boys and men 16 through 26 years of age N=1,399. Pain, Any=mild, moderate, severe or unknown intensity Pain, Severe=incapacitating with inability to work or do usual activity Swelling, Any=any size or size unknown Swelling, Severe=maximum size greater than 2 inches Erythema, Any=any size or size unknown Erythema, Severe=maximum size greater than 2 inches Serious Adverse Events in Clinical Studies: Serious adverse events were collected throughout the entire study period (range one month to 48 months post-last dose) for the seven clinical studies for GARDASIL 9. Out of the 15,705 individuals who were administered GARDASIL 9 and had safety follow-up, 354 reported a serious adverse event, representing 2.3% of the population. As a comparison, of the 7,378 individuals who were administered GARDASIL and had safety follow-up, 185 reported a serious adverse event, representing 2.5% of the population. Four GARDASIL 9 recipients each reported at least one serious adverse event that was determined to be vaccine-related. The vaccine-related serious adverse reactions were pyrexia, allergy to vaccine, asthmaic crisis, and headache.

Deaths in the Entire Study Population: Across the clinical studies, ten deaths occurred (five each in the GARDASIL 9 and GARDASIL groups) none were assessed as vaccine-related. Causes of death in the GARDASIL 9 group included one automobile accident, one suicide, one case of acute lymphocytic leukemia, one case of hypovolemic septic shock, and one unexplained sudden death 678 days following the last dose of GARDASIL 9. Causes of death in the GARDASIL control group included one automobile accident, one airplane crash, one cerebral hemorrhage, one gun-shot wound, and one stomach adenocarcinoma.

Systemic Autoimmune Disorders: In all of the clinical trials with GARDASIL 9 subjects were evaluated for new medical conditions potentially indicative of a systemic autoimmune disorder. In total, 2.2% (351/15,703) of GARDASIL 9 recipients and 3.3% (240/7,378) of GARDASIL recipients reported new medical conditions potentially indicative of systemic autoimmune disorders, which were similar to rates reported following GARDASIL AAHS control, or saline placebo in historical clinical trials.

Clinical Trials Experience for GARDASIL 9 in Individuals Who Have Been Previously Vaccinated with GARDASIL: A clinical study (Study 4) evaluated the safety of GARDASIL 9 in 20-28-year-old girls and women who had previously been vaccinated with at least three doses of GARDASIL. The time interval between the last injection of GARDASIL and the first injection of GARDASIL 9 ranged from approximately 12 to 36 months. Individuals were administered GARDASIL 9 or saline placebo and safety was evaluated using VRC-aided surveillance for 14 days after each injection of GARDASIL 9 or saline placebo in these individuals. The individuals who were monitored included 608 individuals who received GARDASIL 9 and 305 individuals who received saline placebo. Few (0.5%) individuals who received GARDASIL 9 discontinued due to adverse reactions. The vaccine-related adverse experiences that were observed among recipients of GARDASIL 9 at a frequency of at least 1.0% and also at a greater frequency than that observed among saline placebo recipients are shown in Table 4. Overall the safety profile was similar between individuals vaccinated with GARDASIL AAHS=Amorphous Aluminum Hydroxyphosphate Sulfate.
with GARDASIL 9 who were previously vaccinated with GARDASIL and those who were naïve to GARDASIL. The immunologic response to GARDASIL 9 may be diminished in immunocompromised individuals.

### DRUG INTERACTIONS

Use with Systemic Immunosuppressive Medications: Immunosuppressive therapies, including irradiation, antimetabolites, alkylation agents, cytotoxic drugs, and corticosteroids (used in greater than physiologic doses), may reduce the immune responses to vaccines.

### USE IN SPECIFIC POPULATIONS

**Pregnancy:** Pregnancy Exposure Registry

There is a pregnancy exposure registry to monitor pregnancy outcomes in women exposed to GARDASIL 9 during pregnancy. To enroll in or obtain information about the registry, call Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., at 1-800-986-8999.

**Risk Summary:**

All pregnancies have a risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively. There are no adequate and well-controlled studies of GARDASIL 9 in pregnant women. Available human data do not demonstrate vaccine-associated increase in risk of major birth defects and miscarriages when GARDASIL 9 is administered during pregnancy.

In one developmental toxicity study, 0.5 mL of a vaccine formulation containing between 1 and 1.5 – fold of each of the 9 HPV antigen types was administered to female rats prior to mating and during gestation. In another study, animals were administered a single human dose (0.5 mL) of GARDASIL 9 prior to mating, during gestation and during lactation. These animal studies revealed no evidence of harm to the fetus due to GARDASIL 9.

**Data**

In pre-licensure clinical studies of GARDASIL 9, women underwent pregnancy testing immediately prior to administration of each dose of GARDASIL 9 or control vaccine (GARDASIL). [Data from GARDASIL are relevant to GARDASIL 9 because both vaccines are manufactured using the same process and have overlapping compositions.] Subjects who were determined to be pregnant were instructed to defer vaccination until the end of their pregnancy. Despite this pregnancy screening regimen, some subjects were vaccinated very early in pregnancy before human chorionic gonadotropin (HCG) was detectable. An analysis was conducted to evaluate pregnancy outcomes for pregnancies with onset within 39 days before or after vaccination with GARDASIL 9 or GARDASIL. Among such pregnancies, there were 62 and 55 with known outcomes (excluding ectopic pregnancies and elective terminations) for GARDASIL 9 and GARDASIL, respectively, including 44 and 48 live births, respectively. The rates of pregnancies that resulted in a miscarriage were 27.4% (17/62) and 12.7% (7/55) in subjects who received GARDASIL 9 or GARDASIL, respectively. The rates of live births with major birth defects were 0% (0/44) and 2.1% (1/48) in subjects who received GARDASIL 9 or GARDASIL, respectively.

A five-year pregnancy registry enrolled 2,942 women who were inadvertently exposed to GARDASIL within one month prior to the last menstrual period (LMP) or at any time during pregnancy, 2,566 of whom were prospectively followed. After excluding elective terminations (n=107), ectopic pregnancies (n=5) and those lost to follow-up (n=814), there were 1,640 pregnancies with known outcomes. Rates of miscarriage and major birth defects were 6.8% of pregnancies (111/1,640) and 2.4% of live born infants (37/1,527), respectively. These rates of assessed outcomes in the prospective population were consistent with estimated background rates.

In two post-marketing studies of GARDASIL (one conducted in the U.S., and the other in Nordic countries), pregnancy outcomes among subjects who received GARDASIL during pregnancy were evaluated retrospectively. Among the 1,740 pregnancies included in the U.S. study database, outcomes were available to assess the rates of major birth defects and miscarriage. Among the 498 pregnancies included in the Nordic study database, outcomes were available to assess the rates of major birth defects. In both studies, rates of assessed outcomes did not increase an increased risk with the administration of GARDASIL during pregnancy.

**Animal Data**

Developmental toxicity studies were conducted in female rats. In one study, animals were administered 0.5 mL of a vaccine formulation containing between 1 and 1.5 – fold of each of the 9 HPV antigen types 5 and 2 weeks prior to mating, and on gestation day 6. In a second study, animals were administered a single human dose (0.5 mL of GARDASIL 9) 5 and 2 weeks prior to mating, on gestation day 6, and on lactation day 7. No adverse effects on pre- and post-weaning development were observed. There were no vaccine-related fetal malformations or variations.

**Lactation:** Risk Summary: Available data are not sufficient to assess the effects of GARDASIL 9 on the breastfed infant or on milk production/excretion. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for GARDASIL 9 and any potential adverse effects on the breastfed child from GARDASIL 9 or from the underlying maternal condition. For preventive vaccines, the underlying maternal condition is susceptibility to disease prevented by the vaccine.

**Pediatric Use:** Safety and effectiveness have not been established in pediatric patients below 9 years of age.

**Geriatric Use:** The safety and effectiveness of GARDASIL 9 have not been evaluated in a geriatric population, defined as individuals aged 65 years and over.

**Immunocompromised Individuals:** The immunologic response to GARDASIL 9 may be diminished in immunocompromised individuals.

For more detailed information, please read the Prescribing Information.
Three strategies for building physician professionalism

“When physicians have the freedom to innovate, they can thrive as they build upon their passion for medicine.”

and apply innovations more broadly to meet patients’ needs.

With the right infrastructure, physicians can draw from the core principles of physician professionalism to offer personalized, responsive care. Here are three strategies physician practices can incorporate to build a framework for physician professionalism that drives greater value for both providers and patients.

INVEST IN REAL-TIME DATA SHARING CAPABILITIES WITH PROVIDERS.

Accessing data from multiple providers at the point of care through a community health information exchange (HIE) provides a critical line of sight into patients’ care needs and concerns. When an electronic health record (EHR) is combined with a rich community HIE, physicians can more easily identify patients who are at high risk of developing chronic conditions or who show signs of complex health issues that are not being properly managed. They are also better positioned to support continuity of care, reduce redundant workflows, and ensure appropriate allocation of resources when they gain access to a complete narrative of patients’ health history.

In addition, support of a community HIE reflects the four core values of excellence (supporting high-quality care), humanism and altruism (sharing data with competitors for the good of the patient), and accountability (putting the patient first in every aspect).

Holston Medical Group (HMG), a regional medical group serving northeast Tennessee and southwest Virginia, began participating in the area’s only fully functioning, bidirectional, common medical record system in 2012. The group cares for 200,000 patients, many of whom are economically disadvantaged and have substantial healthcare issues.

