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**Medical Economics**

**SMARTER BUSINESS. BETTER PATIENT CARE.**

**JULY 25, 2018**

**VOL. 95 NO. 14**

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Experts offer tips to get paid right the first time

- Level 3 and 4 E/M
- Chronic & transitional care management
- Modifiers -25, -26, and -59
- Denied claims

DOCTOR: BLAME CONGRESS FOR MEDICAL ERRORS
Patients are taking more control over their healthcare costs. From seeking price transparency for procedures to going online to search for the least expensive prescription, they are firmly in the driver’s seat today.

However, like any driver, proper caution can avoid a major disaster. And right now, the healthcare highway is a dangerous place for many Americans … and it could get worse.

Eight years ago, when the Affordable Care Act became law, the nation’s physicians were introduced to marketplace (or insurance exchange) plans. The goal? To save consumers money by letting them shop for what they believe is the right level of coverage for their healthcare needs at a price they could afford. The power of the healthcare dollar put right in the hands of consumers.

For patients, a less expensive plan often meant higher deductibles, copays, and costs for needed prescriptions. For physicians, tracking plan eligibility was a nightmare, turning them into insurance salesmen, explaining coverage and altering treatment plans.

Since then, enrollment has ebbed and flowed, premiums spiked, and costs rose for many seeking coverage.

Fast forward to today and the new “association health plans.” Seen by the Trump Administration as the answer to those Obamacare-induced high prices, the plans allow small businesses to join together to obtain coverage as a de facto single employer.

Many also see this as a way around the administration’s failed attempts to cut essential benefits from required health plans. The nation’s payer association—America’s Health Insurance Plans—warns that consumers may purchase association plans without knowing that they don’t offer these essential benefits.

The American College of Physicians is one of many physician groups that has voiced its concern that cheaper plans may offer fewer benefits.

What could possibly go wrong? I mean, besides destabilizing the insurance markets in some regions, causing premiums to skyrocket, and leaving individuals with large medical bills?

It’s 2018. Healthcare is politics as it was in 2010. That doesn’t mean making the same mistakes under a new name.

Patients—and physicians—deserve much better. All Americans must have better healthcare coverage that meets their financial means. The nation’s doctors need more avenues, not obstacles, to improve patient care. They shouldn’t have to navigate myriad cut-rate plans and find workarounds to much-needed treatment.

Washington, D.C., should be focused on providing better solutions to take care of its citizenry, not fighting over who had the better bad idea.

Keith L. Martin is editorial director of Medical Economics. Do you think association health plans will help or hurt those they cover? Tell us at medec@ubm.com.
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Blame Congress for medical errors
Our elected representatives have harmed the doctor-patient relationship, writes Ken Fisher, MD.

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MEDICAL ECONOMICS® SMARTER BUSINESS. BETTER PATIENT CARE.
Physicians make ideal wellness coaches

Wellness coaching is a growing field attracting doctors as a supplement to or as a replacement for medical practice. Primary care doctors, in particular, are well suited for this type of work because of the inherent experience with integrating overall health with day-to-day wellness.

The motivation for branching out into coaching varies from one physician to another. For example, Nancy Whatley, MD, of Asheville, N.C., has been practicing for almost 30 years and has seen many changes in medicine that interfered with the traditional doctor-patient relationship. These changes are what motivated her to make get into wellness coaching.

Having survived as a defendant in a medical malpractice case herself, Stacia Dearmin, MD, a primary care physician in Akron, Ohio, was motivated to help others because she felt that it was such an isolating experience.

Mani Saint-Victor, MD, who lives in the District of Columbia, specifically coaches doctors who are looking for clarity in their lives and careers. “The single most important thing I want doctors to know is that we put in an immense amount of work to get as far as we have and we deserve to be happy,” Saint-Victor says.

To read more, visit bit.ly/doc-to-coach.

9 ways to combat physician suicide

Pamela Wible, MD, has made it her mission to call attention to U.S. physician suicide. Here’s what Wible says physicians can do about the issue to help themselves and others.

bit.ly/9-suicide-prevention

Educating physicians about the dangers of opioids and limiting the prescriptions written is elementary. We already know the basic premise. ... However, most of the lay and medical community are not educated about the disease of addiction.”

— Leslie Rae Dye, MD, FACMT, on the true key to stopping America’s opioid crisis

“The solo private practice of medicine serves the patient that sits before us. It is an art as well as a science. It is a calling that needs to be nurtured and taught.”

— Howard Mandel, MD, defending the need for independent practice

VACCINES

Study: Pertussis vaccine is imperfect, but effective
- Vaccine harnesses immune system to fight opioid abuse
- Report: Immune cells could be reprogrammed to find hidden invaders like HIV

For more, visit bit.ly/MEC-vaccines.
As things change, private practice remains the same

n “No matter pressure applied, independent physicians will survive” (First Take, April 25), that 80-year-old physician who stated private practice will survive is absolutely right.

The reason is today’s healthcare is fueled by greed: from hospital corporations, pharmacy benefit managers, insurance companies, and the government. And greed breeds more greed—it is inevitable. And then the goose that laid the golden egg gets killed and what is left standing is physicians like him and myself (42 years in practice). I’ve seen it all before. The practice of medicine has been around since the ancient Greeks. There is nothing new as it’s all been done before and still the private practice remains essentially unchanged: one physician and one patient doing what has been done for thousands of years.

Dennis Grollo, MD
LIBERTYVILLE, ILL.

52 years in private practice and counting

Thank you for the editorial “No matter pressure applied, independent physicians will survive.” I have been in my private family practice for 52 years, practice full time, and like what I do. I am also a former chief of staff of Blount Memorial Hospital. It recently purchased a 50-member East Tennessee medical group, and to admit patients they must go through ED and, if admitted, on to the hospitalists.

Access to care is poor and many people are surprised when at times I actually answer my phone. Yes, I even find time to garden, play tennis, be on the local school board, and even recently published a book “A Family Doctor’s Journey and Diversions along the Way.”

Robert “Bob” Proffitt, MD
MARYVILLE, TENN.
Customer service quality will save or sink your practice

“Consumers have higher expectations for healthcare, perhaps more so than in any other industry.”
— Andrei Zimiles, CEO and co-founder, Doctor.com

Fair or not, here is what physicians are facing: Your customer service is being compared to Amazon. The online retail giant has changed what customers expect from a transaction, and that includes healthcare. Doctor.com surveyed more than 1,000 patients this year to discover how they shop for healthcare. Here are three takeaways from their research for physicians:

1. Patients depend on the internet to find a physician. Your digital presence impacts a patient’s decision at every step.
   - 76% of respondents over 60 years of age have made healthcare-related searches in the last year.
   - 63% of patients will choose one physician over another because of a strong online presence.
   - 82% of patients ranked customer service as the most important factor influencing their loyalty to a physician.

Source: Doctor.com

2. Word-of-mouth referrals are great, but must be accompanied by a strong online presence.
   - 81% of patients research providers, even after they received a word-of-mouth referral from friends or family.
   - 90% of patients will frequently change their mind about a referral they’ve received if the provider has a poor or weak online reputation.
   - 74% of patients will choose one physician over another because of negative online reviews.

3. Patients will not return to a practice or healthcare organization if they don’t enjoy a consistent customer experience throughout.
   - 86% of patients said if they are receiving quality care, a good customer experience is the most important element to earning a five-star review.
   - 62% of patients say good communication and continuous engagement influence their loyalty to your practice.
   - 42% of patients say text and email appointment reminders can increase their loyalty to a physician.
STATISTICALLY SIGNIFICANT REDUCTIONS IN A1C WHEN ADDED

Primary end point: A1C change from baseline at week 26

* N includes all randomized and treated patients with a baseline measurement of the outcome variable. At week 26, the primary A1C end point was missing for 10%, 11%, and 7% of patients, and during the trial, rescue medication was initiated by 16%, 1%, and 2% of patients randomized to placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively. Missing week 26 measurements were imputed using multiple imputation with a mean equal to the baseline value of the patient. Results include measurements collected after initiation of rescue medication. For those patients who did not receive rescue medication and had values measured at 26 weeks, the mean changes from baseline for A1C were −0.2%, −0.8%, and −0.9% for placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively.

b Intent-to-treat analysis using ANCOVA adjusted for baseline value, prior antihyperglycemic medication, and baseline estimated glomerular filtration rate (eGFR).

BL=baseline; LS=least squares.
Study design: 463 adults with type 2 diabetes, inadequately controlled (A1C between 7% and 10.5%) on metformin (≥1500 mg/day for ≥8 weeks) and sitagliptin 100 mg once daily participated in a randomized, double-blind, multicenter, 26-week, placebo-controlled study to evaluate the efficacy and safety of STEGLATRO. Study subjects were randomized to STEGLATRO 5 mg, STEGLATRO 15 mg, or placebo administered once daily in addition to continuation of background metformin and sitagliptin therapy. The primary efficacy end point was the change from baseline in A1C at week 26.

