Physicians voice frustration over payer interference.

Doctors rate their payers.
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Physicians, patients should take on payer nuisance together

In the typical physician-patient interaction there is a constant presence lurking unseen in the exam room. Both parties know it’s there. The physician knows about the intruder, as it likely affects their recommended course of treatment. And the patient knows as well, often sweating out the doctor’s advice and next steps, as the same question rattles around their head: “Can I afford this?”

By now you’ve figured out who the lurker is: the insurance company. That constant nuisance to both medical professional and everyday patient. The payer does have its value and is, after decades of evolution, a standard part of life we’ve all learned to live with. But that doesn’t make it less annoying.

And to add to the irritation of both patient and doctor (who are both asked to “control costs” before and after their interaction) the average health insurance CEO’s salary was $16 million in 2016, according to the SEC. That’s around $307,000 per week to intervene in the healthcare of America’s patients and second-guess doctors who’ve spent years in school and real-life experience.

I understand health insurance companies are businesses, but tell that to the doctor wasting precious time with patients to haggle over a prescription. The patient needs critical medication, but it isn’t “on the list,” so if they want it, they can pay out of pocket. And tell that to the patient, who often has to decide between groceries on a given month or medication that will assist—or in some cases save—their lives.

Healthcare has adapted with new models like concierge medicine and direct primary care, two ways to get that pesky payer out of the room once and for all. But every doctor in the U.S. can’t decide to dump payers, or else that would throw healthcare into a tailspin.

Patients need insurance to offset costs for their medical care. Physicians need payers as partners to get compensated for those treatments. At this point, there is likely no going back.

But physicians and patients should work together to drive change in how payers interlope in their relationship. The cliché “strength in numbers” is appropriate here as larger numbers tend to force change. Instead of suffering in silent silos, the two sides should be working together to unify their voices.

Meet with legislators and suggest bills to better patient care. Hold press conferences side-by-side. Use social media to highlight and call out egregious actions.

It’s unlikely to reverse the obscene salaries of insurance CEOs, but true collaboration between our nation’s caregivers and patients’ customers can make some noise. And if there’s one thing payers hate more than seeing their bottom line slip, it is bad public relations—it’s not good for business.

Keith L. Martin is editorial director of Medical Economics. What is the key to reducing payer interference? Tell us at medec@ubm.com.
Cover Story

Drive change with payers

Physicians and patients must unite to apply pressure  PAGE 10

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Primary care physicians must harness the power of nutrition to improve patient outcomes, writes Glen R. Stream, MD. PAGE 41

In Every Issue

Interactive
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Funny bone

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SMARTER BUSINESS. BETTER PATIENT CARE.
5 tips to manage high-deductible health plans

With the rise in high-deductible health plans (HDHPs), practices must have a strategy to collect co-payments and co-insurance amounts before services are rendered, said Lovell D. Davis, MHA, CPC, director of revenue cycle management at Virginia Eye Institute in Richmond, Va.

Why are up-front collections important? "Once the patient leaves the office, the probability of collecting any outstanding balance decreases dramatically," said Davis.

Physicians sometimes shy away from up-front collections out of fear that patients will seek care elsewhere. However, up-front collections are a critical part of maintaining practice revenue, he said.

"This is the money that's used to maintain provider and staff salaries, purchase equipment, purchase new real estate, and more," said Lovell. "All of this money collected through insurance and patient responsibility goes back to the practice. Every effort must be made to collect dollars owed prior to rendering services."

Collecting patient payments up front also reduces write-offs, saves time, and reduces operational costs related to invoicing and follow-up, he said. It can also eliminate or significantly reduce the practice's reliance on costly collection agencies.

Lovell provided five tips to help practices manage patient payments more effectively.

MORE ONLINE To read the tips, visit bit.ly/HDHP-tips.

Bloggers

"With each year working in an underserved community, I am learning again and again that my patients' 'non-compliance' has less to do with a willful decision to disregard my medical advice, but much more to do with my poor understanding of the many barriers they face toward becoming healthy, and my failure to adjust my treatment plan accordingly."

Jack Tsai, MD, a California-based primary care physician on the importance of addressing social determinants of health

"I had always made it a point to stay utterly professional on the wards—no laughing, no crying, no weakness. But I found tears streaming down my face. I looked at him in dismay—with no solutions in hand—lost as to how a prion disease could annihilate someone's brain like this."

Ramin Rajaii, MD/ MBA candidate, on when doctors are defeated by a disease

MORE ONLINE Visit the Blog section at MedicalEconomics.com

For more, visit bit.ly/MEC-vaccines.
Physicians shouldn’t be saddled with ‘lousy EHRs’

The EHR as an obstacle to patient-doctor interaction in the exam room is another common physician complaint. Interestingly, it rarely comes up as a negative comment in our patient satisfaction survey. I find that very hard to believe. Every day I hear patients complaining that the “last doctor put their head in the computer and never even looked up at me when I was speaking.” It is not our job nor expertise to make the lousy EHRs work. I agree that they work very well for data mining. However, they are next to useless in the exam room. Have you not read the data stating that “for every hour a doctor spends with patients, we spend two hours documenting”? I don’t know what EHR you use, but it must be better that what the rest of us are using. Perhaps you could teach us how to “improve” our EHR.

(Online comment in response to “Don’t implode EHR use, improve it,” MedicalEconomics.com)

Kathleen Rheaume, MD
CHESTERFIELD, MICH.

Trust needs to be built on time together

The biggest factor for the loss of trust between physicians and patients (“The eroding trust between patients and doctors,” April 10), is the frenetic pace that most doctors work at. Perhaps older docs who have paid off their mortgages and educated their children can afford to spend 30 minute- to 60 minute-visits with patients, but younger ones just starting out cannot. They have to see 20 to 25 patients a day and it is impossible to develop a good relationship at that pace—whether they are in independent practice or employees of hospitals.

And now that telemedicine is being touted, trust will become even rarer as the “tele-docs” compete with patients’ primary care doctors.

“Perhaps older docs who have paid off their mortgages and educated their children can afford to spend 30 minute- to 60 minute-visits with patients, but younger ones just starting out cannot.”

Edward Volpintesta, MD
BETHEL, CONN.

Interaction with pharma reps is necessary

It’s a shame that these days, the companies that make the medications we use daily are getting a bad rep. Without them, there would be no medications. You and I didn’t invent them, they did. It’s unfortunate that today’s medical students and residents are taught that interaction with drug representatives is biased and unethical. Later, when they are in private practice, they will not know how to interact with pharmaceutical representatives and will likely get behind on offering their patients the best treatment plan.

I welcome representatives to update me on the newest medications, new guidelines, and ways to save my patients money. They are not twisting my arm. I am not biased. I have a brain. I can prescribe what I feel is best for my patient. And no, pharma companies are not taking my focus away from my patients. EHRs are, but don’t get me started about that.

Manoj Mohan, DO
OKEMOS, MICH.

Younger docs can’t really like EHRs . . . right?

I just made 20 copies of “Physicians need to take back the medical profession from EHRs” (Your Voice, March 25) to send to all my colleagues over 50 years old. Do providers who are less than 10 years into the profession see this the same way?

Joe Baum, MD
FLOYD, VA.
Physicians still find jobs the old-fashioned way

Most young physicians do not use social media to find a career in medicine. Instead, physicians use two decidedly old-fashioned, but still tried and true, methods: referrals and networking.

A new report from physician staffing firm CompHealth details how physicians search for their first job in medicine, what they are looking for in their careers, and provides a glimpse into how the medical job market is changing.

Here are four key findings from the report:

Physician job satisfaction remains high …

4 out of 5 physicians who finished residency between 2014 and 2016 are still working at their first position. 65% of these physicians say they are satisfied with their first job. Of those doctors who left to take a new position, 84% are satisfied with their second position.

… but physicians are still looking for new opportunities

The top 3 reasons physicians look for new jobs are:

- Compensation: 59%
- Work-life balance: 51%
- Bad management: 45%

*Men are more likely to leave due to compensation (69%); women are more likely to leave due to lack of work-life balance (56%).