For HMG, access to the community HIE provides a more comprehensive picture of each patient’s health history and challenges at the point of care, thereby strengthening performance under value-based contracts. Since joining the community HIE, HMG:

- Increased pay-for-value payments by 44 percent, with more than $13 million in value-based revenue annually.
- Increased fee-for-service payments by 7 percent.
- Significantly reduced readmissions, down nearly 7.5 percent through participation in an accountable care organization (ACO).
and decreases between 6.8 and 12.3 percent under contracts with payers.

- Reduced the employee-to-provider ratio by 0.7 full-time employees.
- Reduced emergency department (ED) visits, with an ED utilization rate that is 25 percent better than other providers in the market.

BUILD AUTOMATIC ALERTS INTO THE EHR TO IMPROVE ONE-ON-ONE PATIENT INTERACTIONS.

This is an important step toward fulfilling the core value of excellence. Building automatic prompts can alert front-desk staff to patients who are covered by value contracts. With this information at hand, front-desk staff can better ensure these patients are seen right away when they call for assistance and limit the number of patients who seek care in the ED.

Meanwhile, instant decision support for physicians and nurses provides frontline access to information that could be important to determining next steps in care. With automatic alerts, data from a patient’s recent trip to the ED is available in just a few clicks—even when the patient forgets to share that such a visit took place. The clinical data received and the one-on-one conversations that occur afterward may lead to adjustments in the patient’s chronic care plan.

“Digital innovation and a demand for 24/7 access to data are blurring the lines between where and how physicians provide care.”

Provide room for frontline innovation. Providing opportunities for physicians to share and act upon the creative ideas without worry of approval reflects the core values of humanism, excellence, and accountability. Typically, this approach is easier to implement in a physician-owned practice; however, collaboration among practice leaders and a hospital or health system’s performance excellence committee could also support development of the appropriate innovation structure for your practice.

Something to consider is the establishment of an innovation committee that meets monthly to present ideas that challenge legacy approaches to care, such as:

- Nontraditional partnerships that position providers to test the application of precision medicine in clinical settings.
- Care delivery innovations that help patients with complex care needs avoid a trip to the ED, such as after-hours care for patients with specific conditions.
- The use of nurse-facing technologies to continually monitor vital healthcare data from patients with complex needs.

When physicians have the freedom to innovate, they can thrive as they build upon their passion for medicine and display high levels of professionalism while elevating patient care.

A core model for value

The decisions physicians make have important implications for downstream medical care, such as through specialty referrals, imaging and laboratory testing sites, urgent care facilities, and end-of-life support. Developing a framework for physician professionalism that is supported by access to comprehensive data—including data that stem from physician-led innovation—ensures the core values of professionalism are reflected in every decision made at the point of care and beyond.

It’s an approach that strengthens the value of care while supporting the long-term sustainability of vital health resources for the communities served.

Scott Fowler, MD, is president and CEO of Holston Medical Group.
Treating obesity: How to individualize care

Obesity, whether it’s on the list of medical concerns or a stand-alone appointment, is difficult for physicians to treat during the 15 minutes or so allotted for primary care visits.

Even with time constraints, it’s possible for primary care physicians to compassionately and effectively guide patients in decreasing their weight. Weight loss experts say obesity should have a treatment pathway in primary care settings like what was developed for smoking cessation and depression. Given the multi-factorial treatment approach, the key is individualizing care.

An estimated 39.8 percent of U.S. adults over age 20 have obesity, with another 31.8 percent considered overweight, according to the 2015-2016 National Health and Nutrition Examination Survey. Obesity increases the risk for many medical issues, including hypertension, diabetes, sleep apnea, cardiac disease, arthritis, hyperlipidemia, and certain cancers. The U.S. spends approximately $190 billion annually, or 21 percent of healthcare dollars, on obesity and related conditions.

“We need to start treating the largest disease in our country, as all other health issues go along with it,” says Craig Primack, MD, board certified in internal medicine and obesity medicine, and co-founder of the Scottsdale Weight Loss Center in Arizona.

DISPELLING MYTHS AND ASSUMPTIONS

The first step is combatting two major false assumptions that many physicians and patients often have. They are that weight loss is a matter of “calories in, calories out” and that obesity is only due to patient behaviors, says Rekha Kumar, MD, assistant professor of medicine and attending endocrinologist at the Weill Cornell Medical College in New York City.

The American Medical Association declared obesity a disease in 2013, but many doctors still don’t appreciate that and rely on stereotypes that patients with obesity are lazy or lack self control.

Decreasing weight is more than just changing diet and exercise routines. While there may be a behavioral component, Kumar says “there are things that go wrong in the body that perpetuate weight problems. There is significant appetite dysregulation with hormones and neurotransmitters.”

There’s no room for judgment when it comes to treating obesity, Primack says. “I take care of people who go to the gym five or six times a week and run marathons, and still have weight problems,” says Primack. “You don’t say a person with cancer is cancerous. A woman has obesity, she is not obese,” Primack says.

Understanding obesity genetics is import-

“I take care of people who go to the gym five or six times a week and run marathons, and still have weight problems. You don’t say a person with cancer is cancerous. A woman has obesity, she is not obese.”

—CRAIG PRIMACK, MD, INTERNIST AND CO-FOUNDER, SCOTTSDALE WEIGHT LOSS CENTER, ARIZONA
ant for understanding how those with obesity issues may differ from those without. Hormone levels involved in body regulation signal if a person should be full or hungry, and these may not function properly in patients with obesity. Primack notes a landmark 2011 New England Journal of Medicine study measuring hormones related to weight. In the study, diet-induced weight loss changed the levels of hormones regulating weight. In the year after losing the weight, the subjects’ bodies used less energy and their appetites increased, resulting in weight gain.

Genetics also affect the body’s ease in losing weight. Since human bodies are programmed for survival, Kumar says, the brain’s setpoint remembers a person’s highest weight. When the person loses weight or burns too many calories, the brain perceives intense hunger and stores fat to survive.

“The human body is not engineered to lose weight,” says Angela Fitch, MD, board certified in internal medicine and obesity medicine, and associate medical director of the Massachusetts General Hospital Weight Center in Boston. “If you’re trying to lose weight, you’re trying to be abnormal. It’s normal to gain weight.”

HOW TO TALK ABOUT OBESITY
Primary care physicians don’t have to know everything about body regulation, says Kumar, but they should bring up obesity without blaming the patient. When approaching patients, experts recommend applying the five A’s used for smoking cessation to obesity: ask, advise, assess, assist, and arrange. This gives physicians a framework to work from.

Start by asking the patient if obesity is something they are interested in talking about. Even if the patient isn’t interested, it plants the seed for the future. The doctor can advise the patient on how much weight they recommend that the patient loses, and on the importance of exercise and diet. They can then assess whether the patient is interested in losing weight. The doctor can assist the patient by asking if they want to see a nutritionist or schedule time to come back to talk in more depth, and arrange follow-up with the primary care office or with a referral.

Some physicians are concerned about upsetting their patients, Fitch says. But “people want us to ask about it,” she says. “We just don’t, because we think they’ll be offended.”

After calculating the patient’s BMI, physicians can tell patients if it’s in a range that could contribute to their medical problems. She also brings up genetic and hormone connection to weight gain, and tries to find an appropriate balance between presenting medical information and addressing lifestyle factors.

Fitch encourages primary care clinics to come up with a treatment model that can be individualized to each patient. The patient chart should contain an action plan, showing what the patient will do to increase physical activity. The doctor can provide a handout with nutrition options, which can include meal replacement plans using information from the Look AHEAD study, or recommend a commercial plan like Weight Watchers. The physician can also prescribe anti-obesity medication. “If every primary care practice had that at a basic level—a handout, medication, and follow-up—that would produce significant results,” Fitch says. “There are 2,500 board certified obesity medicine physicians, and 98 million Americans with obesity. Each one of us would have to care for 32,000 people. Some of the care has to be delivered at a different level.”

A primary care physician likely won’t provide all nutritional counseling and behavior support for obesity, but can track height, weight, and BMI, and encourage patients to maintain a healthy weight. It’s appropriate to suggest a three month trial of lifestyle interventions, says Kumar. Treatment can and should involve healthcare extenders, as the physician likely won’t have time to offer the needed education, accountability, and program structure. Referrals to a specialist are an option as well.

Treating obesity is like treating other chronic diseases. Different treatments are used until the right one works. Starting treatment with a primary care physician, and then escalating treatment to a specialist is appropriate, just as is done with diabetes, depression, and cardiac health. Obe-

“‐ANGELA FITCH, MD, ASSOCIATE MEDICAL DIRECTOR, MASSACHUSETTS GENERAL HOSPITAL WEIGHT CENTER, BOSTON
Nutrition

“We need to eat differently,” says Tom Campbell, MD, board certified in family medicine and the medical director of the Weight Management and Lifestyle Center at the University of Rochester Medical Center’s Highland Hospital.

He advises patients that food is essential to their health, and if they eat the standard American diet, they will not lose weight, as the food is calorie dense, and eating less of it will not be filling enough. “The idea of eating less has been overplayed. We need to eat different foods, whole natural foods.” As long as the patient sticks to mostly whole, unprocessed foods, it doesn’t matter which specific diet a patient chooses, be it Atkins, low-carb, Paleo, or vegan. “There’s a lot more consensus in nutrition than people realize. The guidelines from established organizations are to eat more fruit and vegetables and less processed foods,” says Campbell. Weight loss diets fall along the spectrum, from processed American foods at one end, and plant-based foods at the other end. Other diets are all gradations along the spectrum.