STEGLATRO is indicated as an adjunct to diet and exercise for appropriate adults with type 2 diabetes. STEGLATRO is not recommended in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis.

SELECTED SAFETY INFORMATION

Contraindications: STEGLATRO is contraindicated in patients with severe renal impairment, end-stage renal disease, or on dialysis, and/or a history of a serious hypersensitivity reaction to ertugliflozin.

Hypotension: STEGLATRO causes intravascular volume contraction. Symptomatic hypotension may occur after initiating STEGLATRO, particularly in patients with impaired renal function (estimated glomerular filtration rate [eGFR] less than 60 mL/min/1.73 m²), elderly patients (≥65 years), patients with low systolic blood pressure, or patients on diuretics. Before initiating STEGLATRO, volume status should be assessed and corrected if indicated. Monitor for signs and symptoms after initiating therapy.

Ketoacidosis: Ketoacidosis, a serious life-threatening condition requiring urgent hospitalization, has been reported in patients with type 1 and type 2 diabetes receiving sodium glucose co-transporter 2 (SGLT2) inhibitors, including STEGLATRO. Some cases were fatal. Assess patients with signs and symptoms of metabolic acidosis for ketoacidosis, regardless of blood glucose level. If ketoacidosis is suspected, STEGLATRO should be discontinued, patients should be evaluated, and prompt treatment should be instituted. Before initiating STEGLATRO, consider risk factors for ketoacidosis, including pancreatic insulin deficiency from any cause, caloric restriction, and alcohol abuse. In patients treated with STEGLATRO, consider monitoring for ketoacidosis and temporarily discontinuing STEGLATRO in clinical situations known to predispose to ketoacidosis (eg, prolonged fasting due to acute illness or surgery).

Additional Selected Safety Information on next page.
SELECTED SAFETY INFORMATION (continued)

Acute Kidney Injury and Impairment in Renal Function: STEGLATRO causes intravascular volume contraction and can cause renal impairment. There have been postmarketing reports of acute kidney injury, some requiring hospitalization and dialysis, in patients receiving SGLT2 inhibitors. Before initiating STEGLATRO, consider factors that may predispose patients to acute kidney injury. Consider temporarily discontinuing STEGLATRO in any setting of reduced oral intake or fluid losses; monitor patients for signs and symptoms of acute kidney injury. If acute kidney injury occurs, discontinue STEGLATRO promptly and institute treatment.

STEGLATRO increases serum creatinine and decreases eGFR. Patients with moderate renal impairment (eGFR 30 to less than 60 mL/min/1.73 m²) may be more susceptible to these changes. Renal function abnormalities can occur after initiating STEGLATRO. Renal function should be evaluated prior to initiating STEGLATRO and periodically thereafter. Use of STEGLATRO is not recommended when eGFR is persistently between 30 and less than 60 mL/min/1.73 m² and is contraindicated in patients with an eGFR less than 30 mL/min/1.73 m².

Urosepsis and Pyelonephritis: There have been postmarketing reports of serious urinary tract infections, including urosepsis and pyelonephritis, requiring hospitalization in patients receiving SGLT2 inhibitors. Cases of pyelonephritis also have been reported in patients treated with STEGLATRO in clinical trials. Treatment with SGLT2 inhibitors increases the risk for urinary tract infections. Evaluate patients for signs and symptoms of urinary tract infections and treat promptly, if indicated.

Lower Limb Amputations: An increased risk for lower limb amputation has been observed in clinical studies with another SGLT2 inhibitor. Across seven Phase 3 clinical trials with STEGLATRO, nontraumatic lower limb amputations were reported in 1 (0.1%) patient in the comparator group, 3 (0.2%) patients in the STEGLATRO 5-mg group, and 8 (0.5%) patients in the STEGLATRO 15-mg group. A causal association between STEGLATRO and lower limb amputation has not been definitively established. Before initiating STEGLATRO, consider factors that may predispose patients to the need for amputations. Monitor patients and discontinue STEGLATRO if complications occur. Counsel patients about the importance of routine preventative foot care.

Hypoglycemia With Concomitant Use With Insulin and Insulin Secretagogues: Insulin and insulin secretagogues (eg, sulfonylurea) are known to cause hypoglycemia. STEGLATRO may increase the risk of hypoglycemia when used in combination with insulin and/or an insulin secretagogue. Therefore, a lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with STEGLATRO.

Genital Mycotic Infections: STEGLATRO increases the risk of genital mycotic infections. Patients who have a history of genital mycotic infections or who are uncircumcised are more likely to develop genital mycotic infections. Monitor and treat appropriately.

Increases in Low-Density Lipoprotein Cholesterol (LDL-C): Dose-related increases in LDL-C can occur with STEGLATRO. Monitor and treat as appropriate.

Macrovascular Outcomes: There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with STEGLATRO.

The most common adverse reactions associated with STEGLATRO (≥5%) were female genital mycotic infections.

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

STEGLATRO™ (ertugliflozin) 5 mg, 15 mg tablets

INDICATIONS AND USAGE

STEGLATRO™ is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitations of Use

- STEGLATRO is not recommended in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis.

DOSE AND ADMINISTRATION

Recommended Dosage. The recommended starting dose of STEGLATRO is 5 mg once daily, taken in the morning, with or without food. In patients tolerating STEGLATRO 5 mg once daily, the dose may be increased to a maximum recommended dose of 15 mg once daily if additional glycemic control is needed. In patients with volume depletion, correct this condition prior to initiation of STEGLATRO (see Warnings and Precautions).

Patients with Renal Impairment. Assess renal function prior to initiation of STEGLATRO and periodically thereafter (see Warnings and Precautions). Use of STEGLATRO is contraindicated in patients with an eGFR less than 30 mL/min/1.73 m² (see Contraindications). Initiation of STEGLATRO is not recommended in patients with an eGFR of 30 mL/min/1.73 m² to less than 60 mL/min/1.73 m² (see Warnings and Precautions and Use in Specific Populations). Continued use of STEGLATRO is not recommended when eGFR is persistently between 30 and less than 60 mL/min/1.73 m². No dose adjustment is needed in patients with mild renal impairment.

CONTRAINDICATIONS

- Severe renal impairment, end-stage renal disease (ESRD), or dialysis (see Warnings and Precautions and Use in Specific Populations).
- History of a serious hypersensitivity reaction to STEGLATRO.

WARNINGS AND PRECAUTIONS

Hypotension. STEGLATRO causes intravascular volume contraction. Therefore, symptomatic hypotension may occur after initiating STEGLATRO (see Adverse Reactions) particularly in patients with impaired renal function (eGFR less than 60 mL/min/1.73 m²) (see Use in Specific Populations), elderly patients (≥65 years), in patients with low systolic blood pressure, and in patients on diuretics. Before initiating STEGLATRO, volume status should be assessed and corrected if indicated. Monitor for signs and symptoms of hypotension after initiating therapy.

Ketoacidosis. Reports of ketoacidosis, a serious life-threatening condition requiring urgent hospitalization, have been identified in clinical trials and postmarketing surveillance in patients with type 1 and type 2 diabetes mellitus receiving sodium glucoside co-transporter-2 (SGLT2) inhibitors and cases have been reported in STEGLATRO-treated patients in clinical trials. Across the clinical program, ketoacidosis was identified in 3 of 3,409 (0.1%) of STEGLATRO-treated patients and 0% of comparator-treated patients. Fatal cases of ketoacidosis have been reported in patients taking SGLT2 inhibitors. STEGLATRO is not indicated for the treatment of patients with type 1 diabetes mellitus (see Indications and Usage).

Patients treated with STEGLATRO who present with signs and symptoms consistent with severe metabolic acidosis should be assessed for ketoacidosis regardless of presenting blood glucose levels, as ketoacidosis associated with STEGLATRO may be present even if blood glucose levels are less than 250 mg/dL. If ketoacidosis is suspected, STEGLATRO should be discontinued, patient should be evaluated, and prompt treatment should be instituted. Treatment of ketoacidosis may require insulin, fluid and carbohydrate replacement.