Top 5 ways physicians found first jobs

- Personal/professional referral: 51%
- Networking: 48%
- Medical-specific online job boards: 39%
- Recruiter: 36%
- Directly through a hospital/facility: 34%

Physicians have financial concerns, mostly student loans

Student loan debt amounts:

- Less than $100,000: 12%
- $100,000 — $199,999: 19%
- More than $200,000: 44%
- No debt: 26%

Source: CompHealth, in partnership with Hanover Research
Understand the ‘midpoint rule’ when using time-based coding

How do I code by time when the time is 20 minutes, since that is exactly between the 15-minute 99213 and the 25-minute 99214?

A: The bad news is that Medicare has pretty clearly said that the “midpoint” rule—meaning more than halfway between two times listed qualifies you for the higher code—does not apply to the E/M codes. So if your practice is using the more conservative Medicare guidance for all patients, then the midpoint isn’t much use for E/M codes. The AMA and the CPT manual endorse this; Medicare specifically doesn’t. So at least for Medicare/Medicaid, if you are between two “typical” times, you have to use the lower. For commercial payers you could go with the midpoint (i.e. 21 minutes is enough for a 99214). But that said, 20 minutes on the dot will still fall to a 99213 if you are coding by time.

Q: For the primary presenting problem, I see the billing modifiers for “worsening,” “stable,” and “improving.” What do I do if a patient is “unstable but not getting worse and not yet getting better”?

A: This sounds like you are describing some menu options your EHR gives you to “characterize” problems. The CPT book and various other coding resources use lots of words to describe “moderate” level decision-making. Worsening, exacerbated, progressing, unstable, uncontrolled, poorly controlled, inadequate control, minor complication, inadequate response to treatment, side effects of treatment, increased risk of functional impairment, uncertain prognosis.... They all seem to reflect “activity” or “not stable.”

Q: We have a patient who is coming in for a hospital follow-up and would like a physical at the same time. Are we allowed to bill both? He isn’t a Medicare patient.

A: These are distinctly different services and should fall under the general provisions of modifier 25. The Transitional management codes 99495 or 99496 cannot have a modifier 25 appended, which may be a hint that it is intended to be billed alone. But a 99396 for example can take a modifier 25. So the combination 99396-25 and 99495 may well be acceptable. This would also be supported by the difference in diagnosis codes for the two services: the preventive code would most likely have a Z00 series code, while the TCM code would be linked to the specific problem diagnosis codes.

The CPT manual only states that the “same individual may report hospital or observation discharge services,” but makes no mention of other E/M codes or modifier 25. So there are no obvious contraindications to using these codes together, but coverage will still be up to any given payer.

Bill Dacey, CPC, MBA, MHA, is principal of the Dacey Group, a consulting firm dedicated to coding, billing, documentation, and compliance. Send your coding questions to medec@ubm.com.
Physicians are increasingly dealing with payer policies that interfere with their delivery of healthcare. Meanwhile, patients are seeing their physicians second-guessed and blocked by insurance companies, leaving them to wonder if they are truly receiving the best care possible or just the cheapest.

In this environment, it should come as no surprise that for the second straight year, the 2018 Medical Economics Payer Scorecard shows that physicians are greatly dissatisfied with the policies payers implement, many of which cost them both time and money.

The healthcare system is too focused on reducing costs and improving payer bottom lines, says Stephen Marmaras, director of state and national advocacy for the Global Healthy Living Foundation, which aims to improve the quality of life for people with chronic illness. "Physician autonomy and patient choice and overall patient outcomes fall victim to that prioritization in the system," he says, adding that prior authorizations and fail-first medication policies are the results of a bottom-line focus by payers.

"I can get one medicine covered for a patient, but only if they try and fail another one first," says Theresa Rohr-Kirchgraber, MD, FACP, an internist and founding member of the Doctor-Patient Rights Project, which advocates for doctors and patients driving care decisions. "It's a hard concept to explain to patients that they have to fail a medication.

The challenge for physicians is that there are multiple sources of interference. Each payer has its own rules and formularies, and state and federal regulations add another layer of frustration. So what can physicians do to fight back to retain their autonomy? Get involved.

Experts say that physicians must align themselves with other like-minded individuals to make sure their voice is heard and their autonomy is protected either through legislation or payer policy changes. This advocacy includes working with patient.
groups, professional societies, and legislators to make a difference in how medicine is practiced.

**WORKING WITH PATIENTS**

A vital ally in the fight for change is patients, says David O. Barbe, MD, MHA, president of the American Medical Association.

"Many of the problems physicians face, such as opaque prescription drug formularies or burdensome prior authorization processes, create difficulties for patients as well as physicians," he says. "And since patients outnumber physicians, having a well-organized patient group on your side amplifies your voice and raises both the visibility and persuasiveness of your argument."

Physicians want to help their patients access the care they need, and this may require recruiting them to help educate legislators or regulators on how their care is affected by policy changes. "This does require you to sometimes educate and encourage patients to be aware of the broader environment in which care is provided," says David Pugach, JD, senior vice president, public policy for the American Osteopathic Association. "Encourage patients to engage in the process when something impacts their ability to seek care. How they do that is up to the individual."

Patient advocacy groups, such as the Global Healthy Living Foundation, and disease-specific groups, may also weigh in on policy related to their disease. For example, the American Cancer Society may advocate for changes in how cancer treatments are covered by payers. These groups can help both physicians and their patients identify who to contact and craft messaging.

But no matter the strategy, Rohr-Kirchgraber says physicians must work with patients to improve healthcare. "I think as a collective group, we can make a difference," she says. "Patients can get a lot more accomplished with physicians alongside them than they could alone. We need stories from individual people and I encourage them to reach out and talk about it."

**WORKING WITH PROFESSIONAL SOCIETIES**

Patients aren’t the only source of help. Most physicians belong to at least one professional society, and these groups have advocacy resources that

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**Challenges of interacting with payers**

On scale of 1-5 (1 not at all challenging and 5 very challenging):

- **Number of prior authorizations**: 4.2
- **Frequent/unexplained denials**: 4.0
- **Negotiating**: 4.0
- **Customer service**: 3.9
- **Narrowing of networks**: 3.7

76% of solo physicians say negotiating contracts with payers is very challenging.
can help protect the profession from outside interference. “The old saying is true: There is strength in numbers,” says Barbe. “Physicians will be more successful in their efforts if they work through state medical societies, their national specialty societies, and local chapters. These membership organizations exist to serve their members and patients, and they want to hear from practicing physicians about obstacles they face in providing high-quality care.”

Pugach says phone calls from physicians about the same payer issue help direct his organization’s advocacy efforts and that they make a difference. “In public policy work, if we are not aware of the real-world impact of a policy change, we won’t know what to advocate for on behalf of doctors.”

Another way doctors can help with advocacy efforts is providing specific examples of how a particular policy affects patient care. Practice data can also help sway opinions in favor of doctors. “Changing processes that waste time and resources or those that impede public health policy goals are probably areas that are most responsive to good arguments and data,” says Barbe. “In fact, it is always a good idea to bolster your arguments with data, even if it is just from your own practice.”

WORKING WITH LEGISLATORS
Physician participation in the legislative process is important to protect autonomy, says Marmaras. The challenge for many doctors is finding the time for advocacy, but every contribution helps.

“One of the simplest things a physician can do is when there is a particular bill in their state on an issue, they can write an email to the sponsor of [the] legislation expressing support—that would be helpful for the sponsor,” he says. “The next step would be to write letters to the editor in local newspapers, and advocacy experts from profes-

How to ensure correct reimbursement from payers

Continued on page 34

Biggest frustration with prior authorizations

36% Time spent to get authorizations
35% Feeling as though a payer is telling me how to do my job/what’s best for my patients
9% Reasons for denial
8% Lack of clarity on what requires a prior authorization
8% Managing the number of outstanding requests
1% Other

AVERAGE NUMBER OF HOURS PER WEEK FOR PHYSICIANS

5.5 HOURS

AVERAGE NUMBER OF HOURS PER WEEK FOR STAFF

13.6 HOURS

Time spent weekly on prior authorizations

More than 20 hours

23%

Less than 11 hours

46%

0 hours

11%

Less than 11 hours

46%

0 hours

11%

Less than 11 hours

46%

0 hours

11%

More than 20 hours

4%

16-20 hours

3%

11-15 hours

4%

11%

Less than 11 hours

46%

0 hours

11%

Less than 11 hours

46%

0 hours

11%
Physicians might seem among the best-equipped people to deal with the harrowing and unexpected nature of emergencies, from manmade calamity to natural disasters.