Though he says a plant-based diet is best, he recognizes that some people have lifelong eating habits that are socially and emotionally related. The nutritional plan should meet people where they are, or patients are less likely to change.

“The key is not which diet works. All diets work. It’s which works for [the patient], that’s the clincher,” says Fitch.

Exercise

Exercise does not produce weight loss, Fitch says. It is important, though, and should be enjoyable, as the patient should maintain some form of physical activity during and after losing weight. Doctors can suggest different types of exercise that might appeal to the patient, whether it’s walking, a group fitness class or swimming, for example. A patient may find motivation using a fitness tracker, counting steps, or by enrolling in a race and training for it.

Activity only accounts for up to 20 percent of weight loss, says Primack, with dietary changes accounting for the rest. Once the weight is gone, however, the metabolism slows down, so continuing to exercise is an important part of weight maintenance. Primack says that lack of exercise accounts for half of weight regained. The Look AHEAD study, which followed 8,000 subjects for eight years during and after initial weight loss, shows that those who successfully maintained a 10 percent weight loss reported “significantly more” physical activity than those who regained weight.

Behavior

Learning a person’s triggers for eating too much or eating the wrong foods is another element in tackling weight loss. People feel bad if they don’t have the willpower to avoid food, like the contents in a bowl full of candy, says Fitch. “It’s normal not to be able to avoid it. That’s why controlling the environment is important for people trying to lose weight,” she says. The Look AHEAD study demonstrates that by providing more structure, patients can lose more weight and maintain it. That can include meal and snack replacements, as studies show that using them helps provide structure, so patients can sustain longer term weight loss. Otherwise they underestimate the number of calories in their food, and making food choices is difficult. The study also recommends providing the patient with a shopping list and detailed menu plan, which adds structure to help control their environment. Regular group and individual meetings with a lifestyle counselor provide structure, as did weekly physical activity goals, to exercise a certain number of minutes per week.

Patients were also advised to record their daily food intake and exercise time. Physician and type 2 diabetes in a September 2018 report by the U.S. Preventative Service Task Force, compared to the control group. Combining behavioral interventions with anti-obesity medications, however, yielded greater weight loss and maintenance over 12-18 months than just behavioral interventions.

ANTI-OBESEITY MEDICATIONS

Medications are indicated when a person’s BMI is 30 or higher, or 27 or more with relat-
Nine ways primary care physicians can address patient obesity

By Kayla Matthews Contributing author

Primary care physicians (PCPs) have a responsibility to their patients to help them stay healthy and safeguarded against the latest threats to their well-being. Therefore, it’s crucial for them to tackle the growing problem of obesity.

A recent study of obesity prevalence indicated two in five American adults are obese, and the same is true for about 18.5 percent of kids. In addition, the percentage of obese patients is rising in both the adult and child populations.

How can physicians respond if their patients are obese or at risk for obesity?

Family doctors in the U.S. were polled about 10 chronic disorders, including obesity. They reported that the treatments for obesity were less effective than all but those for drug addiction. These findings suggest a need for PCPs to rethink their strategies when assisting obese patients. The following suggestions could help them do that.

Use the 5As Model of Obesity Management

PCPs can build a weight-loss framework by using what’s known as the 5As Model of Obesity Management: assess, advise, agree, assist, and arrange.

During the assess phase, the PCP checks a patient’s body mass index to see if it falls under the obesity category. Depending on the results, the PCP either advises weight maintenance or weight loss. The agree phase relates to checking for patient readiness to lose weight, while the assist phase encompasses physician-led counseling or other types of weight-loss programs.

Finally, the arrange stage requires the PCP to regularly communicate with a patient and their third-party providers about progress, pitfalls, and concerns.

Although many courses of action fall under each of those steps, following the model decreases the likelihood that PCPs might overlook a key component.

Determine Patients’ Readiness to Lose Weight

A thorough discussion of obesity with patients includes assessing their willingness to change. One effective way to do that is by relying on a 10-point scale question. In this case, 10 means a patient is 100 percent ready to lose weight. A patient response from one to four indicates a minimal intention to lose weight, so the PCP might ask what it would take for the score to be higher.

A score from five to seven indicates the patient is uncertain. In that case, it’s crucial for the PCP to suspend judgment and ask what would need to happen for a patient to be more on board with weight loss. A score from eight to 10 means a patient is very ready to lose weight.

Patients who score in the one to seven range are not fully ready to lose weight and may need more information and tools to equip them for success first.

Suggest Patients Use Personal Activity Monitors (ASSIST)

Research shows that using personal activity monitors was as effective as working with a health coach for weight loss. When people combined their approaches by utilizing both health coaching and activity monitors, the results were especially notable.

Since many personal health devices are budget-friendly and models are widely available, the gadgets could give patients the kickstart they need to lose weight and maintain healthier lifestyles. Plus, such monitors act as obesity preventives.

Encourage Patients to Connect With Local Services (ASSIST, ADVISE AND ARRANGE)

Besides giving encouragement during the initial discussion about weight loss, PCPs should recommend that patients seek support and treatment beyond what’s offered during a primary care visit and follow up with patients to inquire about any actions taken.

PCPs can refer patients to specialists, such as nutritionists, weight management experts, and dieticians. In addition, regardless of where a patient lives, the community likely has specialty resources that provide weight loss interventions. A
the science behind them, says Kumar. Pharmacotherapy is not a cure for obesity, but an ongoing treatment for a chronic condition. Once the patient stops taking the medication, their appetite will return. Less than 1 percent of eligible patients are prescribed anti-obesity medications. Insurance typically does not cover them as a standard treatment and only 30 percent of employer health plans cover these medications, Fitch says.

Surgery
Bariatric surgery is reserved as the last stage in the weight loss journey. It’s been shown to have a dramatic benefit in weight reduction, quickly resolve diabetes, and also reduce cancer risk. “It’s pretty effective for weight loss and related chronic diseases. There’s absolutely a place for surgery for people who can’t or won’t change diet and lifestyle,” Campbell says.

Coach Patients to Set Achievable Goals (AGREE)
Getting patients engaged in weight management means empowering them to make lasting changes. PCPs should aid patients in taking small steps by setting goals they can meet. For example, it’s not feasible for a person who has not exercised in a decade to start going to the gym every day, but a goal of taking a brisk stroll for at least 30 minutes on most days of the week is a good start.

Review Patients’ Prescribed Medications at Every Visit (ASSESS)
It’s essential that PCPs review their patients’ charts to monitor which prescribed medicines they take and remember that some of those prescriptions may contribute to weight gain.
A study from King’s College London found that individuals taking antidepressants were 21 percent more likely to put on weight than those in the control group that did not take antidepressants.
If patients report dissatisfaction related to the side effects of medications, PCPs must facilitate weighing the pros and cons of potential alternative treatments. They should also consider whether stopping a particular drug that causes weight gain is worth the broader outcomes of not treating an illness.
Furthermore, PCPs need to remind their patients of the dangers of suddenly ceasing to take any prescribed medication, as that approach could lead to withdrawal symptoms.

Be Specific About Recommended Exercise Changes (ADVISE)
Exercise is not a straightforward solution for weight loss, so PCPs must provide targeted guidance when advising patients about exercise regimens.
While a key component to a healthy lifestyle, exercise alone will not lead to weight loss. PCPs must emphasize that patients should not expect to lose weight with exercise if they are still maintaining high-calorie and unhealthy diets.
In addition, PCPs should consider factors such as socioeconomic status and other health conditions, that can impact patients’ ability to exercise successfully.
If a patient lives with other obese people and those individuals are not trying to lose weight, they could unintentionally become bad influences. Instead of recommending that the patient exercises at home, a PCP can suggest joining a neighborhood walking group or local gym to put the patient in the presence of encouraging people.
Some patients may lack access to a gym or feel unsafe exercising outside. If at-home exercises are not possible, a PCP can provide tips on how to incorporate exercise throughout the day, such as taking the stairs and choosing a parking spot further from the entrance to work or a store.
Health conditions could dictate the best kinds of exercise, too. A patient with arthritis may find swimming or other low-impact activities more suitable than running.
Legally Speaking

Why old computers are a liability risk

One common recurring seasonal business risk for doctor’s offices is created when businesses take advantage of year end deals and surplus taxable income to replace computers and other business equipment. Making sure your practice has appropriate amounts of cyber liability insurance as well as sound and enforced policies on how your old equipment is stored and disposed of is vital practice risk management.

Wiping data is vital

Taking a tax deduction for donating safe electronic equipment after determining it does not contain confidential information is a relatively standard business practice. Whether your devices are going to be destroyed, donated, or recycled, all data on the computer must be wiped as a minimal first step. Security software available at most office stores can help and may already be present in your operating system or anti-virus programs. Remember that “deleted” data on personal computers is not actually “erased” unless the hard drive itself is virtually destroyed.

Beyond “computers”

While computers themselves pose the most obvious threat to legally onerous financial and HIPAA-protected information, they are not your only risk. Other devices, including scanners, printers, and fax machines, can store thousands of images and pages of data. Your practice must securely dispose of a variety of computer and related electronic devices including the following, admittedly incomplete list:

- Computers, tablets, and smartphones that have been used to access or relay protected data
- Networked printers, faxes, scanners, etc.
- Computer servers and arrays
- Devices that combine hardware and software for a specific medical or administrative function
- Networking equipment
- Electronic data storage devices and backups

Organized crime syndicates commonly instigate hacking, spoofing, phishing, and other online fraud and have pierced the security of even the biggest retailers and healthcare systems.