In many of the reported cases, and particularly in patients with type 1 diabetes, the presence of ketoacidosis was not immediately recognized and institution of treatment was delayed because presenting blood glucose levels were below those typically expected for diabetic ketoacidosis (often less than 250 mg/dL). Signs and symptoms at presentation were consistent with dehydration and severe metabolic acidosis and included nausea, vomiting, abdominal pain, generalized malaise, and shortness of breath. In some but not all cases, factors predisposing to ketoacidosis such as insulin dose reduction, acute febrile illness, reduced caloric intake due to illness or surgery, pancreatic disorders suggesting insulin deficiency (e.g., type 1 diabetes, history of pancreatitis or pancreatic surgery), and alcohol abuse were identified.

Before initiating STEGLATRO, consider factors in the patient history that may predispose to ketoacidosis, including pancreatic insulin deficiency from any cause, caloric restriction, and alcohol abuse. In patients treated with STEGLATRO consider monitoring for ketoacidosis and temporarily discontinuing STEGLATRO in clinical situations known to predispose to ketoacidosis (e.g., prolonged fasting due to acute illness or surgery).

Acute Kidney Injury and Impairment in Renal Function. STEGLATRO causes intravascular volume contraction and can cause renal impairment (see Adverse Reactions). There have been postmarketing reports of acute kidney injury and some requiring hospitalization and dialysis in patients receiving SGLT2 inhibitors.

Before initiating STEGLATRO, consider factors that may predispose patients to acute kidney injury including hypovolemia, chronic renal insufficiency, congestive heart failure and concomitant medications (diuretics, ACE inhibitors, ARBs, NSAIDs). Consider temporarily discontinuing STEGLATRO in any setting of reduced oral intake (such as acute illness or fasting) or fluid losses (such as gastrointestinal illness or excessive heat exposure); monitor patients for signs and symptoms of acute kidney injury. If acute kidney injury occurs, discontinue STEGLATRO promptly and institute treatment.

STEGLATRO increases serum creatinine and decreases eGFR. Patients with moderate renal impairment (eGFR 30 to less than 60 mL/min/1.73 m²) may be more susceptible to these changes. Renal function abnormalities can occur after initiating STEGLATRO (see Adverse Reactions). Renal function should be evaluated prior to initiating STEGLATRO and periodically thereafter. Use of STEGLATRO is not recommended when eGFR is persistently between 30 and less than 60 mL/min/1.73 m² and is contraindicated in patients with an eGFR less than 30 mL/min/1.73 m² (see Dosage and Administration, Contraindications, and Use in Specific Populations).

Urosepsis and Pyelonephritis. There have been postmarketing reports of serious urinary tract infections, including urosepsis and pyelonephritis, requiring hospitalization in patients receiving SGLT2 inhibitors. Cases of pyelonephritis also have been reported in STEGLATRO-treated patients in clinical trials. Treatment with SGLT2 inhibitors increases the risk for urinary tract infections. Evaluate patients for signs and symptoms of urinary tract infections and treat promptly, if indicated (see Adverse Reactions).

Lower Limb Amputation. An increased risk for lower limb amputation (primarily of the toe) has been observed in clinical trials with another SGLT2 inhibitor. Across seven Phase 3 clinical trials in the STEGLATRO development program, non-traumatic lower limb amputations were reported in 1 (0.1%) patient in the comparator group, 3 (0.2%) patients in the STEGLATRO 5 mg group, and 8 (0.5%) patients in the STEGLATRO 15 mg group. A causal association between STEGLATRO and lower limb amputation has not been definitively established.

Before initiating STEGLATRO, consider factors in the patient history that may predispose them to the need for amputations, such as a history of prior amputation, peripheral vascular disease, neuropathy and diabetic foot ulcers. Counsel patients about the importance of routine preventative foot care. Monitor patients receiving STEGLATRO for signs and symptoms of infection (including osteomyelitis), new pain or tenderness, sores or ulcers involving the lower limbs, and discontinue STEGLATRO if these complications occur.

Hypoglycemia with Concomitant Use with Insulin and Insulin Secretagogues. Insulin and insulin secretagogues (e.g., sulfonylureas) are known to cause hypoglycemia. STEGLATRO may increase the risk of hypoglycemia when used in combination with insulin and/or an insulin secretagogue (see Adverse Reactions). Therefore, a lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with STEGLATRO.

Genital Mycotic Infections. STEGLATRO increases the risk of genital mycotic infections. Patients who have a history of genital mycotic infections or who are uncircumcised are more likely to develop genital mycotic infections (see Adverse Reactions). Monitor and treat appropriately.

Increases in Low-Density Lipoprotein Cholesterol (LDL-C). Dose-related increases in LDL-C can occur with STEGLATRO (see Adverse Reactions). Monitor and treat as appropriate.

Macrovascular Outcomes. There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with STEGLATRO.

ADVERSE REACTIONS

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

Table of Placebo-Controlled Trials Evaluating STEGLATRO 5 and 15 mg. The data in Table 1 are derived from a pool of three 26-week, placebo-controlled trials. STEGLATRO was used as monotherapy in one trial and as add-on therapy in two trials. These data reflect exposure of 1,029 patients to STEGLATRO with a mean exposure duration of approximately 25 weeks. Patients received STEGLATRO 5 mg (N=519), STEGLATRO 15 mg (N=510), or placebo (N=515) once daily. The mean age of the population was 57 years and 2% were older than 75 years of age. Fifty-three percent (53%) of the population was male and 75% were Caucasian, 15% were Asian, and 7% were Black or African American. At baseline the population had diabetes for an average of 7.5 years, had a mean HbA1c of 8.1%, and 19.4% had established microvascular complications of diabetes. Baseline renal function (mean eGFR 88.9 mL/min/1.73 m²) was normal or mildly impaired in 97% of patients and moderately impaired in 3% of patients.
Table 1: Adverse Reactions Reported in ≥2% of Patients with Type 2 Diabetes Mellitus Treated with STEGLATRO™ and Greater than Placebo in Pooled Placebo-Controlled Clinical Studies of STEGLATRO™ Monotherapy or Combination Therapy

<table>
<thead>
<tr>
<th></th>
<th>Placebo N = 515</th>
<th>STEGLATRO 5 mg N = 519</th>
<th>STEGLATRO 15 mg N = 510</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female genital mycotic infections</strong>¹</td>
<td>3.0%</td>
<td>9.1%</td>
<td>12.2%</td>
</tr>
<tr>
<td><strong>Male genital mycotic infections</strong>²</td>
<td>0.4%</td>
<td>3.7%</td>
<td>4.2%</td>
</tr>
<tr>
<td><strong>Urinary tract infections</strong>³</td>
<td>3.9%</td>
<td>4.0%</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>Headache</strong></td>
<td>2.3%</td>
<td>3.5%</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Vaginal pruritus</strong>⁴</td>
<td>0.4%</td>
<td>2.8%</td>
<td>2.4%</td>
</tr>
<tr>
<td><strong>Increased urination</strong>⁵</td>
<td>1.0%</td>
<td>2.7%</td>
<td>2.4%</td>
</tr>
<tr>
<td><strong>Nasopharyngitis</strong></td>
<td>2.3%</td>
<td>2.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Back pain</strong></td>
<td>2.3%</td>
<td>1.7%</td>
<td>2.5%</td>
</tr>
<tr>
<td><strong>Weight decreased</strong></td>
<td>1.0%</td>
<td>1.2%</td>
<td>2.4%</td>
</tr>
<tr>
<td><strong>Thirst</strong>⁶</td>
<td>0.6%</td>
<td>2.7%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

¹ Includes: genital candidiasis, genital infection fungal, vaginal infection, vulvitis, vulvovaginal candidiasis, vulvovaginal mycotic infection, and vulvovaginitis. Percentages calculated with the number of female patients in each group as denominator: placebo (N=235), STEGLATRO 5 mg (N=252), STEGLATRO 15 mg (N=245).
² Includes: balanitis candida, balanoposthitis, genital infection, and genital infection fungal. Percentages calculated with the number of male patients in each group as denominator: placebo (N=280), STEGLATRO 5 mg (N=261), STEGLATRO 15 mg (N=265).
³ Includes: cystitis, dysuria, streptococcal urinary tract infection, urethritis, urinary tract infection.
⁴ Includes: vulvovaginal pruritus and pruritus genital. Percentages calculated with the number of female patients in each group as denominator: placebo (N=235), ertugliflozin 5 mg (N=252), ertugliflozin 15 mg (N=245).
⁵ Includes: polikakia, retention urgency, prolapse, urine output increased, and nocturia.
⁶ Includes: thirst, dry mouth, polydipsia, and dry throat.

Volume Depletion. STEGLATRO causes an osmotic diuresis, which may lead to intravascular volume contraction and adverse reactions related to volume depletion, particularly in patients with imppaired renal function (eGFR less than 60 mL/min/1.73 m²). In patients with moderate renal impairment, adverse reactions related to volume depletion (e.g., dehydration, diziness, palpitations, syncope, syncope, hypotension, and orthostatic hypotension) were reported in 0%, 4.4%, and 1.9% of patients treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively. STEGLATRO may also increase the risk of hypotension in other patients at risk for volume depletion (see Use in Specific Populations).