However, research shows that many physicians are not as prepared as they could be. According to a 2015 study in Disaster Medicine and Public Health Preparedness, fewer than half of 1,603 practicing physicians interviewed felt prepared to handle a natural disaster. Additionally, less than one third signed up to receive mobile alerts for future emergencies with local and federal agencies.

"Where I see practices being successful is when they make emergency preparation an ongoing part of their operation, and they realize the importance of business continuity," says Molly Evans, JD, Washington, D.C.-based principal with the law firm Feldesman Tucker Fidell LLP, and an expert in CMS emergency preparedness rules.

Consider the experience of Jeff Giulian, MD, chief medical officer of hospital services for DaVita Kidney Care in Beaumont, Texas. When he heard of the threat of Hurricane Harvey in August 2017, his institution’s risk assessment made him aware that such a storm could threaten dialysis operations, which rely upon fresh, clean water for the procedure.

"We were able to start planning on the outpatient and inpatient dialysis side, [and] start working with our internal emergency management team to look for resources ahead of time," he says.

When the storm caused a water outage, DaVita’s preparation made it possible to obtain special dialysis machines that run on prepared bags of water, and to train nurses and technicians on how to use them within 48 hours.

"Had we not had those brainstorming sessions on Friday we wouldn’t have been ready to hit the ground running on Saturday, and dialyzing patients by Monday," Giulian says.

While CMS requires any practice or hospital that serves Medicare or Medicaid patients to comply with its new Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, state and local laws vary widely or may be vague, which may leave physicians waiting until after disaster strikes to put together a plan. However, Evans feels it would be a mistake for a practice to minimize the importance of emergency preparation.
**Trends**

Emergency preparedness

“At the debrief, everybody spoke up about how great it was to really be able to get quick communication out through this messaging application.”

—JAMES MCCABE, MD, CHIEF MEDICAL INFORMATION OFFICER, JEFFERSON HEALTH, IN CHERRY HILL, N.J.

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**WEIGH THE RISKS**

Assessing risks begins with what Evans calls a hazard vulnerability analysis of the most likely physical dangers to a practice’s safety and operations. “It’s important in healthcare that you figure out what are the likely scenarios you might face,” Evans explains.

For instance, practices on the east coast are more likely to face hurricanes and tornados, while those on the west coast may expect earthquakes, wildfires, and mudslides. However, unexpected situations could affect any practice, ranging from fire to network communications failures to active shooter situations.

As part of a risk assessment, Evans suggests developing relationships with local law enforcement agencies so that practices are not figuring out who to call in the middle of a crisis. She also recommends that physicians take advantage of checklists and recommendations from emergency management organizations such as the Red Cross, FEMA, and OSHA.

Lastly, don’t forget about the legal liabilities of emergency preparation.

“A failure to have a comprehensive emergency plan in place could definitely lead to heightened liabilities,” says Diane Doherty, MS, a former hospital risk manager and now senior vice president of Chubb Healthcare, which insures healthcare institutions. She recommends physicians look to their insurance carrier to conduct risk assessments and help train staff.

**PLANS IN ADVANCE**

Once a practice has assessed its risks, it’s crucial to develop an emergency plan that includes procedures and protocol for these events, and practice them at least once a year, Evans says.

The first thing physicians need to do after developing such a plan is to decide who is going to be responsible for implementing that plan, suggests Doherty. “You want to make sure the staff is educated about whatever policies you’re putting into place,” she says.

Joshua Weil, MD, assistant chief of hospital operations, and an emergency physician for Kaiser Permanente Santa Rosa Medical Center, in Santa Rosa, Calif., evacuated his hospital in October 2017, when wildfires devastated parts of northern California. He was grateful for the annual drills and practice runs.

“The more planned and prepared you are, the easier it is not to panic,” he says.

Weil reported to work in the emergency department just after midnight, with the scent of smoke heavy in the air. Accustomed to wildfires at that time of year, he didn’t think much of it until he overheard the chatter of fire-related injuries on the paramedics’ radios as they came in and out of the ED.

By 1 a.m. the ED was becoming chaotic and Weil made the call to open a command center, “a structure we have for managing crisis that can be anything from a power outage to equipment failure to something large scale like this,” he says.

He called in as many extra staff as he could get. At 2 a.m., when the fire commander on the scene told him the fire was just 200 yards away from the hospital but was not suggesting that evacuation was necessary yet, Weil made the call to evacuate all 122 patients from the hospital and ED anyway.

“In retrospect, it was clearly the right decision, as all major roads to evacuate by grew increasingly dangerous with fire and smoke, but in the moment I was thinking ‘I’m going to get in a lot of trouble for this,’” he says.

Weil credits quick thinking, prior drills, and a culture of...
“collegiality and cooperation” in which staff were all able to put aside hierarchy in favor of doing what was right for the patients, for the relatively smooth and quick evacuation.

COMMUNICATION IS KEY

Procedures and plans are only as productive as a practice’s communications plan, Evans says. Communication has to flow smoothly between physicians and staff, and between staff and patients.

“You want to know how you are going to get in touch with your staff when you are facing an emergency, and how you’re going to communicate externally with the local, state, and even federal emergency response personnel,” Evans says. In emergencies, particularly natural disasters, it’s easy to lose power and thus networks, threatening communications. Evans says it’s important to have backups.

In June 2015, a severe storm took down the computer network of Jefferson Health, in Cherry Hill, N.J., disrupting all the system’s operations. The network is a key part of patient care. “We document in their chart, place orders, review results and look at X-rays all electronically,” says James McCabe, MD, chief medical information officer.

He needed to get the word out to his staff all at once, particularly front-line staff such as physicians, nurses, x-ray technicians, and physical therapists. Fortunately, they had begun using a text messaging app called Tiger Connect that allows clinicians to text or message each other securely.

Through the app, which works on both Wi-Fi and cellular signals, he was able to message all staff members at once about the network disruption. And they were then able to relay news of the outage and its disruption to their patients.

“At the debrief, everybody spoke up about how great it was to really be able to get quick communication out through this messaging application,” McCabe says. Being able to message everyone simultaneously was especially valuable because it saved time and mitigated some frustrations.

KEEP PATIENTS INFORMED

In the face of an emergency, informing patients of challenges and disruptions to their care is as important as the flow of information between staff. Juan Carlos Millon, MD, a private practice pediatrician in Miami, Fla., alerted his patients by email several days in advance of Hurricane Irma’s touchdown in August 2017, that he would be closing his office several days prior. However, he knew that patients might become anxious about their healthcare in an emergency situation, so he made himself available for telemedicine visits.

“It was a way of helping our patients have access to some kind of medical care so they didn’t feel like they had to run to the ER in the middle of the storm,” Millon says. He was able to reassure one mother not to rush her baby to the ER, and encourage another patient to go before the storm grew too intense.

His only regret, and something he aims to learn from, is not checking in on his most in-need patients in advance. “I’m going to keep a running list of my sickest patients, because I had a couple of patients who went to the hospital probably unnecessarily because they were nervous,” he says.

He’s also looking for a way to contact patients via text message instead of email for the future, because it’s a quicker and more effective way of communicating.

STAY FLEXIBLE AND CREATIVE

No emergency will ever perfectly match the plan you lay out, says Kaiser’s Weil, so “creativity and flexibility are crucial.”