Top-notch professional IT support that includes security software and online security training for your staff should be considered mandatory for business asset protection and risk management. Some IT providers can also help securely dispose of your equipment.

Finally, consider if your business insurance coverage adequately protects you in case of accidents, mistakes, or breaches. Your practice should have seven figures in data breach/cyber liability insurance, not just a $50K or $100K rider that shares limits with your malpractice policy.

A device security plan

- Secure all old equipment. Many practices put outdated equipment into a storage area that no one pays attention to or takes inventory on until something goes missing or a breach occurs.
- Have a plan and make a specific individual responsible for implementing it. Create a written chain of custody and educate the person in charge about the risks and gravity of the task at hand.
- Keep records of all devices, including the ones being destroyed or donated (make a copy for your CPA including a description, serial numbers, estimated depreciated value, and replacement cost), and where they went or how they were disposed of.
- Sign out all users and physically disconnect devices from network. Old machines are often not maintained or updated and may actually create a security risk while still in your office.

Ike Devji, JD, has practiced in the areas of asset protection, risk management, and wealth preservation law exclusively for the last 15 years. Send your legal questions to medec@ubm.com
It’s probably difficult for most internists to imagine: Seeing patients when it’s convenient for the physician, largely avoiding high-deductible health plans, and ensuring a steady income with few interruptions. For Connecticut-based internist Jeffrey Kagan, MD, this dream is a reality thanks to the fact that he spends 20 percent of his time seeing patients in nursing homes.

“There’s a myth out there that you don’t get paid much to see patients in the nursing home, and that’s just not true,” says Kagan. “With nursing homes, it’s actually a nice constant flow of revenue.”

Kagan especially likes that he rarely sees denials unless a patient with Medicare switches to a Medicare Advantage plan (or vice versa) and doesn’t notify his office. “We try to get accurate information from the very beginning,” he adds. “If the patient’s insurance doesn’t change, then it works, and billing goes smoothly.”

Other physicians say nursing home services can be lucrative but not without challenges. Vishal Aggarwal, MD, a geriatrician at Elite Medical Clinic in Tulsa, Okla., previously spent 50 percent of his time seeing patients in nursing homes but decided to stop last year because of the difficulty in getting paid. One challenge was that Oklahoma Medicaid only paid for two nursing home visits per month. This meant that when Aggarwal saw Medicaid patients more than that, his work was unpaid—even when it was medically necessary.

Connecticut Medicaid doesn’t limit the number of medically necessary visits per month, says Kagan. “For example, it would be medically necessary to see someone for an acute problem like pneumonia or vomiting but not necessary to adjust the dose of warfarin or insulin,” he says.

Another challenge for Aggarwal was that he often felt pressured by the nursing home to see patients even when he wasn’t a participating provider in their Medicare Advantage network. When this happened, patients were often responsible for the bill, and it was nearly impossible to collect from them, he says. “It was easier to not see the patient, but you can’t say that to the nursing home. It put me in a very difficult situation,” he adds.

Kagan doesn’t have this problem because he participates with each of the local Medicare Advantage plans.

Finally, when patients didn’t have a primary care physician or didn’t see any other physician during an Accountable Care Organization (ACO) performance year, the ACO to which Aggarwal belonged attributed nursing home patients to him. This meant he was responsible for providing a year’s worth of preventive care for patients he only saw once or twice. When he didn’t provide these services, the data falsely indicated that he wasn’t managing patients effectively, and his clinic’s reputation started to suffer.

Kagan says some ACOs can eliminate nursing home patients from a physician’s attributed list so they aren’t responsible for all of a patient’s care. Kagan’s ACO is revamping...
“There’s a myth out there that you don’t get paid much to see patients in the nursing home, and that’s just not true. With nursing homes, it’s actually a nice constant flow of revenue.”

— JEFFREY KAGAN, MD, INTERNIST, MEDICAL ECONOMICS EDITORIAL ADVISORY BOARD MEMBER

its process for nursing home patient attribution so he isn’t penalized when there are gaps in preventive care.

Although physicians can’t control some of these payment barriers, there are certainly steps they can take to make nursing home services more lucrative, says Vanessa Moldovan, CPC, CPMA, senior billing specialist at Medic Management Group LLC, a healthcare consulting company in Akron, Ohio. Here are seven tips to consider.

**Do your homework before seeing patients in the nursing home.**

To avoid denials, physicians—and any non-physician providers they employ to treat patients in the nursing home—must be credentialed with every nursing facility in which they render services, says Michele Rodgers, certified medical manager at Healthstone Primary Care Partners, an internal medicine practice in Hollywood, Fla.

The practice’s administrative staff should also contact the nursing home to obtain each patient’s demographic and insurance information to determine whether the physician is contracted with the patient’s insurance provider, says Rodgers. To minimize denials, this determination should take place as soon as possible. For patients with Medicare, it should take place before the first mandated visit, which Medicare states must occur within 48 hours of admission to the nursing facility, she adds.

If the physician isn’t contracted with the patient’s payer, the services will likely be subject to the patient’s out-of-network benefits—and the patient could owe a significant co-insurance, says Rodgers. When patients have this information in advance, they may be more likely to follow through with payment or go to another nursing home that has an arrangement with a physician who’s in the patient’s network, she adds.

**Know what codes to report.**

Report a CPT code from the 99304-99306 code range for the initial nursing home visit, depending on the severity of the patient’s diagnosis and services rendered, says Moldovan. For all other medically necessary visits, report a CPT code from the 99307-99310 code range, she adds. This includes the federally-mandated visits for Medicare patients that occur every 30 days for the first 90 days after admission to the facility and at least once every 60 days thereafter.

It can get tricky when a patient with Medicare or a commercial plan leaves the nursing facility and returns a short time later. Kagan provides this example: A patient is discharged to rehab following a hip repair. On the third day of rehab, the patient develops respiratory distress and is re-hospitalized for acute hypoxic respiratory failure due to pneumonia.

Physicians must determine whether the return to the nursing facility is considered an initial visit or subsequent, says Kagan. He provides this guidance: Unless the patient or their family pays to hold the bed in the patient’s absence—typically $300 to $400 per day—physicians can report an initial services code upon that patient’s return. If the patient or their family pays to hold the bed, then the original nursing home stay continues, and physicians must report a subsequent visit code when the patient returns.

However, physicians should keep in mind that Medicare and many commercial payers track all admission and discharge dates, says Moldovan. If a physician tries to bill an initial visit before the nursing home discharges the patient, the payer will likely deny payment for the visit, she adds.

Something else to keep in mind: Medicaid requirements may differ from state to state. For example, Connecticut Medicaid requires nursing homes to hold the bed for 14 days, says Kagan. If a patient with Medicaid is readmitted to the nursing home during that time, the physician must report a subsequent services code. If it’s after 14 days, the physician can report an initial services code, he adds.

If there’s any question as to whether the service is initial or subsequent, Kagan suggests contacting the director of admissions or biller at the nursing facility. Physicians shouldn’t assume that every patient is a re-admission because they could be missing out on approximately $48 or more per visit (the difference between the initial and subsequent visits for a patient of similar clinical complexity), he says.

Report CPT codes 99315 or 99316 for nursing facility discharge services, depending on the time spent performing these services. Discharge services include final examination of the...
## Nursing home services

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>Initial services that include a detailed or comprehensive history; detailed or comprehensive exam; and straightforward or low-complexity medical decision making</td>
</tr>
</tbody>
</table>

### Severity of problems requiring admission
- **Low severity**

### Average time spent
- **25 minutes at the bedside and on the patient’s facility floor or unit**

### 2018 national average Medicare payment amount for non-facility services*
- **$92.88**

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99305</td>
<td>Initial services that include a comprehensive history; comprehensive exam; and moderate-complexity medical decision making</td>
</tr>
</tbody>
</table>

### Severity of problems requiring admission
- **Moderate severity**

### Average time spent
- **35 minutes at the bedside and on the patient’s facility floor or unit**

### 2018 national average Medicare payment amount for non-facility services*
- **$132.84**

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99306</td>
<td>Initial services that include a comprehensive history; comprehensive exam; and high-complexity medical decision making</td>
</tr>
</tbody>
</table>

### Severity of problems requiring admission
- **High severity**

### Average time spent
- **45 minutes at the bedside and on the patient’s facility floor or unit**

### 2018 national average Medicare payment amount for non-facility services*
- **$169.92**

## Subsequent nursing facility services

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>99307</td>
<td>Subsequent services that include two of the following: problem-focused interval history, problem-focused exam, or straightforward medical decision making</td>
</tr>
</tbody>
</table>

### Severity of problems requiring admission
- **Stable, recovering, or improving**

### Average time spent
- **10 minutes at the bedside and on the patient’s facility floor or unit**

### 2018 national average Medicare payment amount for non-facility services*
- **$45.36**

<table>
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<tr>
<th>CPT code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99308</td>
<td>Subsequent services that include two of the following: expanded problem-focused interval history, expanded problem-focused exam, or low complexity medical decision making</td>
</tr>
</tbody>
</table>

### Severity of problems requiring admission
- **Responding inadequately to therapy or has developed a minor complication**

### Average time spent
- **15 minutes at the bedside and on the patient’s facility floor or unit**

### 2018 national average Medicare payment amount for non-facility services*
- **$70.56**

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99309</td>
<td>Subsequent services that include two of the following: detailed interval history, detailed exam, or moderate complexity medical decision-making</td>
</tr>
</tbody>
</table>

### Severity of problems requiring admission
- **Patient has developed a significant complication or a significant new problem**