Ketoacidosis. Across the clinical program, ketoacidosis was identified in 3 of 3,409 (0.1%) ertugliflozin-treated patients and 0.0% of comparator-treated patients. (see Warnings and Precautions).

Impairment in Renal Function. Treatment with STEGLATRO was associated with increases in serum creatinine and decreases in eGFR (see Table 2). Patients with moderate renal impairment at baseline had larger mean changes. In a study patients with moderate renal impairment, these abnormal laboratory findings were observed to reverse after treatment discontinuation (see Use in Specific Populations).

Table 2: Changes from Baseline in Serum Creatinine and eGFR in the Pool of Three 26-Week Placebo-Controlled Studies, and a 26-Week Moderate Renal Impairment Study in Patients with Type 2 Diabetes Mellitus

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Baseline Mean</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine (mg/dL)</td>
<td>0.83</td>
<td>0.82</td>
<td>0.82</td>
</tr>
<tr>
<td>eGFR (mL/min/1.73 m²)</td>
<td>89.5</td>
<td>88.2</td>
<td>89.0</td>
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<tr>
<td><strong>Week 6 Change</strong></td>
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<tr>
<td>Creatinine (mg/dL)</td>
<td>0.00</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>eGFR (mL/min/1.73 m²)</td>
<td>-0.3</td>
<td>-2.7</td>
<td>-3.1</td>
</tr>
<tr>
<td><strong>Week 26 Change</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine (mg/dL)</td>
<td>-0.01</td>
<td>0.00</td>
<td>0.01</td>
</tr>
<tr>
<td>eGFR (mL/min/1.73 m²)</td>
<td>0.6</td>
<td>-3.2</td>
<td>-4.1</td>
</tr>
</tbody>
</table>

Renal-related adverse reactions (e.g., acute kidney injury, renal impairment, acute renal failure) may occur in patients treated with STEGLATRO, particularly in patients with moderate renal impairment where the incidence of renald-related adverse reactions was 0.6%, 2.5%, and 1.3% in patients treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively. Lower Limb Amputation. Across seven Place 3 clinical trials in which STEGLATRO was studied as monotherapy and in combination with other antihyperglycemic agents, non-traumatic lower limb amputations occurred in 1 of 1,450 (0.1%) in the non-STEGLATRO group, 3 of 1,716 (0.2%) in the STEGLATRO 5 mg group, and 8 of 1,693 (0.5%) in the STEGLATRO 15 mg group.

Hypoglycemia. The incidence of hypoglycemia by study is shown in Table 3.

Table 3: Incidence of Overall* and Severe† Hypoglycemia in Placebo-Controlled Clinical Studies in Patients with Type 2 Diabetes Mellitus

<table>
<thead>
<tr>
<th></th>
<th>Placebo (N=235)</th>
<th>STEGLATRO 5 mg (N=252)</th>
<th>STEGLATRO 15 mg (N=245)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypoglycemic events</td>
<td>48 (36.1)</td>
<td>53 (35.8)</td>
<td>39 (27.3)</td>
</tr>
<tr>
<td>Severe</td>
<td>3 (2.3)</td>
<td>5 (3.4)</td>
<td>3 (2.1)</td>
</tr>
</tbody>
</table>

* Overall hypoglycemic events: plasma or capillary glucose of less than or equal to 70 mg/dL.
† Severe hypoglycemic events: required assistance, lost consciousness, or experienced a seizure regardless of blood glucose.
Genital Mycotic Infections. In the pool of three placebo-controlled clinical trials, the incidence of male genital mycotic infections (e.g., balanitis candida, balanoposthitis, genital infection, genital infection fungus) occurred in 4.4%, 3.7%, and 4.2% of males treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively (see Table 1). Male genital mycotic infections occurred more commonly in uncircumcised males. In males, discontinuations due to male genital mycotic infections occurred in 0% and 0.2% of patients treated with placebo and STEGLATRO, respectively. Phimosis was reported in 8% of the STEGLATRO-treated patients, of which four required circumcision.

Drug Interactions

Concomitant Use with Insulin and Insulin Secretagogues. STEGLATRO may increase the risk of hypoglycemia when used in combination with insulin and/or on insulin secretagogues (see Adverse Reactions). Therefore, a lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with STEGLATRO (see Warnings and Precautions).

Positive Urine Glucose Test. Monitoring glyceric control with urine glucose tests is not recommended in patients taking SGLT2 inhibitors or SGLT2 inhibitors increase urinary glucose excretion and will lead to positive urine glucose tests. Use alternative methods to monitor glyceric control.

Interference with 1,5-anhydroglucitol (1,5-AG) Assay. Monitoring glyceric control with 1,5-AG assay is not recommended as measurements of 1,5-AG are unreliable in assessing glyceric control in patients taking SGLT2 inhibitors. Use alternative methods to monitor glyceric control.

Use in Specific Populations

Pregnancy.

Risk Summary. Based on animal data showing adverse renal effects, STEGLATRO is not recommended during the second and third trimesters of pregnancy. The limited available data with STEGLATRO in pregnant women are not sufficient to determine a drug-associated risk of adverse developmental outcomes. There are risks to the mother and fetus associated with poorly controlled diabetes in pregnant women are not sufficient to determine a drug-associated risk of adverse developmental outcomes. Use alternative methods to monitor glyceric control.

In animal studies, adverse renal changes were observed in rats when erugliflozin was administered during a period of renal development corresponding to the late second and third trimesters of human pregnancy. Doses approximately 10 times the maximum clinical dose caused renal pelvic and tubule dilations and renal mineralization that were not fully reversible. There was no evidence of fetal harm in rats or rabbits at exposures of erugliflozin approximately 300 times higher than the maximal clinical dose of 15 mg/day when administered during organogenesis (see Data). The estimated background risk of major birth defects is 6-10% in women with pre-gestational diabetes with a HbA1c >7 and has been reported to be as high as 20-25% in women with HbA1c >10. The estimated background risk of miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% and 15-20%, respectively.

Clinical Considerations.

In utero and during the first month of life, STEGLATRO did not adversely affect developmental outcomes in rats and rabbits at maternal exposures that were approximately 300 times the human exposure at the maximum clinical dose of 15 mg/day, based on AUC. A maternally toxic dose (250 mg/kg/day) in rats (707 times the clinical dose), was associated with reduced fetal viability, and a higher incidence of a visceral malformation (membranous ventricular septal defect). In the pre- and post-natal development study in pregnant rats, erugliflozin was administered to the dams from gestation day 6 through lactation day 21 (weaning). Decreased post-natal growth (weight gain) was observed at maternal doses ≥100 mg/kg/day (greater than or equal to 331 times the human exposure at the maximum clinical dose of 15 mg/day, based on AUC).

Lactation.

Risk Summary. There is no information regarding the presence of STEGLATRO in human milk, the effects on the breastfed infant, or the effects on milk production. Ertugliflozin is present in the milk of lactating rats (see Data). Since human kidney maturation occurs in utero and during the first 2 years of life when lactational exposure may occur, there may be risk to the developing human kidney. Because of the potential for serious adverse reactions in a breastfed infant, advise women that the use of STEGLATRO is not recommended while breastfeeding.

Data.

Animal Data. The lacteal excretion of radiolabeled erugliflozin in lactating rats was evaluated 10 to 12 days after parturition. Ertugliflozin derived radioactivity exposure in milk and plasma were similar, with a milk/plasma ratio of 1.07, based on AUC. Juvenile rats directly exposed to STEGLATRO during a developmental period corresponding to human kidney maturation were associated with a risk to the developing kidney (persistent increased organ weight, renal mineralization, and renal pelvic and tubular dilations). STEGLATRO is expected to have diminished efficacy in elderly patients with renal impairment (see Use in Specific Populations).

Renal Impairment. The safety and efficacy of STEGLATRO have not been established in patients with type 2 diabetes mellitus and moderate renal impairment. Compared to placebo-treated patients, patients with moderate renal impairment treated with STEGLATRO did not have improvement in glycemic control, and had increased risks for renal impairment, renally related adverse reactions and volume depletion adverse reactions (see Dosage and Administration, Warnings and Precautions and Adverse Reactions). Therefore, STEGLATRO is not recommended in this population. STEGLATRO is contraindicated in patients with severe renal impairment, ESRD, or receiving dialysis. STEGLATRO is not expected to be effective in these patient populations (see Contraindications). STEGLATRO was not studied in patients with severe renal impairment and is not recommended for use in this patient population.