When they were about to begin evacuations, because tracking patients turned out to be very challenging, he says, each patient was assigned a staff member to make sure they weren’t declining or in crisis. As they were evacuating, one of his colleagues suggested using their iPhones to take pictures of each patient’s wristband as they were leaving the hospital. After evacuation, they reconciled their lists of patients who had been in the hospital with where they had landed to make sure everyone was accounted for.

He also recommends, when possible, partnering with other clinics, practices, and hospitals, especially if patient care is interrupted. With some 5,000 homes destroyed in the wildfire and evacuees fleeing with only minutes to spare and the clothes on their backs, Kaiser staff realized they would need to help patients refill medications and other prescriptions quickly. They worked with neighboring pharmacies to help patients fill prescriptions in a way that didn’t require them to come up with large sums of money.

“Had we not had those brainstorming sessions on Friday we wouldn’t have been ready to hit the ground running on Saturday.”

—JEFF GIULLIAN, MD, CHIEF MEDICAL OFFICER OF HOSPITAL SERVICES, DAVITA KIDNEY CARE, BEAUMONT, TEXAS
Lessons from the Las Vegas shooting

On Sunday, Oct. 1, 2017, Scott Scherr, MD, regional medical director for Team Health’s Sunrise Hospital in Las Vegas, Nev., received a text message that no physician wants to read: an active shooter was on the Las Vegas strip.

The gunman had opened fire with a semi-automatic weapon on concertgoers attending the Route 91 Harvest Music Festival. Considered the deadliest mass shooting by an individual in the United States, 58 people were killed and 851 more were injured.

Scherr jumped into action. “I just got on my scrubs and went into the hospital and got there shortly after all of the patients started to arrive. It was a crazy night,” he says.

Scherr had never seen a crisis of that magnitude in the ED. “We documented 215 patients that night, all of whom came in within the first fifteen minutes to an hour after the first shots.”

Under Scherr’s lead, the staff of the ED launched immediately into triage mode. Patients already in the 50-bed ED were moved to a smaller area or discharged. The space required for the shooting victims spilled over from the adult emergency department into the pediatric emergency department, he says. His step-tracking app revealed he put in 12.5 miles going to and from the adult emergency department and checking on the needs of patients and staff that night.

“Communication was difficult,” he recalls. Staff communicated primarily by walkie-talkies, but the sheer number of casualties threatened to overrun their resources. Fortunately, he was able to enlist 20 off-duty staff to come in and assist.

His medical school training to triage trauma victims by a color-coded system came in especially handy: Red-coded patients were the most critical and needed immediate care. Yellow patients had non-life threatening injuries but required observation. Green patients were walking wounded who would need medical care at some point. Patients coded black were not likely to survive. This allowed the staff to see, at a glance, who needed to go to the operating room most urgently, and how to prioritize their attentions.

Of the 215 patients arriving at the ED, there were over 60 admissions, 31 of them critical, and about 160 of them with shrapnel injuries or orthopedic injuries.

The scope of the crisis pushed staff to sacrifice traditional procedures in order to keep in their pockets. Next, they came up with a radiology workaround. “One of our radiologists followed the X-ray machine around and wrote the read on the patients’ gurneys. If they needed any immediate intervention, they would directly communicate with physicians,” Scherr says.

After they realized computer data entry was costing them time they didn’t have and not allowing for proper documentation in the chaos, they moved to a paper system, a step he highly recommends for mass casualty incidents.

He is especially proud that “egos were all thrown out the window,” as staff worked side-by-side to handle the influx of patients.

While emergency medical personnel see a lot of crises, Scherr says, “We are not used to seeing this scope of terror.” Treating such trauma left a lasting impact on staff, who processed the event in different ways. “The most important thing is to take your debriefing seriously,” Scherr urges.

Though this shooting may seem like a freak event, he urges any practice or medical system to be prepared for such an incident. “Mass casualty incidents are becoming more common. I’d like to say this was the last time this is going to happen, but that’s just not reality.”

“Mass casualty incidents are becoming more common. I’d like to say this was the last time this is going to happen, but that’s just not reality.”

—SCOTT SCHERR, MD, REGIONAL MEDICAL DIRECTOR, TEAM HEALTH’S SUNRISE HOSPITAL, LAS VEGAS, NEV.

“Lessons from the Las Vegas shooting”
Missed appointments and late arrivals: Who to bill and when

Late appointment cancellations and missed appointments are common. Unfortunately, patient actions affect physicians and patients in multiple ways. The patient is not receiving the medical treatment he or she needs, another patient who requires medical treatment is unable to take that appointment slot, and the physician’s office loses money because it cannot charge for services the physician would have otherwise rendered during that appointment.

No payer reimbursement
There is no Current Procedural Terminology code for late cancellations or missed appointments. When a patient does not cancel with adequate notice or fails to show for an appointment, payers, both government and commercial, refuse to reimburse because they do not consider it a medically necessary or covered service. In other words, a no-show falls outside the umbrella of what payers will reimburse, leaving the practice holding the bag.

While payers may not reimburse for no-shows, they also often do not prevent physicians from imposing financial penalties. Unless the physician has entered into a contract with a payer that prohibits late cancellation or no-show charges, the patient can be held directly liable if certain conditions are followed. Under CMS guidelines, Medicare also allows a no-show fee (assuming there is no contract that says otherwise) if the practice follows the rules.

Although each payer may have its own guidelines (which is why it is important that physicians look at each contract), most have the same basic requirements. The terms of the guidelines govern the circumstances under which a patient can be billed. For example, the practice may state that it can charge patients who cancel with less than 24-hours’ advance notice, or that showing up more than 30 minutes late can result in a no-show and a bill. Patients, however, must first be advised of the rules and, significantly, must sign an agreement whereby they explicitly consent to financial responsibility.

How much to charge?
The amount of the fee is left to the physician’s discretion, but it is important that the charge reflect a missed business opportunity, and not the amount the practice would have received had the patient not canceled or missed the appointment. Practices should also ensure that their no-show policy is consistent for all patients, regardless of the patient’s payer, and the dollar amount should be contained within the signed patient agreement. It is also good practice to document in the patient’s file any no-show instances to support the billing.

Written policy essential
Practices must provide a written policy that requires the respective patient’s signature prior to rendering services and (1) advises patients that their insurer or CMS will not cover late cancellations, missed appointments, or late arrivals because they are not covered services; (2) makes clear that by signing the agreement, the patient is consenting to financial liability for missed or late appointments; (3) explains that missed or late appointment charges are reflective of a missed business opportunity (e.g. “When you do not show up for a scheduled appointment, you are taking an appointment slot that could have been used for another patient”); and (4) specifies what the cancelation fee will be (e.g. $40 or $70).

Actually billing the no-shows or late arrivals is a powerful behavior tool that can reduce headaches while capturing what would otherwise be lost revenue.

Andrew H. Selesnick is a shareholder and Gemma Karapetyan is an attorney in Buchalter’s Los Angeles office, and members of the firm’s litigation and health care practice groups. Send your financial questions to medec@ubm.com.
Workplace

How to manage staff time off

Physicians can be both firm and fair when employees need personal time away

When she was younger, primary care physician Dana Corriel, MD, worked at Disneyland as an outdoor vendor in a bright yellow uniform. There, says the director of quality at Highland Medical, PC, in Pearl River, N.Y., she and her fellow employees of the park felt like family.

That feeling, she says, results in employees being happier and at a medical practice, patients pick up on that.

To achieve this balance, employees’ requests need to be respected—as do the employer’s.

A former practice owner, Corriel operated on the family principle. Employees were given the benefit of the doubt and requests for sick time were typically honored. If “abuse” occurred, she’d discuss it with the employee, but always aimed for a mutual respect and understanding from both sides.

Now in her hospital-owned office, employees who can’t find child care can bring sick children in to play in an isolated room, instead of not coming to work.

“[Doctors] feel we can’t call out or we’ll feel guilty,” she says. “There was a stigma attached to that, even during the rigorous years of residency training.”

Some practices in the hospital’s system have adopted strict rules now, even docking employees their vacation time when offices close for a snow day. “That doesn’t seem fair,” she says, “but those are the hospital’s rules. It makes us think long and hard before closing the office.”