### Average time spent
- **25 minutes at the bedside and on the patient’s facility floor or unit**

### 2018 national average Medicare payment amount for non-facility services*
- **$93.24**

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99310</td>
<td>Subsequent services that include two of the following: comprehensive interval history, comprehensive exam, or high complexity medical decision making</td>
</tr>
</tbody>
</table>

### Severity of problems requiring admission
- **Patient may be unstable or developed a significant new problem requiring immediate physician attention**

### Average time spent
- **35 minutes at the bedside and on the patient’s facility floor or unit**

### 2018 national average Medicare payment amount for non-facility services*
- **$138.60**

## Nursing facility discharge services

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>99315</td>
<td>Nursing facility discharge day management</td>
</tr>
</tbody>
</table>

### Average time spent
- **30 minutes or less**

### 2018 national average Medicare payment amount for non-facility services*
- **$74.16**

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<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99316</td>
<td>Nursing facility discharge day management</td>
</tr>
</tbody>
</table>

### Average time spent
- **More than 30 minutes**

### 2018 national average Medicare payment amount for non-facility services*
- **$108.00**

## Other nursing facility services

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>99318</td>
<td>Evaluation and management of a patient involving an annual nursing facility assessment that includes a detailed interval history, comprehensive exam, and low to moderate-complexity medical decision making</td>
</tr>
</tbody>
</table>

### Severity of problems requiring admission
- **Patient is stable, recovering, or improving**

### Average time spent
- **35 minutes at the bedside and on the patient’s facility floor or unit**

### 2018 national average Medicare payment amount for non-facility services*
- **$97.92**

*Medicare payment varies based on each Medicare Administrative Contractor (MAC).

patient, providing continuing care instructions to relevant caregivers, preparing the discharge records, completing referrals, and ordering prescriptions. Report CPT code 99318 for the annual nursing facility assessment.

**Double-check the place of service (POS) code.**

Many physicians incorrectly use POS code 11 (office) rather than POS code 31 (skilled nursing facility) or 32 (nursing facility), says Moldovan. Physicians must report the correct POS code in two places on the claim form—next to the name and address of the facility where services are rendered and next to the CPT code itself, she says. Some EHRs pre-populate the facility name and/or the POS code, and physicians may need to override one or both manually, she adds.

**Append modifiers, when necessary.**

To be paid appropriately for providing nursing home services to Medicare patients receiving hospice care, physicians must append one of the following modifiers: -GV (when a provider performs a service related to the problem for which a patient was admitted into hospice) or modifier -GW (when the service is not related to the hospice patient’s terminal condition), says Rodgers. “If providers don’t usually treat patients on hospice, they may not be aware of these modifiers,” she explains.

**Ensure documentation supports each CPT code.**

“Providers using these codes must familiarize themselves with what they need to document to substantiate the bill,” says Rodgers.

Each code requires a chief complaint, history, exam, and medical decision-making, says Jane Miller, practice manager and auditor at a two-physician primary care practice in southern Ohio. “These codes require just as much documentation as regular office visit codes, she says.

As with office visit E/M codes, higher-level nursing facility codes can raise questions with payers if documentation is sparse, says Miller. She provides the example of CPT code 99310—the highest-level code for a subsequent nursing facility service. “You have to be really careful with this code, and you need to make sure that documentation reflects severity,” she adds.

**Distinguish between nursing and assisted living facilities.**

The CPT manual describes assisted living facilities as those that provide room, board, and other personal assistance services, generally on a long-term basis. These facilities do not include a medical component. When physicians render services in an assisted living facility, they should report a CPT code from the 99324–99328 code range for new patients and the 99334–99337 code range for established patients, says Moldovan. Report POS code 13 with these CPT codes, she adds.

**Don’t forget prolonged services.**

Kagan says he bills CPT codes 99358–99359 (prolonged services without direct patient contact) for time spent on the phone with nurses, family, or other physicians. Note that these codes must be reported in addition to an E/M code, and they require at least an additional 60 minutes of services beyond what’s typically associated with the E/M code. Physicians can also report CPT codes 99351–99355 for prolonged services with direct patient contact.

“Seeing patients in a nursing home can be rewarding in several ways,” says Kagan. “The schedule is flexible, and the patients and staff are very appreciative. Also, a dedicated nursing home practice requires minimal overhead and can be quite profitable.”

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“Providers using these codes must familiarize themselves with what they need to document to substantiate the bill.”

—MICHELE RODGERS, CERTIFIED MEDICAL MANAGER, HEALTHSTONE PRIMARY CARE PARTNERS, HOLLYWOOD, FLA.
The benefit of flexible patient payment options

Strategies to Increase your collection rate in 2019

by JORDAN ROSENFELD Contributing author

The new year brings new health plans, often with higher deductibles, and old bills that patients may be struggling to pay. According to 2018 data compiled by MedData, 83 percent of physician practices with fewer than five practitioners reported that their top collection challenge was slow payment among high-deductible plan patients.

In this landscape, physicians may have to get creative in order to increase their revenue. Experts suggest that the more payment options physicians offer their patients, the better the chance that bills will get paid.

Patients are growing accustomed to an Amazon-like consumer experience, where they can click on a link and pay in an instant, ideally from their mobile phones, according to Deirdre Ruttle, vice president of strategy, for InstaMed, a healthcare payments network in Philadelphia, Pa.

“We live in an always connected world. According to research, 75 percent of adults are online daily, and one in four adults report being connected all the time,” she says.

Technology has made paying for goods and services incredibly convenient, Ruttle says, with options such as digital wallets, e-statements, and text reminders to pay balances owed, but it’s also increasing consumer demand for a variety of payment options.

The MedData study also found that 68 percent of consumers would prefer to pay their medical bills electronically, and 92 percent want to know what their patient responsibility is in advance of service.

As a result, Ruttle says, “Physicians should give patients multiple options with payment channels and payment methods so that you can really meet patients where they already are.”

ASSESS YOUR PATIENTS’ FINANCIAL HEALTH

In order to determine what options to offer, physicians should adopt some tools for assessing their patients’ fiscal health, according to Kevin Fleming, CEO of Loyale Healthcare, a healthcare technology company in Lafayette, Calif.

Fleming breaks this assessment down into a series of measures:

- The patient’s:
  - ability to pay
  - financial capacity
  - income

As well as:

- where they aren’t paying
- how they can pay

“When patients aren’t paying, they’re already communicating strongly to you, in very real terms, that there’s a problem.”

And rather than treating that problem as a hassle, Fleming encourages physicians...
Money

Patient payments

“The majority of the country has a [healthcare] affordability problem now. People with jobs, with families, with mortgages and auto loans, people who are credit worthy.”

—MARK SPINNER, PRESIDENT AND CEO, ACCESSONE, CHARLOTTE, N.C.

Patients use smartphones for so many purchases it only makes sense that they want to pay for their healthcare that way. Now that patients are also shouldering a greater burden of their healthcare costs, the pressure is mounting on physicians to offer mobile and online payment options.

Probably the easiest method for most practices is to create a payment portal to the practice management system, either accessible via the web or through a patient’s mobile device, says Craig Cooper, product manager for AdvanceMD, a medical practice management and EHR company out of South Jordan, Utah.

“This gives them the opportunity to receive a text saying they have a balance due and go make that payment.”

“When we offer more convenience to a patient, the more the patient will participate,” says Paul Gordon, manager of business development for Micro Office Systems in Cleveland, Ohio.

Gordon recommends that physicians take advantage of some form of online payment service, whether an app or a patient portal. “Whatever you use—the Square app, PayPal, or a bank’s basic shopping cart func-

Should physicians use payment apps?

by Jordan Rosenfeld

Patients use smartphones for so many purchases it only makes sense that they want to pay for their healthcare that way. Now that patients are also shouldering a greater burden of their healthcare costs, the pressure is mounting on physicians to offer mobile and online payment options.

Probably the easiest method for most practices is to create a payment portal to the practice management system, either accessible via the web or through a patient’s mobile device, says Craig Cooper, product manager for AdvanceMD, a medical practice management and EHR company out of South Jordan, Utah.

“This gives them the opportunity to receive a text saying they have a balance due and go make that payment.”

“When we offer more convenience to a patient, the more the patient will participate,” says Paul Gordon, manager of business development for Micro Office Systems in Cleveland, Ohio.

Gordon recommends that physicians take advantage of some form of online payment service, whether an app or a patient portal. “Whatever you use—the Square app, PayPal, or a bank’s basic shopping cart func-

PHYSICIAN CHARGE ACCOUNTS

When determining which payment methods to offer, physicians should consider that affording healthcare costs is not just a problem for the low-income, says Mark Spinner, president and CEO of AccessOne, a patient finance company based in Charlotte, N.C. “The majority of the country has a [healthcare] affordability problem now. The majority of the country has a [healthcare] affordability problem now. People with jobs, with families, with mortgages and auto loans, people who are credit worthy.”

—MARK SPINNER, PRESIDENT AND CEO, ACCESSONE, CHARLOTTE, N.C.
People with jobs, with families, with mortgages and auto loans, people who are credit worthy. AccessOne is among many companies that offer “co-branded, personalized financing,” much like a store brand charge account that a person might get at Home Depot or Nordstrom.

These accounts work much like a credit card, so physicians see their revenue, and the patients can pay down their balance in the ways that work best for them.

There are multiple kinds of accounts, too within this framework. “Some accounts are built as part of deductible plans, some are built for catastrophic balances, some are built for partial charity or partial financial assistance recipients. Those different programs help the provider deliver a positive payment alternative for every patient that walks through their doors.” Patients can even obtain plans that offer zero interest for a set rate of time and the option to pay off their balances as needed.