OVERDOSAGE

In the event of an overdose with STEGLATRO, contact the Poison Control Center. Employ the usual supportive measures as dictated by the patient's clinical status. Removal of erugliflozin by hemodialysis has not been studied.

For more detailed information, please read the prescribing information. uspirk8835+r1712r000

Revised 12/2017

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DIAB-1251861-0003 06/18
Submitting codes for reimbursement can be time-consuming, and it doesn’t even guarantee payment. However, it’s also a necessary part of accepting insurance.

The good news is physicians can employ several strategies to rid themselves of billing headaches and collect the money they’re entitled. We’ve focused on six coding-related topics that readers have identified as particularly problematic to help physicians generate and retain revenue.

**Coding tips from the pros:**

1. **Level 3 vs. 4 evaluation and management**
2. **Chronic care management**
3. **Transitional care management**
4. **Time-based evaluation and management**
5. **Modifiers -25, -26, and -59**
6. **Denied claims**
Money

The difference between a level 3 and level 4 office visit might not seem like much, but to payers, these visit types each tell a completely different story about the work that’s required to treat a patient.

When physicians report a level 4 evaluation and management (E/M) code, they're telling payers they should be paid more because their patient requires medical management for an exacerbation of an existing chronic condition, a complication, or a new problem, says Raemarie Jimenez, CPC, vice president of membership and certification solutions at AAPC in Salt Lake City, Utah. Payers may deny level 4 E/M codes for patients who respond well to treatment and are generally well-managed, she adds.

When using an EHR, though, it’s easy for physicians to default to a level 4 E/M code that might not be justified, says Jimenez. That’s because the EHR pulls information forward that might not be clinically relevant or even pre-populates information that falsely inflates the actual work the physician performs. “The computer just picks up on keywords and boxes, but it’s not smart enough to realize that a visit might be over-documented,” she adds.

For example, pulling information forward, such as a comprehensive family history or a complete review of systems, can inadvertently drive a level 4 E/M code when the nature of the presenting problem (e.g., otitis media) in no way supports this level of service, explains Jimenez. Over time, it may appear to payers that a physician is upcoding as compared to peers.

To avoid payer scrutiny, Jimenez advises physicians always to ask themselves these three questions before assigning a level 4 E/M code:
1. Is this patient sicker than most of the patients I see?
2. What specifically elevates the level of effort that’s required to treat this patient? Have I documented this information in the record?
3. Have I reported the most specific ICD-10-CM diagnosis code to justify patient severity?

Physicians should also know whether their EHR might be putting them at risk for upcoding. Jimenez says to consider these three questions:
1. Does the EHR auto-populate information and require physicians to deselect what’s not pertinent to the visit?
   For example, an EHR might auto-populate a complete review of systems and require physicians to deselect the systems they don’t review with the patient. This practice is extremely risky because physicians don’t often remember to review the information or they may simply forget to deselect it, says Jimenez. Best practice is for physicians to manually select what they want to bring forward. It shouldn’t happen automatically, she adds.
2. Do diagnosis-specific templates require physicians to perform certain tasks every time they see a patient?
   All work must be clinically relevant, says Jimenez. “Physicians shouldn’t be forced to do something just because the EHR is telling them to do it. Everything they do should be based on their own clinical judgment.”

— RAEMARIE JIMENEZ, CPC, VICE PRESIDENT OF MEMBERSHIP AND CERTIFICATION SOLUTIONS, AAPC, SALT LAKE CITY, UTAH

LEVEL 3 VS. 4 EVALUATION AND MANAGEMENT

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
<th>2018 national average Medicare payment</th>
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</thead>
<tbody>
<tr>
<td>99203</td>
<td>Level 3 office visit</td>
<td>New patient</td>
</tr>
<tr>
<td>99204</td>
<td>Level 4 office visit</td>
<td>New patient</td>
</tr>
<tr>
<td>99213</td>
<td>Level 3 office visit</td>
<td>Established patient</td>
</tr>
<tr>
<td>99214</td>
<td>Level 4 office visit</td>
<td>Established patient</td>
</tr>
</tbody>
</table>

“Physicians shouldn’t be forced to do something just because the EHR is telling them to do it. Everything they do should be based on their own clinical judgment.”

— RAEMARIE JIMENEZ, CPC, VICE PRESIDENT OF MEMBERSHIP AND CERTIFICATION SOLUTIONS, AAPC, SALT LAKE CITY, UTAH

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them to do it. Everything they do should be based on their own clinical judgment.”

3. Does the EHR require physicians to bill a certain code?
The code that the system calculates may not be accurate, and physicians always need the ability to override it when necessary, says Jimenez.

She provides the example of a physician who includes rule-out diagnoses for continuity-of-care purposes. If the physician isn’t actively managing these conditions, they shouldn’t be counted toward the visit’s E/M level. If the EHR gives credit for this information, physicians need to recognize that the E/M level may be inflated, and they should override the code manually, she says. □

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**CHRONIC CARE MANAGEMENT (CCM)**

<table>
<thead>
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<th>CPT code</th>
<th>Description</th>
<th>2018 national average Medicare payment</th>
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</thead>
<tbody>
<tr>
<td>99490</td>
<td>Chronic care management</td>
<td>$42.84</td>
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<tr>
<td>99487</td>
<td>Complex chronic care management</td>
<td>$94.68</td>
</tr>
<tr>
<td>99489</td>
<td>Each additional 30 minutes</td>
<td>$47.16</td>
</tr>
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</table>

PAYERS AND THE OFFICE OF INSPECTOR GENERAL (OIG) ARE STARTING TO CRACK DOWN ON IMPROPER PAYMENTS FOR CCM. THE MESSAGE TO PRACTICES IS: FOCUS ON ACCURATE CODING, OR RUN THE RISK OF RECOUPMENTS, SAYS KIM GARNER HUEY, CPC, OWNER OF KGG CODING AND REIMBURSEMENT CONSULTING IN BIRMINGHAM, ALA.

Here are some common CCM denials and how to avoid them:

**Reason for denial:** More than one provider bills CCM for the same patient during the same 30-day timeframe.

**How to avoid it:** Coordinate care with specialists to avoid duplication, says Huey. This coordination should occur at the physician-to-physician level. The primary care physician and specialist should collaborate and decide who will perform all or a majority of the care management activities, including addressing the patient’s psychosocial needs. This is the provider who should bill the CCM code, she adds.

**Reason for denial:** The care plan is too generic.

**How to avoid it:** Document a comprehensive plan of care that addresses all of the patient’s medical needs—not only the two minimum qualifying chronic conditions, says Huey. Avoid using templated language that isn’t specific to the patient, she adds.

**Reason for denial:** CCM services aren’t appropriate for the patient.

**How to avoid it:** Explain why the chronic conditions put the patient at significant risk of death or decline, says Huey. For example, one patient may have well-controlled diabetes while another could be uncontrolled or have multiple complications. Always choose the most specific diagnosis code in the EHR, and avoid unspecified codes when possible, she adds. □

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Continued on page 36

MEDICAL ECONOMICS 1 JULY 25, 2018

MEDICALECONOMICS.com
Today, a significant majority of our personal electronics are embedded with virtual assistant software: the Google Assistant, Apple’s Siri, and Amazon’s Alexa among them. With these virtual assistants safely residing in our devices, we can speak to our phones, watches, computers, and now smart speakers.

Smart speakers are capable of understanding and implementing tens of thousands of actions based on simple voice commands. These devices have slowly trickled into our offices due to their massive potential and ability to keep track of calendar entries with a simple voice command. It goes without saying that many physicians and healthcare professionals will be tempted to use their functions for note taking, web research, or accessing medical records.

But before you do, don’t.

Beware smart speakers

These virtual assistant programs are not yet in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

The well-known goal of HIPAA is to protect patient protected health information. Private health information is the most sensitive, and incredibly under-secured, information in the world today.

It is understandable that Alexa and the Google Assistant need to jump through some more hoops before being allowed in a hospital room and access to medical records. While Google and Amazon have worked on making their cloud services compliant with HIPAA’s standards, neither smart speaker with their respective virtual assistant is HIPAA compliant at this time.

Physicians, hospitals, and practices should proceed—for the near term—as though Alexa, Siri, and the Google Assistant are not HIPAA-compliant. Failure on the part of the physician to secure medical record data can cost them hundreds of thousands of dollars and enable identity theft.

The challenges

Virtual assistants must first be programmed to avoid mistakes and abuse related to healthcare. For example, if hospitals use Alexa to draft hospital notes and include the ability to make orders for procedures or medications, hospital procedures would need to be implemented to prevent anyone who is not a physician from walking into someone’s room and creating an order. Also, if the smart speaker incorrectly “hears” the name of a medication and places an order for the wrong one, that would create obvious issues.