To allow some flexibility to staff while also maintaining a business, plan to get creative and organized about it all, says Kate Othus, MHA, of Aldrich CPAs and Advisors in Oregon. She recommends these seven strategies:

1. Start a paid time off (PTO) bank.

The idea is to pool vacation days, sick time, and an employee’s personal time, so the employee can use what they need when they need it. Think about work-life balance. According to the Society for Human Resource Management, PTO excludes paid holidays, such as Labor Day, Memorial Day, and Thanksgiving.

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“PTO allows the employee to say, ‘I need the day off,’ without explaining why, so it creates some privacy for them,” says Othus. Salary.com notes that many healthcare organizations provide one set amount of paid days off for use at the employee’s discretion. Days off generally accumulate through years of service and the level of the employee within the organization.

2. Be consistent.

An employee handbook allows policy to be set in stone and avoid future conflict. “Maybe you think you’re creating a more flexible work environment,” says Othus. “But if you go case by case, instead of following what’s documented, a couple of employees compare notes, you may have to deal with poor morale issues, or be accused of favoritism—and not by design.”

3. Don’t mess with guessing.

Othus recommends a tracking system as part of your payroll software, to chronicle absenteeism. “Then you have actual data to measure, if an employee’s requests or time off become a problem,” she says.

Creating a record also means that when Employee A asks, and there is a record that they’ve been prompt and diligent, you can say, “You’re always here, and you can absolutely take the day off or leave early if you need to, because you always more than make up for that time.”

Conversely, if Employee B is almost always late, and may be having other “social” issues at work, and both are impacting their ability to perform to expectations, documentation is key when you say: “Wow, you were late five times out of 20 last month, so I’m going to have a hard time granting this request while your work piles up, and your co-worker is being asked to cover.”

That trumps a more subjective response such as, “Well, you’ve ‘kind of’ been late a lot,” and now you’re into the “feeling” part of deciding time off when you need to be tougher. Make sure from the get-go that policies
are written, updated, and understood, Othus says.

4. **Get legal help.**
   Maybe you’re wondering, “Is this vacation time or PTO?” Federal and state guidelines come into play, and since you’re a healthcare professional and not a lawyer, it’s always best to seek the advice of a practice employment attorney to ensure you’re not violating any statutes. Develop the policy, have it reviewed, and then explain it to your employees, maybe more than once.

5. **Understand all the options.**
   With a PTO program, you’ll need to make a few decisions. For example, is the time earned based on accrual and if so, can employees take time prior to full accrual? Your practice will need to develop guidelines for maternity, paternity, adoption, and surrogacy leave, along with bereavement leave. And, don’t forget jury duty. Have your handbook reviewed by your employment attorney, because issues related to leave can be complicated.

   Having a grasp, or paying someone to have that grasp, means less disruption to your small practice, says Othus. “Most small, independent practices run lean, with just the right amount of staff, or maybe even one short,” she says. “It’s rare to be overstaffed and physicians tend to err on the side of ‘just right.’”

6. **Have a Plan B.**
   It isn’t ideal when one employee has already gone to Mexico on a honeymoon, and another got called on to jury duty you thought would be one day, but could be long-term. “You may need to roll up your sleeves and call a temp service. And that person may not initially understand the organizational workflow, which is tough,” says Othus. “Still, it’s an option.”

7. **See the big picture.**
   Invest time into your human resources infrastructure so staff knows how to use their benefits. “This impacts your culture, which impacts patient care,” Othus says.

Stephanie Stephens is a California-based freelance digital journalist, producer, and host. Send your human resources questions to medec@ubm.com.
Leasing vs. buying medical office space

Securing space to practice is a big decision. Make sure to weigh all the risks and benefits of both options first

by JANET KIDD STEWART Contributing author

AS THE VALUE of medical office real estate rises, physicians may be leaning toward buying their offices rather than leasing. Owners typically have more control over occupancy costs and a shot at long-term appreciation, among other benefits, but experts say it's critical to understand both the local market and the career timeline of practice partners before deciding. Leasing, particularly over shorter time horizons, can be a much cheaper and safer option, experts say.

It's impossible to precisely forecast future real estate returns, and there are a host of individual factors that influence whether a physician should lease or own. Local market conditions, individual risk tolerance, likely length of stay in a given location, and the stability of a practice all factor into the decision.

Emotion often plays a role as well, even though practice experts typically try to dissuade clients from clinging too tightly to their biases. "Some doctors just seem to like to own things," says J.P. Roach, JD, MBA, senior vice president with Hughes Marino, an Irvine, Calif.-based real estate firm. "There's not much more teeth to their argument than that; they'd just rather own than lease."

To help make the best decision, consider both the benefits and risks of both options.

WHEN TO BUY

Physicians with both money and time can build equity and, over time, actually lower the cost of running a practice compared with leasing, experts say. Leasing, after all, involves paying a building owner a premium for occupying space.

Roach and other advisers say they typically like to see clients with at least 10 to 15 more years of active practice still ahead of them to make buying the best option. Toward the end of that timeline, mortgages are typically paid off or close to it, with the practice now owning a large share of equity in the office building. Meanwhile, leasing costs have risen most years and the practice has no equity to show for a lease.

The purchase price varies widely by location, of course, but loan terms to physicians tend to be favorable compared with other types of occupants because of their credit history and typically longer lengths of stay, experts say. Hospitals and private equity firms, meanwhile, have been aggressive medical office buyers in recent years, pushing down vacancy rates and boosting sales prices and lease rates in many markets.

"There's a lot of appeal in this segment for investors because we're late in the [economic] cycle and medical offices perform better than other..."
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Operations

Buying vs leasing

“I think it’s risky for a physician today to own their practice real estate, particularly if they are in primary care or are approaching retirement.”

—MARY BETH KUZMANOVICH, MBA, NATIONAL DIRECTOR OF HEALTHCARE SERVICES, COLLIERS INTERNATIONAL

Types of properties during recessions. That, along with the demographic trends, makes it compelling,” says Andrea Cross, Americas head of office research for Los Angeles-based CBRE Group Inc., a commercial real estate investment and services firm. Aging baby boomers’ increasing health needs are expected to keep demand high for medical real estate, she says, though there will be cycles to the growth.

“Demand for medical office investments is at an all-time high,” says Chris Bodnar, vice chairman and co-head of CBRE’s Healthcare Capital Markets Group. “It’s classified as recession-resistant based on previous market cycles, and investors putting money into spaces are looking at what type of real estate is going to perform best in the near-term. It’s a very good time to be a seller,” he says. And the sector’s ability to withstand economic downturns should maintain its appeal as an investment, he says.

Surging demand prompted CBRE in the summer of 2017 to issue its first-ever industry report on the U.S. medical office market. It found absorption of medical space surpassed supply during the previous seven years, lowering the national vacancy rate to 8 percent from about 11 percent in 2010.

There may also be a bonus to buying in the form of a recruiting tool. “[Private-practice] physicians often can’t offer loan forgiveness, but they can offer the opportunity to buy into a medical office building that builds equity,” says Amanda Waesch, JD, a partner with law firm Brennan, Manna & Diamond LLC who works with clients in several states.

All of my clients who have sold their office properties in the last 10 years have done extremely well,” says Waesch.

The downside? In a word: risk. If a nearby hospital moves, physicians could be stuck with a location that is no longer convenient for patients. Remodeling costs to keep the office attractive fall to owners as well.

And the pace of change within the medical office market has accelerated, increasing occupancy costs and the pressure to move. In a recent Medical Group Management Association (MGMA) poll, more than half of respondents reported they had remodeled their practices’ offices, added square footage or changed location in the last two years to stay relevant to patients, another possible downside to owning

Particularly after several years of expansion, it’s important to understand how a practice that owns its building would be affected by a real estate market reversal, experts say. Physicians who have purchased a building containing tenants, for example, need to be aware that when the market turns down, lease rates they are able to get from tenants will decline as well.

When to lease

Leasing is traditionally the safer option, according to Keith Borglum, CHBC, CBB, a longtime practice appraiser.