“Anything I can do to make the [payment] process easier and give the patient more options, I’m all for it.” — Saya Nagori, MD

PAYMENT PLANS
Many physician practices offer standard payment plans, which Fleming says are only moderately successful in obtaining revenue.

He has seen physicians be successful with
Money

Patient payments

83% of small physician practices said slow payment by high-deductible plan patients is their top collections challenge

Source: MedData, 2018

a prompt-payment discount for paying within a certain time frame. “You’d be amazed at what a simple discount of 10 to 20 percent will do to the psychology of the whole transaction,” Fleming says. “The patient is getting additional cash back in their wallet.”

A more common model is to break a bill down into monthly payments over a time period, such as a year, but there is still a financial risk to the physician. He says that sometimes physicians have to be willing to increase the length of payment time. “When the patient just can’t afford say $200 per month, they might need three-year financing on something like an emergency room visit or cancer treatment.”

Additionally, he says, allowing patients to set the payment parameters can lead to better results. “When patients self-construct plans, selecting an amount and the period that works for them, they’re able to keep up their end of the bargain and pay.”

Another option is to pre-pay before a large and planned medical cost, such as childbirth or a big equipment purchase like hearing aids, according to Leonard Wenyon, BSBA, vice president of IKS Health, a practice management consulting company in Newark, Del.

Then, when the baby is born, or the equipment comes in, the patient doesn’t owe anything.

If none of those options bring in prompt payment, Wenyon says, physicians can consider outsourcing to a collection agency.

SELF-PAY OPTIONS

When the patient’s deductible is extremely high, or if they don’t have insurance, Wenyon recommends physicians consider offering some basic services at a flat rate. “You tell the patient ‘this is the rate we expect at time of service.’”

He took advantage of such an opportunity while on vacation in Hawaii, when his daughter became sick and the local hospital did not take his insurance, but did offer a flat rate. The advantage is that the patient knows what they’re paying up front, and once it’s paid, there’s no bill to collect on. Sometimes, he says, commercial insurance or Medicare will cover it retroactively.

THE IMPORTANCE OF THE FRONT DESK

No matter what payment options a physician offers, front desk staff will play a crucial role in making them work, Ruttle says. “There is a great opportunity for providers to bring those financial conversations up at the beginning of the encounter, not the end,” she says.

She says taking the taboo out of talking about money up front helps to eliminate some of the fear and confusion that is so prevalent in healthcare payments today.

This requires training front desk staff to become comfortable talking about money and getting some form of payment at the point of service. It doesn’t have to be awkward, Ruttle says, comparing it to the experience of checking into a hotel, where the consumer knows in advance that they’ll have to provide a credit card upon arrival, but will only be charged for specific things.

Fleming says patients want to feel cared for not just from a clinical aspect but from a financial aspect, too. Having these conversations when the patient checks in, he says, allows the patient relief from the financial stress or burden, and helps them focus on their clinical care they’re seeking.

Shelton says that just asking patients about obstacles to paying has led to his clients’ point-of-service collections increasing by as much as 20 percent.

“Our experience is that most people truly want to pay their bill,” Shelton says. “The challenge has always been whether the healthcare provider will have the conversation with them at the very beginning, taking into account their financial challenges or opportunities.”

If physicians are worried about the costs of adding any of these payment options to their EHRs or practice management software, Ruttle points out, “The overall cost is a very small percentage of what bad debt looks like. The return on investment (ROI) is very strong.” She recommends that physicians who feel overwhelmed by choices start with an online payment portal and e-statements and phase in other options over time.
Over the next five years, industry experts predict big changes that will significantly impact managed care.

“As industries continue to blur, traditional healthcare companies will need to break down silos to drive value across the industry ecosystem,” says David Friend, MD, MBA, chief transformation officer and managing director, The BDO Center for Healthcare Excellence & Innovation, a healthcare accounting and consulting firm. “To compete with disruptors, healthcare companies will need to capitalize on data, maximize profitability, and innovate patient care all while managing growing risk in the areas of patient privacy and data security.”

It’s a daunting challenge, but preparation can help ensure success. Here are some of the biggest areas of disruption that could impact your practice or medical organization.

1. **ONLINE RETAILERS**

   This year a flurry of discussions and deal-making occurred between retailers and healthcare organizations, Friend says. This includes:

   - Walmart’s reported early-stage talks to acquire Humana;
   - The Amazon, JPMorgan, and Berkshire Hathaway venture that aims to transform its employees’ healthcare; and most recently, Amazon’s billion-dollar acquisition of online pharmacy PillPack.

   Other companies disrupting healthcare include big retail pharmacy chains such as Walgreens and CVS Caremark Corp., which are combining their thousands of stores and walk-in clinics with their e-commerce systems to create new digital healthcare delivery platforms, says Kim A. Buckey, vice president, Client Services, DirectPath, LLC, which helps employees become better healthcare consumers. For example, Walgreens partnered with MDLIVE in 2015 to facilitate telemedicine offerings to consumers.

   Health-specific retailers that have entered the space, such as FSASTore.com and HealthWarehouse.com, offer price transparency and product delivery to consumers who are price-sensitive, Buckey says.

   Another notable entrant is large employers that are working alongside or acquiring emerging health and wellness companies, Buckey says. Under Armour, for instance, has invested heavily in wearable devices and, with the acquisition of companies such as MapMyFitness and MyFitnessPal, has become the major player in digital fitness. Under the umbrella of its Connected Fitness segment, Under Armour has access to tremendous amounts of health data.

   Traditional technology entities are building healthcare apps, wearables, and other connected devices, and consumers are using them to track their health prog-
Policy

Healthcare disrupters

ress and feed data back to their provider, payer, or both, says Friend. “Technology has brought healthcare to consumers’ fingertips, putting them at the nucleus of care and blurring the definition of a healthcare organization.”

Retailers are partnering with pharmacies, to share data and reach more consumers, he adds. Insurers are partnering with pharmaceutical manufacturers to leverage patient data to improve outcomes and lower health costs. “Everyone is getting into everyone’s business and will continue to do so to provide improved patient outcomes and ensure survival in a consumer-centric industry.”

The most valuable resource in healthcare is data, which online retailers—with their growing consumer health and wellness products—have in spades, says Friend. “Access to data and the ability to capitalize on that data is key to developing consumer-centric models of care, improving patient outcomes, and lowering costs.”

Online retailers like Amazon are entering the healthcare industry on other fronts, Buckey says. For example, they are selling personal health equipment such as walkers and canes directly to consumers and medical supplies such as gloves and syringes to providers. “Because of their experience negotiating low prices, ability to deliver products directly to consumers on a timely basis, and its built-in price transparency, they are well-positioned to disrupt the healthcare delivery landscape in particular,” Buckey says. For example, online retailers give consumers the opportunity to order medications or supplies online and have them delivered to their home or arrange for pickup at a local store.

“We’ve already seen a shift away from brick-and-mortar stores in other sectors; it was only a matter of time before we saw something similar with healthcare,” Buckey says. “Healthcare services and supplies are just as much a commodity as electronics, clothing, or even cars. With more purchasing power leaning toward consumers, it’s no surprise to see them opting for more convenient options when shopping for the healthcare treatments, services, and products they need.”

“We’ve already seen a shift away from brick-and-mortar stores in other sectors; it was only a matter of time before we saw something similar with healthcare.”

— KIM A. BUCKEY, DIRECTPATH, LLC

Social determinants of health

Social determinants of health include economic stability, education, health and healthcare, neighborhood and built environment, and social and community context, according to Healthy People 2020, which provides 10-year national objectives for improving Americans’ health. “These are the conditions in which people are born, grow, live, work, and age, as well as the circumstances that impact their health,” says Lori Tremmel Freeman, MBA, CEO, National Association of County and City Health Officials, which advocates for local health departments. “Social determinants of health undergird many current healthcare challenges, including obesity, heart disease, diabetes, and depression.”

While genetics plays a role in an individual’s overall health, most health outcomes are the result of circumstances outside the healthcare system. “The conditions in which someone lives, whether they have transportation to a clinic when needed, their support network, and other factors beyond the doctor’s office are as important to an individual’s overall health and well-being as being treated for an illness,” says Joseph Valenti, MD, board member, The Physicians Foundation, an organization that seeks to help physicians deliver high-quality care. “As
the healthcare system effectively addresses these issues, the overall price of healthcare in the United States will decrease and people will generally be healthier."

Some states, insurers, and hospitals are already factoring social determinants into healthcare by doing things like ensuring patients have adequate housing and access to needed resources and programs.

Freeman says more attention to social determinants would provide a more balanced approach to health.

From a public health perspective, she says healthcare can be categorized at three levels:

1. **Primary**
   - focused on disease prevention;

2. **Secondary**
   - treating disease in the early stages; or

3. **Tertiary**
   - treating the effects of a disease or illness.

Considering diabetes as an example, primary care would include a focus on healthy lifestyle, secondary care would involve monitoring of blood levels and medication, and tertiary care could include amputation.

Primary, secondary, and tertiary care can be targeted at the individual, interpersonal, organizational, community, or public policy level, Freeman says. Naloxone, a medication designed to rapidly reverse opioid overdose, for example, is tertiary care at an individual level. On the other hand, given that unemployment is thought to contribute to patterns of opioid use, a strategy of increasing job opportunities becomes primary care at a community level. By focusing on the social determinants, organizations can better address population health problems.