Once the technology is more advanced and protections are in place, it will be up to hospitals to properly implement the voice-activated technology into the healthcare system.

What you can do

This does not mean that your new, eager virtual assistant cannot be used for healthcare purposes. For example, getting your patient to use his or her smart home device to set a reminder to take medications at a certain time would be an acceptable use because it is a generic request. However, ordering a prescription for your patient through the service to set a reminder to take medications at a certain time would be an acceptable use because it is a generic request.

Asking Google to look up the definition of a medical term is acceptable; however, setting a reminder to tell patient Jane at her appointment that her headaches are caused by eating ice cream too quickly would be a HIPAA violation as this act would be synonymous with leaving a handwritten note with the same information out in your office lobby for anyone to read.

Kevin Peek, JD, is an associate and Kyle Habrich, JD, is counsel at Sandberg Phoenix in St. Louis. Send your technology questions to medec@ubm.com.
Providing primary care to the uninsured patient

by ROB LAMBERTS, MD, FACP Contributing author

The Affordable Care Act (ACA) was supposed to eliminate the problem of uninsured patients by making affordable insurance available to all Americans. While the law made an early impact, the cost of even the least comprehensive plans eventually rose out of the affordable range for many people. The repeal of the ACA individual mandate will likely cause a surge in the number of people not carrying individual policies. While the biggest impact of this will be in the hospital and specialty areas (where cost is highest), the effect on primary care practices will be significant.

Working in a direct primary care practice (that does not accept insurance for payment), I have a higher proportion of uninsured patients and have had to develop strategies of getting care for these patients. I will address this issue mainly from a primary care perspective.

The uninsured patient is at constant risk of developing conditions that could quickly bankrupt them. This makes the job of the PCP—who has to manage the care in such a way to minimize need for specialists and hospital care—critical to both the health and financial well-being of the patient. Attention to this real and significant stress will not only help the patient, but will reassure them that the care they are getting is comprehensive.

Here are some guidelines for handling uninsured patients in the primary care setting.

COST WILL DRIVE CARE
People can’t pay for what they can’t afford. This seems obvious, but in healthcare this causes significant stress. The patient with diabetes who has no medication coverage will usually choose high sugar food over paying $300 per month for a medication that doesn’t change how they feel. Don’t get frustrated at this fact; it’s just life priorities.

Yes, there are some who would take high sugars over a $20 per month cost, but don’t confuse the two. It is our job as clinicians to offer care that can actually be received by the patient. Ignoring cost is no different than ignoring a medication’s side effects.

This also means that the clinician must understand the difference between “recommended” and “necessary.” Getting a chest X-ray for possible pneumonia may be recommended, but often it’s only necessary to treat with antibiotics. A person with a possible foot or hand fracture doesn’t always need to go to the ED or even the specialist. Many fractures can be managed without problem in the primary care setting and be done at a fraction of the cost. Simply focusing on those necessary tests and procedures can save significant money.

KNOW WHERE TO GET THE LOWEST PRICES
Medicine is notorious for having opaque pricing, and this can drive people to access-
Trends

“People are more than just physical bodies, and should be considered on all levels, including economic. Caring for people’s financial health may lead to better overall health.”

Possible but often dangerous alternatives to the care we provide. This may need to be the case with insured patients, as the “cost” of any procedure or medication will depend on negotiated prices and formularies. But the uninsured (or underinsured) patient does have the advantage of being able to discuss prices up front.

For medications, there are several websites that can be used to compare and reduce prices. GoodRx, the most well-known of these sites (which also has a smartphone app), allows users to put in a drug name and compare prices at local pharmacies. The prices listed are actually discounted prices, negotiated and agreed upon by both the pharmacy and GoodRx.

We check GoodRx whenever prescribing anything for an uninsured patient, either to find them the lowest price or to see if they can afford the medication at all. It’s often very eye-opening to see just how expensive even generic medications can be.

There are other websites/apps that do the same, such as Blink Health or LowestMed. Encourage your patients to download one or all of these apps to reduce their cost burden.

Prices are seldom affordable for brand-name medications, but pharmaceutical companies have fairly liberal policies for giving medications away to people with low to moderate incomes. My staff uses NeedyMed to search across multiple drug companies’ programs for free medications.

Once the staff becomes familiar with the requirements and the mechanics of filling out the forms, the process can be quite fast and people can get the medications needed to manage their diseases.

Price shopping is not limited to medications. We have found low prices for radiology tests ($250 CT scans, $550 MRI scans), cardiac testing ($100 stress tests, $150 echocardiograms), and recently found a gynecologist that did colposcopies for $150 cash (plus $88 for biopsy). All we did was to call around and ask the various facilities for their cash prices. Yes, it’s really that easy.

BE FIRM WHEN YOU HAVE TO

There are obviously times when cost has to be ignored. A person with appendicitis or sepsis doesn’t have the option to shop for care. They simply have to get care now and worry about cost later.

Fortunately, most hospitals will negotiate down prices substantially after the patient is discharged. Plus, grant money is available to most hospitals for the care of indigent and uninsured patients. The social workers in these facilities will do whatever is necessary to get the patient some sort of funding for their care. The financial reward for doing so is huge.

The care of the uninsured patient is certainly more challenging in many ways. It causes great frustration when a person needs care they simply cannot afford. But there are ways to address that cost and doing so can definitely be seen as part of the process of giving care. People are more than just physical bodies, and should be considered on all levels, including economic.

Caring for people’s financial health may lead to better overall health, as they get care they can afford and are willing to follow through. Doing so will not only make things better for the patients, but it will win their gratitude and trust, both of which are key to a healthy therapeutic partnership.

Robert Lamberts, MD, is a board certified internist and pediatrician who runs Dr. Rob Lamberts, LLC, a direct primary care practice in Augusta, Ga.
Physicians may suspect providers they know or do business with may be involved in illegal arrangements. Being proactive, counsel can make the difference between physicians continuing to practice medicine and having their license suspended, even if they haven’t done anything wrong. Here are two examples.

Preventive measures
A client had concerns about a practice for which he had been providing services one day per week as a contractor for several years. He was paid a percentage of his own collections and received weekly statements of the work he had performed and the amounts collected. My client heard rumors that the owner’s license to practice had been suspended and that there may have been improper billing by the owner under other providers’ national provider identifiers (NPIs). My client didn’t want to accuse his long-time colleague without more information, but also didn’t want to jeopardize his job. My client questioned the owner about the rumors in person and via email/text. He received no solid answers but was reassured it was a “misunderstanding.”

I convinced him immediate action was needed. He provided notice of termination and requested a summary of all billing performed in his name and under his NPI. He also reminded the practice owner that his NPI, Drug Enforcement Administration (DEA) registration number, name, and other identifying information could no longer be used by the practice. He took steps to make sure any authorizations were terminated.

Days later, my client received a visit from government investigators asking questions about his former boss. Although caught off guard, my client answered all questions and was able to relay and prove his disassociation with the practice.

Suspicious affiliations
In sharp contrast to the above situation, last year I dealt with a physician who learned that parties with whom he worked at a clinic (the “third parties”) had been investigated and indicted related to wrongful use of a physician’s DEA number. Many months after becoming aware of the third parties’ conduct, he finally left the clinic to focus on his own practice. Later, he decided to hire the same third parties to work for him in his own practice.

The DEA soon came to ask why he had allowed the third parties to use his DEA number after he left the clinic. Although he had no knowledge of the wrongful use of his DEA number, his failure to terminate his DEA registration at the site and continued affiliation with the third parties created suspicion. He faced suspension of his medical license.

Precautions all physicians should take:

- Do not allow your NPI, name, or DEA number to be used improperly. Be vigilant and seek out records related to all use of such numbers.
- Terminate the use of your NPI/DEA by an organization when you terminate employment/engagement.
- Do not sign off on documents you have not reviewed or do not understand.
- Terminate any mid-level supervision arrangement with the state, if applicable, when you leave an organization.
- Never accept cash or gifts from third parties without questioning legitimacy.
- Question activities in which your employer/colleagues are engaged if you believe they are illegal or non-compliant. Check with counsel in advance for certainty.
- Be mindful of the company you keep. Association with those who engage in wrongful conduct can impact you and potentially open you to investigation.
- Consider terminating any arrangement for which you have evidence is illegal/non-compliant and puts you at risk.

The bottom line
Review every situation that arises before making any decision. It’s important to remember that in some cases, physicians may simply be mistaken. Asking the right questions can resolve the issue. If not, take immediate action.