“I am discouraging physicians from owning their own buildings; the main reason being that it puts their real estate investment in the same risk basket as their professional risk. If they become disabled or lose a big insurance contract, their building also potentially loses a key tenant,” he says, meaning that a practice could take a hit substantial enough that it can no longer afford to stay in the building.

Leasing also typically has the advantage of significantly lower costs in the early years, though that often changes if a practice remains in a location long enough. Having an accountant project total costs over time for each strategy, including tax
implications, is critical to understanding where a practice's break-even points are, experts say.

Higher costs for leasing over longer periods compared to purchasing aren’t a given, says Russell Still, CVA, CHBC, executive vice president of Atlanta-based Medical Management Associates Inc. Owners may have a catastrophic event and be forced to sell at a loss, for example, a situation that would be mitigated if the practice leased space on a limited term.

Owners who get in a financial bind could rent the space out to other providers, but the rental market could be soft at that point and not bring in enough income to cover the cost of the mortgage, he says. And over the lifetime of a practice, the neighborhood could become less desirable, depressing resale prices.

He cites the example of a client who purchased a $300,000 building and after 15 years sold it for just $240,000. "It's half of what he originally expected, but at least he was able to sell," he says, which isn't always the case with highly undesirable locations. Selling at a loss can still be considered a win if it's cheaper than what the leasing costs would have been over time, though opportunity costs associated with tying up money in an owned building for many years would also have to be weighed.

"I think it's risky for a physician today to own their practice real estate, particularly if they are in primary care or are approaching retirement," says Mary Beth Kuzmanovich, MBA, national director of healthcare services for Colliers International, a global commercial real estate firm.

Primary care providers, as acquisition targets for hospitals, may find it a messy job to sort out a practice buyout offer if there are different real estate ownership structures for different partners, she says. These details can be written into a buy-sell agreement, but the complexity can be a turnoff for both buyers and sellers, she says.

And when some partners own while others rent, there can be a lot of tension around fair market value as owners may want to see higher rents for tax purposes than what non-owners expect to pay, she says. Again, these arrangements are typically spelled out in practice agreements, but they can be a continuing source of conflict as market values fluctuate, she says.

WHEN TO SELL AND LEASE

Remember that market conditions are a factor when deciding whether to buy or lease, and they are a factor when it comes time to sell as well.

Many physicians use their own medical office space as part of their retirement plan, leasing the space to younger physicians to produce a steady income stream when they stop practicing or selling and investing the proceeds. But there are other ways to play the hand, experts say.

For example, if a major hospital is expanding its footprint by acquisition, owners of nearby medical office properties could be in a good position to sell immediately for a strong price, even if retirement is not imminent. In those markets, experts say, physicians may consider selling their buildings and leasing them back from the buyer for the last few years before retirement rather than trying to become a landlord once they are no longer practicing. Similarly, trying to sell a vacant building after a physician retires reduces the pool of potential buyers because there is no longer a tenant. Having or adding practitioners to the practice can mitigate this, of course.

Alternatively, physicians could use their building as a kind of insurance policy by entering into an employment agreement and leasing the office to a hospital rather than selling, Waesch says. If the employment situation doesn't work out, the physician still owns his or her space and can go back to private practice after the lease terminates.

In the end, experts say, consider what the local market is saying about the type of location that will best suit patients over the long run. In some of the best locations, there sim-
Operations

Buying vs leasing

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—KÉITH BORGLUM, CHBC, CBB, PRACTICE CONSULTANT

ply aren’t buildings available for purchase, notes Kenneth T. Hertz, FACPMP, principal for MGMA’s Healthcare Consulting Group. In others, there may be relatively cheap land in a spot patients will love for years to come. “Is there a glut of office space there or a paucity?” he says. Taking advantage of what you have to work with in your community will pay dividends later on.

While it’s difficult to forecast far into the future where real estate is concerned, it’s important to keep the eventual sale of a medical office in mind when factoring in the needs of a practice’s partners, says Hertz.

Owning a property that houses a large group practice and leases space to other providers is an enviable position to be in today, with private equity investors eyeing these types of properties, he says. That’s because larger numbers of physicians mean larger revenue streams and less dependence on one practitioner. That’s a stark departure from just a few years ago, when some doctors struggled to unload office space after they had moved on to a new practice.

Finally, Hertz says, remember that renting or buying is a business decision, not an emotional one. Lining up the total operating costs and tax implications associated with both, and keeping in mind career timelines and current market conditions will help practices discover the right strategy.

Buying could be cheaper in the long run, but leasing a highly desirable location that isn’t available for sale could pay for itself in added revenue.

With this in mind, Hertz recommends a very simple question to the practice financial team to make the decision: “How does it affect the bottom line?”

“If leasing a new space helps you increase patient volume, make sure you project out what it’s going to do to overall costs over time. If the added growth still drops directly to the bottom line, what are you waiting for?”

5 questions to ask before buying or leasing

1. How long will I use it?
Uncertainty regarding market conditions or your practice’s stability means it might be better to lease.

2. Is this a retirement play?
There are better ways to save for retirement, so don’t buy a building just as a place to stash cash.

3. What’s your exit strategy?
Having a plan for unloading real estate is essential, particularly with solo physicians dwindling.

4. What are the real costs?
In a lease deal, make sure you understand annual costs can rise. Negotiating a cap on increases is a good strategy.

5. What are the tax implications?
Consult a tax expert before making any big financial decision, whether the plan is a purchase or a lease.
Tech Talk

3 ways to enhance EHR efficiency

The healthcare industry has been ready for an overhaul of the Meaningful Use program, and CMS Administrator Seema Verma announced at the HIMSS18 conference recently that the agency is prepared to deliver.

What can physicians expect? An increased focus on interoperability that provides timely access to health information combined with updated and streamlined evaluation and management (E/M) billing requirements that will allow physicians to spend less time using their EHRs and more time seeing patients.

The good news is that, right now, physicians can take simple steps to reduce the time they spend using the EHR. Consider the following:

1/ Use time-saving functionality.

Copy and paste or “copy forward” functions have gotten a bad reputation over the years because some physicians have used them to exaggerate the work they perform.

For example, providers clearly shouldn’t copy a level four E/M visit and paste it into an encounter for a sore throat. However, when used correctly (i.e., by taking a few seconds to validate that the information is appropriate and relevant), copy and paste saves considerable time. In addition, every physician should use disease-specific templates to facilitate documentation expediency. When available, physicians should also take advantage of predetermined care plans that include disease order sets for labs, tests, and medications.

One of the most common documentation-related complaints I hear is that physicians must document data points for the Merit-based Incentive Payment System (MIPS) in addition to the charting duties in the normal workflow.

This is essentially double the workload to provide the same exact information. Some EHRs are making progress to reduce this burden, for instance, by providing a reporting dashboard that allows physicians to select measures and easily pull them into a report.

Eventually, artificial intelligence (AI) will solve this problem altogether. Vendors will create AI-driven technology that extracts quality data directly from the narrative itself. We’re not there yet, but it’s only a matter of time before AI is widely used for a sustainable solution.

2/ Divide and conquer the workload.

Delegation is the key to survival under value-based payment models. Physicians can’t possibly fulfill quality metrics and document necessary details while continuing to see the same number of patients. Care managers play a critical role in engaging at-risk patient populations. When practices hire these individuals, they may also be able to more easily bill for chronic care management, transitional care management, and psychiatric collaborative care—three services that help optimize value-based payments.

In-person and virtual scribes are another option. At a median hourly wage of $11.74, medical scribes help physicians focus on patient care without the hassle of burdensome documentation requirements.

3/ Identify a super-user.

This could be a medical coder or administrative staff member who has undergone vendor training and who can serve as an internal resource when EHR-related questions arise (e.g., how to create a new template or update a “favorites” list). It’s like having a support tech embedded within your practice. Be sure to incentivize this individual with a bonus or a raise to reward them for their knowledge.