Social determinants of health could impact how the healthcare industry conducts business. Instead of concentrating on tertiary care for patient populations only, healthcare could participate more in community health, Freeman says. Eventually, as social determinants of health become a greater part of the healthcare portfolio, tertiary care spending would decrease while quality of life would increase for affected communities.

In many places, this has already begun, as hospitals and health insurers work with local health departments around community health concerns, she says. By law, providing community benefit has been central to the tax-exempt status of nonprofit hospitals. The ACA’s explicit requirement for nonprofit hospitals to consider input from those with public health expertise in the development of hospital community health needs assessment and implementation strategies has increased local collaborations around social determinants of health.

**ARTIFICIAL AND AUGMENTED INTELLIGENCE**

As more electronic health data becomes available, artificial intelligence (AI) can unlock the potential for that information to be used to improve healthcare. "No more will ‘doctor knows best’ be sufficient," says Jodi Daniel, a partner in Crowell & Moring’s Healthcare Group and a member of the firm’s Digital Transformation Practice. "Clinicians will need to apply their training and experience along with data and sophisticated systems that can identify new information that may not have been available or transparent before. This could lead to significant improvements in diagnosis and treatment and create efficiencies for provider and patient interactions and administrative functions."

"As the healthcare system effectively addresses these issues, the overall price of healthcare in the United States will decrease and people will generally be healthier.”

— JOSEPH VALENTI, MD, THE PHYSICIANS FOUNDATION
AI applications include:

- **Population health management**, in which AI software can help clinicians and insurers better identify and prioritize patients to provide the right level of resources to minimize costs and improve patient outcomes, Daniel says.

- **Diagnostics**, in which AI is assisting with diagnoses. For example, this year, the FDA approved AI-based tools for detecting wrist fractures and diabetic retinopathy in patients, decreasing time from onset to treatment.

- **Patient care**, in which it can help providers determine the treatment approach. In February, for example, the FDA approved clinical decision support software that uses AI algorithms to analyze images for indicators associated with a stroke, Daniel says.

Growth in the AI health market is expected to reach $6.6 billion by 2021—a compound annual growth rate of 40%, according to Accenture. Several trends are driving that growth:

**The continued, unmanageable increase in healthcare costs.**
"Value-based payment requires that clinicians have actionable data to manage patients and that health plans have data and tools to evaluate performance and health outcomes," says Daniel.

**Concerns continue to grow regarding physician burnout and medical labor shortages.**
"AI software can reduce the burden of providers when doing documentation and data management, and AI tools can help triage patients so that physician time is available to patients with the greatest need," Daniel says.

**Technology advancements across all industries have resulted in patients changing their expectations of their healthcare interactions.**
"Individuals are used to quick responses, electronic access to information, and the ability to be more engaged in decision making," Daniel says. "There will be a growing need for the healthcare sector to adopt AI technology to streamline services and to improve quality of those services."

**A thirst for improving the understanding of complex diseases and treatments and conducting research.**
"AI will be an important tool for analyzing vast amounts of data to develop future treatments," she says.

Ultimately, Daniel says the single-most significant potential for AI is its power to change the standards of practice. "Better analytical tools for improved diagnosis and treatment and more data from outside the clinical care setting such as patient-generated health data and social determinants data can provide a more accurate picture of the patient and improve care decisions and outcomes," she says.

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"AI tools can help triage patients so that physician time is available to patients with the greatest need," Daniel says.

— JODI DANIEL, CROWELL & MORING’S HEALTHCARE GROUP

Editor’s note: This article was first published in our partner publication, Managed Healthcare Executive.
Asking about opioid use now part of Medicare welcome and annual visits

Opioid use has become a top priority, and, as part of that, CMS emphasizes that review of a patient’s opioid use should be a standard element of the Initial Preventative Physical Exam (IPPE) also known as “welcome to Medicare”, and the initial and subsequent Annual Wellness Visit (AWV).

Medicare has included the following language as part of the review of the patient’s medical history for IPPE visits and AWVs: “Medicare would like to emphasize that review of opioid use is a routine component of this element, including Opioid Use Disorder (OUD). If a patient is using opioids, assess the benefit from other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.”

IPPE visits
The IPPE is covered for all Medicare beneficiaries once during their first year of becoming a beneficiary of Part B coverage, and the elements of the IPPE include:

- Review the patient’s medical and social history.
- Review potential risk factors for depression and other mood disorders.
- Review functional ability and level of safety.
- Measurement of height, weight, body mass index (BMI), and visual acuity screening.
- End-of-life planning (upon agreement of the individual).

Annual wellness visits
Medicare covers AWVs for patients who are no longer within their first year of their Part B coverage, and who haven’t had an AWV or IPPE within the last 12 months. The initial AWV is a once in a lifetime benefit, which means that Medicare only pays for this visit once per patient. The subsequent AWV is covered once every 12 months. The elements for the initial AWV are:

- A health risk assessment.
- Establishment of a current list of provider and suppliers.
- Review of medical and family history.
- Measurement of height, weight, BMI, and blood pressure.
- Review of potential risk factors for depression and other mood disorders.
- Review of functional ability and level of safety.
- Detection of any cognitive impairment the patient may have.
- Establishment of a written screening schedule (such as a checklist).
- Establishment of a list of risk factors.
- Provision of personalized health advice and referral to appropriate health education or other preventive services.

Subsequent AWVs include the following elements:

- Review of updated health risk assessment.
- Update medical and family history.
- Update of list of current providers and suppliers.
- Measurement of weight and blood pressure.
- Detection of cognitive impairment the patient may have.
- Update of the written screening schedule (such as a checklist).
- Update of the list of risk factors.
- Provision of personalized health advice and referral to appropriate health education or other preventive services.

Physicians should update templates to include info on patients who are at risk or are using opioids.

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Indiana. Send your coding questions to medec@ubm.com.
Navigating the reimbursement landscape can be confusing for physicians because of the number of entities that exert influence on payments. For example, CMS uses the Medicare Physician Fee Schedule (PFS) to adjust Medicare payments, and sometimes these changes can have dramatic effects on doctor pay. Coding changes reward some types of care while de-emphasizing others through how much reimbursement is allowed for each. In addition, the MIPS program is pushing Medicare into value-based care, distributing bonuses and penalties to doctors depending on how well they meet various quality measures.
Many private payers also use quality metrics, but often, these are somewhat different from those that CMS uses and from each other’s.

And to top it all off, all these rules can change each year. So what reimbursement trends can physicians expect in 2019?

**MIPS BONUSES AND PENALTIES START**

For physicians using the “ignore it and hope it goes away” strategy for MIPS, 2019 might provide a rude awakening as bonuses and penalties based on 2017 claims data go into effect. “The concept of MIPS will not go away, and even if it did, it would just be replaced by something similar,” says Anders Gilberg, MGA, senior vice president, government affairs, for the Medical Group Management Association. “It is one of the few bipartisan-supported concepts in healthcare today.”

The payment adjustments for this year are relatively small—2 percent is the maximum bonus and 4 percent the maximum penalty, depending on how a physician did on the performance measures in 2017. While that might not have much effect on a practice’s financial situation this year, those adjustments are scheduled to increase to 7 percent in 2021 and 9 percent in 2022 and beyond. “Practices have the opportunity to receive a higher increase in 2021 than previous years based on what they do in 2019,” says Gilberg. “But they could also see a significant penalty.”

CMS reported that 93 percent of MIPS-eligible clinicians earned a payment bonus for 2019, but 2017 was a “pick your pace” year to introduce physicians to the program. As performance measures change—and cost containment becomes a bigger component of the score—fewer physicians are likely to qualify for a bonus, especially those not actively monitoring their progress.

“Practices should try to get good advice on how MIPS is going to affect them,” says Mark Friedberg, MD, MPP, senior physician policy researcher for the RAND Corporation. “It is a very complicated and changing payment model.”

**PRIVATE PAYERS REFOCUS ON OUTCOMES**

Private payers and physicians are always haggling over reimbursement rates, and 2019 will be no different. But as the market on both sides continues to consolidate, smaller practices may find it more difficult to negotiate for the rates they desire.

From an insurer standpoint, the overall pie to pay physicians, hospitals, and other providers is fixed, says Mark Dietrich, CPA, member of the National Society of Healthcare Business Consultants. “The largest portion of the pie goes to provider entities that have the greatest amount of negotiating leverage. Smaller practices get what’s left.”

Larger entities can not only negotiate better fee-for-service rates, but also more lucrative quality incentives for value-based care contracts, he adds. Physicians should expect the reimbursement challenges for small practices to continue. “Government policy is really designed to loosen the regulatory restriction on providers coming together,” says Dietrich. “The whole idea is that if they get more integrated provider groups along the continuum of care, they will get better data, better clinical options, and better outcomes.”

The result is that larger practices or those affiliated with health systems can extract significantly higher rates than small, independent practices, according to Dietrich. “It’s all about who has the biggest piece of the pie,” he says. “Like on the savanna, the big lion gets the most and the hyena gets what’s left.”

Small practices can help themselves in negotiations by having strong data that proves they are improving outcomes for patients, as ultimately, this lowers a payer’s costs. Experts agree that practices can expect to see more demands for data from CMS and private payers as the march to value-based care continues.

“Carriers are doing deals that generally reward physicians in value-based contracts, but minimize reimbursement increases if they are not involved in value-based benefits,” says Ken Goulet, former executive vice president of Anthem Inc. and current board member at OODA Health, which focuses on streamlining interactions between payers and providers. While he says fee-for-service won’t be completely eliminated, doctors can expect to see diminishing reimbursements in 2019 and in the future.