Ericka L. Adler, JD is a partner at the firm Roetzel & Andress. Her primary practice focus is in the areas of regulatory and transactional healthcare law. Send your legal questions to medec@ubm.com.
Smartphones are ubiquitous. Beyond phone calls and texting, rarely does a moment go by without an urge to peek at the latest Facebook message or newest Instagram picture. While this may be fine at home, it can cause some problems in a medical practice setting if staff members use their smartphones to access social media.

Nitin S. Damle, MD, MS, MACP, board member and physician at South County Internal Medicine in Wakefield, R.I., says his staff are instructed to leave their phones in their lockers and turned off during work hours. “There is no reason anyone should be getting onto any website other than one that is related to work during working hours,” he says.

What about break time? Some practices allow use of staff smartphones during breaks, but within specific guidelines.

For example, personal social media accounts must be clearly personal and not representative of the office, practice, or health system and no protected patient or other office-related data can appear anywhere on those personal accounts.

Damle adds that the same rules that apply to use of social media at work apply to personal phone calls as well. “There are certainly exceptions in more acute circumstances—for example, when an employee has an ill family member—but an employee who has to be constantly accessible to an elderly parent, for example, taking multiple phone calls from the parent or caregivers during patient care hours wouldn’t bode well for work performance,” he says.

Facebook friends with patients?

A more challenging issue is personal social media relationships between staff and patients.

Sometimes office staff may refer friends or relatives to the practice, which can also be tricky where social media is concerned. In situations like these, the staff member already has a relationship with the patient, so physicians should emphasize that they should not use social media to give medical advice, information, scheduling, test results, or any other practice-related communications via their personal account.

Instead, practice-related communications should flow through normal channels, such as the secure patient portal.

Outside the office

Although it is more difficult to control staff members’ social media behavior outside the office, ground rules can still be established. “Clearly, staff members shouldn’t talk about patients, even if they de-identify them, or about co-employees, or employers,” he says.

Patients also should not post photographs of the work site, patients, physicians, or medical personnel. He emphasizes that if this type of activity comes to his attention, “it is immediate grounds for dismissal.”

However, if the staff member is a friend or relative of a patient, it is acceptable to post pictures that might include the patient in an out-of-office setting. Photographs taken within the office might seem innocuous, but can also potentially compromise the privacy of other staff members. For example, perhaps one of the physicians has pictures of his family on his desk—or of patients, even after hours. These posted pictures can also give the misimpression that the photographer is speaking on behalf of the practice.

Damle concludes by stressing that patient care “is at the center of any medical practice” and anything that causes a distraction or interruption of that care, such as inappropriate use of social media, should be avoided.

Batya Swift Yasgur is a contributing author. Send your human resource questions to medec@ubm.com.
ONE ASPECT THAT physicians may face as they conduct their quality reporting under CMS’s Merit-based Incentive Payment System (MIPS) in 2018 are “topped-out measures.”

This year’s MIPS guidelines require practices to report on a number of categories in order to be evaluated and receive additional reimbursements under the Quality Payment Program (QPP). In MIPS, categories are weighted differently, with the Quality category accounting for 50 percent of the final score practices receive (the most-weighted category in the 2018 reporting period).

Practices will select six quality measures to report on from more than 200 available measures within the Quality category. “Topped-out measures” are specific quality measures in which—according to CMS—“meaningful distinctions and improvement in performance can no longer be made.”

For example, a process measure (which make up half of all measures) would be topped-out if median performance is 95 percent or higher—or 5 percent or lower if it is scored inversely, both of which would be deemed too easily attainable.

Topped-out measures may make it difficult for practices to receive the maximum number of points under the QPP, but by identifying measures as topped-out, CMS is incentivizing practices to choose other measures where considerable performance improvement is more likely.

Looking ahead, CMS will continue to identify and top out measures that do not offer MIPS-eligible clinicians significant improvement opportunities. Once identified, measures will be phased out over a four-year timeline consisting of capping the measure to a lower maximum score, followed by the measure’s removal entirely.

However, some topped-out measures may remain in the program for longer than four years as CMS considers the maintenance of measures that contribute important aspects of patient safety and reliability.

What can practices do to prepare?

1. COMPARE THE CURRENT 2018 MIPS QUALITY BENCHMARKS.

Current benchmarks can help determine if a quality measure is topped-out. An example of a commonly reported topped-out measure is Documentation of Current Medications (Quality Measure ID 130), which is topped-out for all methods of reporting but does not yet have capped scoring. Variance in decile scoring is so limited that one performance mistake could lose you several points, de-
pending on the method of reporting. If a practice is reporting this measure through a qualified registry, or QCDR, they can only score 10 points if they score 100 percent, a perfect performance. Any score of 99.99 percent or less would drop the practice down to the 7th decile (worth 7.0-7.9 points). That leaves practices no leeway in workflow errors, as just one patient missed could keep them from maintaining perfect performance.

2 REVIEW YOUR NUMBERS AT LEAST QUARTERLY.

By reviewing the performance of their clinicians on a quarterly basis, practices can make course corrections throughout the year to ensure they are meeting necessary performance standards. Practices that notice early on that they are not meeting the standards they have selected through their reporting can either select other measures that they might be better suited for reporting or implement processes that allow them to improve their performance before the end of the year.

3 SELECT THE APPROPRIATE MEASURES.

Due to topped-out measures’ scoring limitations, successful practices should carefully consider and select measures that show improvement in performance. For example, Quality ID 236 (Controlling High Blood Pressure) is a high-priority measure practices can select and work with their patients to improve over time. Measures that continue to show meaningful improvement in performance by practices will likely have a longer time span in the MIPS program.

Additionally, practices do not need to look for the easiest measure to meet—or to achieve a “perfect” score as other practices could potentially be doing the same (which then creates a high benchmark that may demonstrate little variance and lead to further top outs). There are many non-topped-out measures where practices can earn the full 10 points without scoring a perfect or close-to-perfect performance.

4 ENGAGE AN EXPERT QUALITY REPORTING TEAM.

One way practices can maximize their reimbursement without losing valuable time with patients is to work with a quality reporting engagement team. This team can assist with guidance on how to understand changing quality measurements, avoid costly missteps, and maintain peace of mind.

CMS will continue to select additional high-performing measures to top out in coming years, impacting a practice’s ability to maintain high MIPS scores above the performance threshold.”

“CMS will continue to select additional high-performing measures to top out in coming years, impacting a practice’s ability to maintain high MIPS scores above the performance threshold.”

Jackie Rogers is the manager of the Quality Reporting Engagement Group at data analysis provider IntrinsiQ Specialty Solutions, a part of AmerisourceBergen.
Congress is the largest cause of medical errors

“What is the reality of today’s patient-physician relationship? The picture is the opposite of what is described as high quality medical practice.”

here has been much published in both the medical and lay press about the magnitude of errors in medicine. This is a contentious subject with wildly variable results most likely due to the difficulties associated with the many and varied complexities of medicine.

Medical errors certainly exist and we should be diligent in trying to completely eliminate them. While knowing that, as with any human enterprise, perfection should be the ultimate goal.

But what constitutes a style of medical practice that minimizes the chances of medical errors? A close, truthful, and thoughtful relationship of adequate time and focused attention with the patient is the best way to avoid medical errors—a situation where the physician has the time to illicit a careful history providing clues to the actual pathophysiology. The physician then needs time to integrate this information into a coherent conceptualization of the issues at hand, a thoughtful differential diagnosis, and a rational plan. At this point the physician can order specific tests.

This careful process also fosters the development of a beneficial therapeutic relationship between patient and physician whereby the physician can advise and the patient follows through on a various number of issues aimed at maximizing the patient’s physical and mental health. In this way, unnecessary testing is eliminated and chasing false leads with its inherent problems does not occur while medicine becomes as error-free as humanly possible.

However, what is the reality of today’s patient-physician relationship? The picture is the opposite of what is described as high-quality medical practice. Recently, there was a published study following physician time spent on direct clinical face time with patients versus time with the EHR and administrative tasks.

According to the findings, for every hour physicians provide direct clinical face time to patients, nearly two additional hours are spent on EHR and desk work within the clinic day. Outside office hours, physicians spend another one to two hours of personal time each night doing computer and clerical work.

These expanded clerical requirements have had a negative impact on the actual time physicians have with patients, thereby compromising care.

Instead of being able to focus their energies on their patients, physicians have been converted into data entry clerks because of ill-advised Congressional actions, primarily the HITECH Act and the Medicare Access and CHIP Reauthorization Act (MACRA).

Making matters worse, the information demanded by these laws is neither rigorous nor based on the scientific method, making the usefulness of this robust data accumulation grossly exaggerated. Thus, the process of skillful medicine does not take place, the patient-physician relationship is being destroyed, medical errors are bound to increase, patients suffer, and physician malcontent is increasing.