Moving forward with EHRs

It’s time for physicians to rewrite the narrative on EHRs. Vendors aren’t perfect, but many are striving to improve the technology so that it better aligns with value-based payment models. Likewise, physicians need to give EHRs a fair shot. They need to use the technology to its fullest capacity and also look beyond it to create workflows that support value-based care.

Tom Giannulli, MD, is a board-certified internist and the chief medical information officer at Kareo, a provider of technology-enabled solutions for independent physician practices. Send your technology questions to medec@ubm.com.
The power of physician voices

Organizations like the American Medical Association (AMA) can help you with that. The highest level of commitment is coming to the statehouse and testifying. Both state and federal issues should be followed by physicians, says Rohr-Kirchgraber. Federal legislation often influences state efforts, so getting involved in legislative efforts at the federal level can end up helping at the state level. Payers are regulated by state insurance agencies, so efforts must be made at the state level to affect decisions at the local level.

Keeping track of all the legislative changes and regulatory processes, and knowing which arguments are likely to sway legislators or regulators, is difficult for individual physicians to do, but if they work with their professional societies, they can stay updated and offer support, says Barbe. “No matter what the level of involvement, it is important for physicians to take time to inform themselves about the policy, the impact, the key decision-makers, and the legislative or regulatory status of the advocacy effort,” he says. “Newsletters and alerts and medical society websites are ready sources of this information.”

MAKING A DIFFERENCE

Many physicians may feel helpless to change a system that often seems stacked against them.

But doctors can absolutely make a difference, Pugach says, both with policymakers and private payers, if they get involved. He cites the increased flexibility in the MIPS program as one example of change. “I still don’t think the flexibility is enough, but continued input from physicians is critical,” he says. On the commercial payer side, he says, physician groups came together to voice opposition to a policy change reducing payments for evaluation and management services, and as a result of their efforts, the payer ultimately withdrew the policy. “There was strong data and the physician community was united and spoke with a singular voice.”

Barbe says that enacting change with private payers presents different challenges than policy issues because elected officials

Resources for physician and patient advocacy:

- Physiciansgrassrootsnetwork.org
- Patientsactionnetwork.org
- Doctorpatientrightsproject.org
- Global Healthy Living Foundation: ghlf.org
- Failfirsthurts.org
- 50statenetwork.org
- usapatientnetwork.org
aren’t involved, but it can still be done. “The AMA, for example, has been directly engaged with national insurer organizations to encourage ‘right-sizing’ of prior authorization policies,” he says.

But to achieve victories like this, physicians must invest the time to advocate on behalf of their profession before it’s too late, says Pugach. “I’ve seen a couple of letters from solo practitioners who are just tired and frustrated,” he says. “Costs for the practice have gone up and the administrative requirements have taken their toll.”

But the letters came too late to make a difference, “To hear something two years after the fact, is hard,” he adds. “The more people that get involved prospectively rather than after the fact, the greater the impact.”

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**How to ensure correct reimbursements from payers**

By Jeff Bendix, senior editor

When doctors join an insurance network, they naturally expect to be paid according to the amounts specified in their contract. But that doesn’t always happen. Experts say insurance companies sometimes underpay the contracted amount for a service or procedure—and practices often are unaware when it happens.

While there are no hard data as to how often or by how much insurance companies underpay, practice management consultants say it occurs frequently enough that doctors need to constantly monitor their reimbursements—particularly at a time when many practices are having difficulty making ends meet.

So what can practices do to guard against being short-changed by insurers? To start with, experts say, have each payer’s contract on-hand, since it will include the rates the practice has negotiated with the payer. And while that sounds fairly basic, a surprising number of practices don’t have copies of their payer contracts, says Ken Hertz, FACCMBE, principal consultant with the Medical Group Management Association.

“I guarantee that if I walked into 20 practices at random, 15 either won’t have their payer contracts or have them but can’t find them,” Hertz says.

With the contract and payment rates in hand, the next—and probably most important—step is to enter the payment data into the practice’s revenue management software. After that, the software will automatically alert the practice any time it receives a payment that doesn’t match the contracted amount. While it sounds simple in concept, practice management consultants acknowledge it’s often difficult to execute. That’s because most practices contract with numerous payers, each of which usually has multiple plans with separate fee schedules. Consequently, loading the fee schedules potentially becomes an extremely time-consuming task that can strain a practice’s resources.

“For most practices these days, it takes everything they’ve got just to get through the day,” says David Zetter, CHBC, founder and principal consultant of Zetter Healthcare in Mechanicsburg, Pa. “So then it becomes a question of, ‘Who’s got time to take on this extra project?’”

Nevertheless, Zetter and Hertz both recommend that practices undertake the task if at all possible, since it’s the most efficient way of determining whether the practice is being paid correctly. Moreover, Hertz notes, the project isn’t always as daunting as it first appears. At most primary care practices, only a handful of payers account for a large percentage of the reimbursements. And within that limited universe, most practices generally bill no more than a few dozen codes on a regular basis. So by focusing on those payers and codes, practices can maximize their return on the time required to load them.

**TAKING ACTION**

What recourse does a practice have if it finds it’s being reimbursed at less than the contracted amount? The first step, Hertz advises, is to see if there have been any changes to the payer’s fee schedule, which the practice usually can determine by checking on the payer’s website. If not, then the practice needs to review the insurer’s recent payments for the service to see if the error is a “one-off” or a regular occurrence.

Armed with that knowledge, the practice should alert the payer and say it expects to be paid the correct amount. If the payer hasn’t responded after about a month, he recommends following up with a request for an update on the corrected payment. “You have to be patient, be tenacious in your follow-up, and you have to be thorough and accurate in the information you present to them.”

If the payer still doesn’t respond, or refuses to correct the error, the next step is to notify the state’s insurance commissioner, since nearly all states have some form of “prompt payment” law. “Explain everything in detail, provide the information, and ask for an intervention/assistance in resolving the matter,” Hertz advises.

Knowing that an insurer has a pattern of underpaying also is important when negotiating the next contract with that payer, says Zetter—a tactic he often uses when bargaining on behalf of clients. “Part of our leverage is the knowledge that they haven’t been paying us [the client] appropriately to begin with,” he says.

“Besides, if [loading the fee schedules] is an awful lot of work if you’re just trying to find out if you’re being paid properly and have no intention of negotiating anything beyond that.”

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MedicalEconomics.com

2018 Payer Scorecard

JUNE 25, 2018 35

MEDICAL ECONOMICS
For the second year, *Medical Economics* has polled doctors to get to the heart of the payer-physician disconnect. More than 700 doctors nationwide shared their day-to-day experiences with insurers, highlighting major pain points and areas for improvement in our 2018 Payer Scorecard.

### Payers accepted

- **Commercial (private)**: 92%
- **Medicare**: 77%
- **Medicaid**: 63%
- **Either Medicare or Medicaid**: 88%
- **None, practice does not accept insurance**: 5%
Do you accept Obamacare plans?

- 75% YES
- 24% NO
- 1% NO ANSWER

Biggest challenges with Obamacare plans

- 58% Addressing high copay/deductible issues with patients
- 54% Low reimbursement from the payer
- 43% Coverage verification
- 37% Getting paid
- 11% None, no challenges with these plans
- 10% Other

-6% DECREASE IN PHYSICIANS ACCEPTING OBAMACARE VERSUS 2017

AVERAGE NUMBER OF PAYERS

14

NUMBER OF PAYERS

1-4 5-7 8-10 11-15 16-20 More than 20

8% 16% 25% 16% 15% 18%
## Payer Scorecard

Average rating of largest payer

### 0-10 scale; 0=poor, 10=excellent

<table>
<thead>
<tr>
<th>Category</th>
<th>Overall Average</th>
<th>Solo Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity of info on patient’s insurance card</td>
<td>4.2</td>
<td>3.9</td>
</tr>
<tr>
<td>Responsiveness to changes in patient data provided by practice</td>
<td>3.8</td>
<td>3.4</td>
</tr>
<tr>
<td>Pre-authorization process</td>
<td>3.7</td>
<td>3.4</td>
</tr>
<tr>
<td>Communication with patient on copays/deductibles</td>
<td>3.6</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Communication with Practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear identification of who practice should contact with inquiries</td>
<td>3.9</td>
<td>3.5</td>
</tr>
<tr>
<td>Notification of contract change</td>
<td>3.8</td>
<td>3.5</td>
</tr>
<tr>
<td>Ease of reporting health plan employer data and information set (HEDIS) info</td>
<td>3.8</td>
<td>3.3</td>
</tr>
<tr>
<td>Easy to navigate website/practice portal</td>
<td>3.7</td>
<td>3.2</td>
</tr>
<tr>
<td>Easy to navigate phone system</td>
<td>3.3</td>
<td>2.9</td>
</tr>
</tbody>
</table>

### Contract negotiations

**Q:** Who at your practice negotiates payer contracts? (multiple answers allowed)

- **Solo practice:** 40%
- **Hospital-owned practice:** 5%
- **Physician:** 46%
- **Practice manager:** 28%
- **Other staff:** 42%
- **Practice does not negotiate payer contracts:** 31%

**Practice does not negotiate payer contracts:** 26%
"Actually pay."

"If there is a denial, spell out clearly why. And if it’s a medication, what others in the class are covered or have to be tried?"