“If you are not using these TCM and CCM codes, you are really missing the boat on getting good reimbursement for time when you are not face-to-face with the patient.”

— NANCY ENOS, FACMPE, ENOS MEDICAL CODING
“Fee-for-service is going to last for a while, but it’s becoming less preferred by carriers,” says Goulet. “In 15 years, it will probably still be here, but there will be significantly higher levels of contracts in value-based care. Anyone still doing fee-for-service will find reimbursement not increasing much, so it will be less and less beneficial to be in those contracts.”

The challenge for primary care providers is that every payer has its own version of what value-based care looks like, with different measures for evaluating quality, outcomes, interaction with other physicians treating the same patient, and efficiency, says Goulet, adding that one model insurers favor is the Patient-Centered Medical Home (PCMH).

“It’s fair to say that a primary care physician or primary care practice can increase earnings by 25 percent in bonus payments if actively engaged in PCMH,” says Goulet. “It allows them to increase quality, improve outcomes, and lower costs, therefore triggering bonus payments.”

The appeal to insurers is to identify patients with chronic conditions and pull them back into primary care practices, which can help them manage their conditions, says Goulet, who notes that it isn’t uncommon for insurers to have patients who visit the emergency department 35 or more times a year. The PCMH model was put in place not only to drive better outcomes, but provide smaller primary care practices a way to thrive in a value-based care market, so he says to expect continued emphasis on this and similar business models.

As Medicare moves toward value-based care and private payers add more incentives focused on outcomes, data becomes increasingly important for a practice’s reimbursement outlook.

Physicians in the MIPS program must track and submit data on a dizzying array of measures, and many private payer contracts have similar metrics that require data as the proof point. If a practice does not have the data to prove patients are achieving desired outcomes, reimbursement can take a substantial hit—up to 9 percent from MIPS alone by 2022. Combine this with private payer contracts that continue to incentivize value-based outcomes, and a substantial part of practice reimbursement could be endangered by a lack of performance data, experts say.

Accumulating and analyzing this data can be expensive, notes Ken Goulet, former president of Anthem Inc. and current board member at OODA Health. Consequently, Goulet says, doctors can expect to see more companies helping independent practices navigate the changing reimbursement landscape for negotiation and technology-support purposes, and insurers investing more in helping practices acquire and evaluate their data.

Goulet adds that another change practices may see as early as this year is more customized arrangements for primary care, based on region or even ZIP code. “Carriers are all going to more cloud-based capability and moving away from significant legacy software systems to pay claims,” he says. Once implemented, these systems will allow for flexibility in value-based contracts, faster payments, and easier interaction between providers and insurers.
While government policy may encourage provider consolidation, private payers don’t necessarily favor it, especially if small practices can work with them to improve outcomes. “Payers do prefer independent practices, and feel that working with them can keep costs down,” says Goulet.

Reimbursement in 2019 and beyond will require an increasing reliance on data from primary care practices proving to payers that they are meeting performance measures. “Reimbursement models will become more complex and also involve more and more measures,” says Friedberg.

PHYSICIAN FEE SCHEDULE AND E/M CHANGES

CMS created quite a stir in 2018 when it proposed consolidating E/M levels 2 through 5 into one payment rate. After listening to concerns from medical associations and others, the merging of payment levels has been delayed to 2021, and as currently proposed, will collapse levels 2-4 into a single payment rate, while retaining level 5 as a separate rate.

“If equating a level 2 visit with a level 5, it could create a disparity in reimbursement for those with multiple chronic conditions,” says Gilberg. Part of the reason behind the delay was the short timeline between the final rule announcement and when it would have to be implemented.

“It would be nearly impossible for all the software systems and EHR and payment vendors to get this up and running,” says Gilberg. So for now, E/M reimbursement levels remain unchanged, but expect to see further debate on what collapsing levels 2-4 would mean to physicians, says Gilberg.

Another significant PFS change for this year is the addition of codes for virtual check-ins, allowing physicians to bill for some evaluations done over the internet or phone. “It’s a little wonky in the sense that they don’t call it telehealth, but it is telehealth,” says Gilberg. “If physicians can now bill for the time spent talking to patients on the phone or internet, that will help alleviate the time taken away from other patients. From a financial standpoint, it allows reimbursement for common communications with patients.”

Nancy Enos, FACMPE, a professional coder, says physicians need to find out if their private payers will reimburse for these new codes. “Having the codes added to Medicare is a good first step, but it remains to be seen what private payers will cover them,” says Enos.

MISSING CODING OPPORTUNITIES

CMS may be adding new codes for remote consults, but Enos points out that physicians will miss out on many 2019 reimbursement opportunities if they don’t focus on the codes already in place, such as those for transitional care management (TCM) and chronic care management (CCM).

“Some docs use them, but don’t use them well,” says Enos, noting that common mistakes include not documenting patient discharge dates or noting phone calls within the required 24-hours of discharge. “If you are not using these TCM and CCM codes, you are really missing the boat on getting good reimbursement for time when you are not face-to-face with the patient.”

Another frequently-lost opportunity is the Medicare annual wellness visit. Enos says doctors often can bill for both the wellness checkup and for dealing with a chronic issue in the same visit provided they document it properly. “For some doctors, these extra codes are seen as either too much work, they don’t understand the details, or they think it’s only for a few extra dollars,” says Enos. “But those dollars add up.”

Enos says successfully capturing all the reimbursement a physician is eligible for requires a commitment by the entire office staff. “Assign a nurse to look at the patients who are due for physicals and coordinate screenings and the annual Medicare wellness check,” she says. “Call those that are overdue for appointments. Another person should be in charge of tracking patients that are in and out of the hospital and documenting what’s necessary for the care management codes.”

She advises starting with one code and working it into the office workflow. “If you say you are suddenly going to start tracking everything on Monday, by the end of the month, it’s all going to fall by the wayside,” says Enos. “You need some sort of reasonable, planned deployment to succeed.”

“Carriers are doing deals that generally reward physicians in value-based contracts, but minimize reimbursement increases if they are not involved in value-based benefits.”

KEN GOULET, FORMER EXECUTIVE VICE PRESIDENT OF ANTHEM INC., CURRENT BOARD MEMBER, OODA HEALTH
Physician moonlighting doesn’t require major travel burdens

Hearing about moonlighting and per-diem opportunities may frequently conjure up images of traveling long distances to go to work. You could be driving to some remote part of your state. You could be hopping on a plane to some far-flung part of the country to cover a hospital or clinic for a few days. That’s how it works, right? Wrong.

How about getting in your car and driving 20 minutes down the road? Or if you live in a big city, walking to work? Yes, it’s very possible to moonlight closer to home if that’s what you want. The great thing about working in this way is that it’s very much on you. Currently, there’s a massive physician shortage across the country, especially among generalists.

This is only getting worse with each passing year, and the shortfall is estimated to be over 100,000 doctors in the next decade. That’s a staggering number and obviously has huge implications for physicians’ work choices.

Healthcare institutions really need you. So if you are a smart about it, there are a multitude of options to take advantage of this supply-demand mismatch.

“The healthcare institutions really need you. So if you are a smart about it, there are a multitude of options to take advantage of this supply-demand mismatch.”

and this is unfortunately reflected in soaring burnout and job dissatisfaction statistics (topping 50 percent overall and climbing for all physicians, according to various reports.)

Breaking free from the administrative and bureaucratic headaches of regular full-time employment with a sole employer is one way to break the cycle and regain a bit of control and autonomy.

I have found that traveling far and having “mini-adventures” initially tended to suit doctors at the beginning or end of their careers. In other words, those without family commitments, or who’ve completed those responsibilities. This has changed over the last couple of years, and now doctors at all stages of their career are taking the leap.

For those desiring to work closer to home, if you live in or near a big urban center, you will likely have your pick of the bunch within a small radius. Will you have to be a bit flexible? Of course. Will you perhaps sacrifice a small amount of pay by working in a non-rural area? Probably. But it’s important to remember that setting yourself free from being beholden to only one place is always worth it, if you do it in a way that returns independence to your work life.

If you do decide that you can handle long-distance travel, most hospitals and clinics will reimburse you for all travel and accommodation costs. That’s something that should always be part of your contract negotiations, assuming you decide not to go through a locums agency or third-party recruiter.

When weighing your options, always consider the pros and cons of every opportunity, and how your work life will pan out logistically and practically. This will depend on a number of individual factors.

I always advise doctors to be as flexible as possible when making any travel decision, because great lucrative offers can be a game-changer. But the ultimate choice on how far you want to voyage is always yours.

Suneel Dhand, MD, is an internal medicine physician, author and speaker, and co-founder of DocsDox.com.
“If you are not using these TCM and CCM codes, you are really missing the boat on getting good reimbursement...”

NANCY ENOS, FACMPE, ENOS MEDICAL CODING
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“All diets work. It’s which works [for the patient], that’s the clincher.”

ANGELA FITCH, MD, MASSACHUSETTS GENERAL HOSPITAL WEIGHT CENTER, BOSTON
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The expected size of the artificial intelligence market in 2021.

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Advertising in Medical Economics has accelerated the growth of our program and business by putting me in contact with Health Care Professionals around the country who are the creators and innovators in their field. It has allowed me to help both my colleagues and their patients.
“Pay for performance means I never see my patients as just numbers anymore... Now, they’re also billing codes.”

The roots of physician burnout

While there are things physicians can do to improve their personal work-life balance, physician burnout is a systemic problem that must be fixed in a systemic way. In our coverage, we interview physicians and experts to discuss the causes of burnout and how physicians can fight for better, more healthy careers in medicine.
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