"Make formularies clear and easily accessible. Inform physicians and patients in advance when an impending formulary change will affect coverage of a medicine they are already prescribing/taking."

"Do not try to tell us how to do our jobs."

"Realistically, they can’t. We operate in a zero-sum game. If one side wins, the other side takes a loss. The physician leadership, from the last generation, conceded way too much ground. Why should they do anything to improve relations with physicians when they don’t have to?"

"Eliminate the need for unnecessary prior authorizations, particularly for medications a patient has used effectively for several years."

"Return phone calls."

"Just let us practice! Let physicians, in the appropriate specialty, decide what is appropriate."

"The U.S. needs a single-payer system. Commercial insurance is broken beyond repair."

"Decrease prior authorization requisitions, increase reimbursement."

"Payers must appreciate the value of smaller practices when negotiating contracts. It seems smaller practices—fewer 10 physicians—have no negotiating power."

"Provide easier, more immediate access to peers when appealing cases."
ABOUT THE PARTICIPANTS

**SPECIALTY**
- Family medicine: 18%
- Internal medicine: 17%
- Pediatrics: 17%
- OB/GYN: 13%
- Surgical specialty: 8%
- Dermatology: 5%
- Cardiology: 2%
- Other IM specialty: 1%
- Other: 19%

**Type of practice**
- Solo practice: 35%
- Independent group practice: 37%
- Owned by hospital/health system: 21%
- VA or other government system: 3%
- Other: 4%

**Number of physicians at practice**
- 1: 35%
- 2-5: 33%
- 6-10: 12%
- 11-25: 8%
- 26 or more: 12%

**Practice location**
- Midwest: 19%
- West: 21%
- Northeast: 22%
- South: 38%

**ABOUT THIS SURVEY**
The findings cited in this report are based on a survey conducted by ReadEx Research on behalf of Medical Economics. Data was collected via online survey between January 19 and February 2, 2018.

The survey received 734 responses from physicians. The results are based on the 626 respondents who indicated they are actively practicing medicine (full or part time). As with any research, the results should be interpreted with the potential of non-response bias in mind. It is unknown how those who responded to the survey may be different from those who did not respond.

The margin of error for percentages based on 626 tabulated responses is ±3.9 percentage points at the 95 percent confidence level. The margin of error for percentages based on smaller sample sizes will be larger.
A prescription for prevention

staggering seven out of every 10 deaths in America are caused by chronic disease complications. This is alarming on its own but especially so when you consider that some of the most common and costly diseases are largely preventable.

Indeed, much of the illness, suffering, and premature death associated with chronic diseases is caused or made worse by certain behaviors, such as lack of physical activity, poor nutrition, and tobacco and alcohol use. Unfortunately, promoting behavior change is often a complex and difficult challenge to address.

But there is hope. Primary care physicians across the nation are on the forefront of initiatives such as prescription-based programs that incentivize healthy behaviors like eating a balanced diet that includes fruits and vegetables.

Nutrition plays a critical role in preventing and managing chronic disease. However, despite the benefits of a healthy diet, fewer than one in five adults in the U.S. eat enough fruits and vegetables. Part of the problem is access; many people in this country, especially those who are poor, lack access to fresh produce, and are often left with few options other than cheap, processed, nutrient-deficient foods.

By “prescribing” healthy fruits and vegetables to patients with chronic diseases, physicians can help close the access gap. A great example is the pilot program being carried out by physicians at the Community Health and Social Services (CHASS) Center, a federally qualified health center in southwest Detroit. CHASS is among the first health centers to establish a fruit and vegetable prescription program, house a farmer’s market on-site and demonstrate improved patient outcomes. Uncontrolled type 2 diabetes patients were prescribed fruits and vegetables and given a Health Rx debit card to be used at the market. At follow up, patients showed a decrease in A1C levels.

According to CHASS Chief Medical Officer Richard Bryce, MD, the Health Rx Prescription Program actively engages patients in improving their own health through nutrition, adding that when patients see indicators, such as lower A1C levels or lower cholesterol levels, it “keeps them motivated to keep exploring more natural ways to improve health.”

Primary care practices across the country are following Bryce’s lead and continuing to foster innovative relationships within their communities to bridge the gap between the healthcare system and access to healthy food. In Texas, the Family Health Center of McLennan County has launched prescription produce and exercise programs. Through the programs, physicians at participating health centers write prescriptions for diet and exercise, World Hunger Relief harvests and delivers produce boxes to clinics where patients can pick them up at no cost, and exercise physiologists at Baylor University coach patients who have been prescribed an exercise protocol. These are just a few examples. Increasingly, health centers across the country are recognizing the value of prescribing fruits and vegetables as a means to address what is arguably the greatest health challenge facing our country today. By increasing access to fresh produce, through programs that deliver fruits and vegetables to those with limited access to them, local stakeholders—including physicians who care for low-income residents—can make a real difference in improving health outcomes and preventing chronic disease.

With 86 percent of our nation’s healthcare costs being spent caring for patients with chronic diseases, the time for innovative approaches to promoting healthy lifestyles is now and primary care physicians are well-positioned to take the lead in this effort. Leafy greens, long walks, and a prescription for prevention may be just what the doctor ordered.

Glen R. Stream, MD, is a primary care physician practicing in La Quinta, Calif. Send your comments to medec@ubm.com.
What is your guilty pleasure food?

<table>
<thead>
<tr>
<th>Advisor</th>
<th>Guilty Pleasure Food</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maria Young Chandler, MD, MBA</td>
<td>“Lobster.”</td>
</tr>
<tr>
<td>George G. Ellis, Jr., MD</td>
<td>“Barbeque ribs.”</td>
</tr>
<tr>
<td>Antonio Gamboa, MD, MBA</td>
<td>“Any carbs basically, but pizza from Home Slice is the ultimate.”</td>
</tr>
<tr>
<td>Jeffrey M. Kagan, MD</td>
<td>“Chocolate.”</td>
</tr>
<tr>
<td>Melissa E. Lucarelli, MD, FAAFP</td>
<td>“Haribo gummy bears.”</td>
</tr>
<tr>
<td>Joseph E. Scherger, MD</td>
<td>“Dark chocolate.”</td>
</tr>
<tr>
<td>Salvatore Volpe, MD</td>
<td>“Chocolate.”</td>
</tr>
</tbody>
</table>

The board members that contribute expertise and analysis to help shape content of *Medical Economics.*
“You have to build trust ahead of time so that when a natural disaster hits, you can all row in the same direction.”

JUAN CARLOS MILLON,
MD, PEDIATRICIAN, MIAMI, FLA.

PAGE 15

“Demand for medical office investments is at an all-time high. It’s a very good time to be a seller.”

CHRIS BODNAR, CBRE’S HEALTHCARE CAPITAL MARKETS GROUP

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54%
of physicians surveyed said low reimbursement is the biggest issue with Obamacare plans

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