It is inescapable that our Congress demonstrated that they have no understanding of the complexities involved in caring for patients. Their misguided obsession of collecting relatively useless data at the expense of patient care makes our Congress the major source of medical errors in the United States.

Ken Fisher, MD, is an internist/nephrologist in Kalamazoo, Mich.
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Focus on specificity when documenting these four diagnoses

Diagnosis codes convey the reason for the visit, and they also capture risk—something that many payers increasingly consider when calculating reimbursement. It’s important for physicians to ensure that the information they document is as specific and complete as possible, said Terri Thomas, RHIA, clinical documentation specialist in San Leandro, Calif., who spoke during a recent national coding conference.

Accurate and complete documentation ultimately reduces denials, said Thomas. Translation? Physicians retain the revenue they generate.

Unspecified diagnosis codes often wreak havoc on cashflow because many payers simply deny them, said Thomas. “We need to be as specific and compliant as possible. That’s one of the reasons why we moved to ICD-10,” she said.

Thomas discussed these four diagnoses and provided checklists of what physicians should document to avoid denials:

1. Chronic obstructive pulmonary disease
   - Body mass index
   - Smoking status, including history of smoking, when applicable
   - Use of home oxygen, BIPAP, or CPAP, when applicable
   - With acute exacerbation, hypoxemia, bronchitis, asthma, emphysema, or upper respiratory infection, when applicable

2. Congestive heart failure
   - History of myocardial infarction, coronary artery bypass graft, or smoking, when applicable
   - Use of home oxygen, when applicable
   - Medication noncompliance, when applicable
   - Presence of heart disease, bradycardia, heart block/type, arrhythmia, or diabetes, when applicable
   - Severity (i.e., acute, chronic, or acute on chronic)
   - Type (i.e., systolic, diastolic, left, right)
   - Use of home oxygen, when applicable
   - With hypertension or renal failure, when applicable

3. Diabetes
   - Long-term insulin use, when applicable
   - Manifestations and complications (e.g., nephropathy, retinopathy, osteomyelitis, and vascular disease), when applicable
   - Medication noncompliance, when applicable
   - Presence of secondary diabetes and cause (e.g., due to neoplasm, steroid-induced, or adverse effect of drugs), when applicable
   - Relationship between diabetes and cellulitis, when present
   - Type (i.e., Type 1 or Type 2)

4. Hypertension
   - Exposure to environmental tobacco smoke, when applicable
   - History of myocardial infarction, coronary artery bypass graft, or any other cardiac condition, when applicable
   - Medication noncompliance, when applicable
   - Relationship with chronic kidney disease, congestive heart failure, or both, when applicable
   - Tobacco dependence, use, or history of tobacco use, when applicable
   - Type (i.e., emergency, urgency, or crisis)

Physicians must ensure that they document all conditions that coexist at the time of the encounter that require or affect treatment. Coders are obligated to query physicians when documentation is conflicting, ambiguous, or incomplete, said Thomas. Physicians can mitigate these queries and protect revenue by taking the time to learn the specificity that’s required for code assignment.

Lisa A. Eramo, MA, is a contributing author. Send your billing and coding questions to medec@ubm.com.
When was the last time an industry rep provided your practice with timely information about new therapies and standards of care without disrupting your workflow?

What ends up happening is that reps show up unannounced, oftentimes asking to speak directly with physicians who are busy seeing patients. Poorly-timed rep visits can disrupt a practice’s workflow.

Is there a solution? Yes. Create a policy for your life sciences reps. A policy ensures that everyone is on the same page. A policy supports operational efficiency and helps practices maximize educational opportunities. It lets reps know what information you need, when you need it, and how frequently they can access physicians and clinical staff. It sets parameters, expectations, and limitations. Every life sciences rep policy should address the following:

1/ The type of reps you will see.
For example, will you allow all life sciences reps? Only those representing drugs and biotechnology or devices? Only medical science liaisons who are physicians or nurses?

2/ The specific days/times you will see reps.
Will you only see them on certain days or at certain times of the day? Consider creating role-based calendars for clinical vs. nonclinical staff so people only hear information relevant to their jobs. Create a separate calendar for shorter appointments when reps can restock samples, co-pay cards, patient education materials, and obtain physician signatures.

3/ Why you see reps.
Life science companies are developing technology that’s changing at an explosive pace. Even the most brilliant doctors have difficulty staying on top of it all. Knowledgeable reps can highlight new products, new indications, and new FDA-approved data or research. Reps also provide information about new patient assistance programs, formulary coverage, and co-pay cards. Take the time to define “new,” and what it means to your practice, and craft a policy that prioritizes what’s important to you.

4/ How reps can make an appointment.
Consider automated solutions that let reps self-schedule appointments during time slots that your practice designates as convenient.

5/ Rep frequency.
How often will you allow individual reps to visit? How does the supply of your physician’s time compare with reps’ demand for it? Setting—and enforcing—the correct frequency rules helps distribute appointments fairly.

6/ Rep requirements.
Having an agenda makes all meetings more efficient, and rep in-services should be no different. Ask reps to submit topics in advance so physicians can decide whether to attend.

7/ Whether you will allow food.
Decide whether you’re able to allow reps in at this time or if you prefer to schedule quick meetings with no meal involved.

8/ Code of conduct.
How do you expect reps to behave in your practice? Will you require reps to sign documents (e.g., a HIPAA policy)? What are the consequences if they don’t follow the rules? Identify a strategy to isolate reps who don’t follow the policy.

9/ Sunshine Act tracking.
Although practices are not required to record or report any data, you may want to record any transfer of value that occurs so you can validate the data and contest any errors during the annual review period. If this is of interest, your policy should require reps to leave a copy of the receipt and their sign-in sheet for each meal.

Dan Gilman is founder and CEO of RxVantage, a free, cloud-based solution that connects physicians and medical staff members with reps. Send your practice management questions to medec@ubm.com.
Money

The profit equation: Stop struggling to make money

By TODD SHRYOCK, Editor

HIGHLIGHTS

➤ Practices that want to survive need to benchmark their financial performance so they know how they are performing.

➤ When considering new positions, cost-benefit calculations need to be made to determine whether it’s worth adding one.

Many physicians find they are working harder than ever, but end up with less money in their pockets at the end of the year.

Reimbursements have become more complicated as patients struggle with high deductibles and payers require more documentation and often pay less than in the past. Meanwhile, office and staff expenses continue to climb, leaving doctors struggling to increase revenue or cut costs.

“There are all sorts of overhead increases, and if we find a decrease, we jump up and celebrate,” says Jeffrey Kagan, MD, an internist in Newington, Conn., and a member of the Medical Economics editorial advisory board. He’s examined expenses for everything from waste removal to his answering service to the electricity provider for his two-doctor practice in an attempt to save money.

“I’ve always tried to look for expenses to cut, but now, it’s even more important. If we have a gap in our patient schedule, I feel like we should go look for more,” he says.

While physicians may prefer to focus their attention on patient care, experts warn that in this economic environment, it’s imperative to carefully analyze expenses as Kagan does and calculate how every business decision can affect overall profitability.

“A medical practice is a business and has to be run like a business with principles and discipline,” says Ken Hertz, FACHE, principal consultant for the Medical Group Management Association.

The allure of bringing in more revenue can often overshadow how much expense is added to obtain it. Getting more patients through the practice is one way to counter flat or decreasing reimbursements, but if a practice has to add staff to do so, that can eliminate any gains in revenue, says David Howard, MPH, MBA, a principal in Grant Thornton’s healthcare advisory practice.

“Increasing revenue is harder for the small practice because of limited resources,” says Ge Bai, Ph.D., CPA, assistant professor at Johns Hopkins Carey Business School. “Containing costs is usually the most feasible option. In an environment where payers are under pressure to reduce prices, small practices must think about how to control their costs.”

EVALUATE STAFFING COSTS

Personnel costs, in terms of salaries and benefits, tend to be the biggest expense for most practices, so experts say it’s a good place to start an analysis. But asking staff members about capacity may not provide an accurate picture.

“You’ll often hear the staff say they are overwhelmed and can’t do any more, so a doctor will throw more money at the problem and add more staff,” says Hertz. “But if you are not managing them well or organizing them well, you may have more people but not necessarily produce better results.”

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“If we find a decrease, we jump up and celebrate. I’ve always tried to look for expenses to cut, but now, it’s even more important.”

—JEFFREY KAGAN, MD, INTERNIST, NEWINGTON, CONN.

Maximize Revenue

30 staff follows and examine what is being done and not being done, says Hertz. If the work not being done produces revenue, then it’s a lot easier to determine if a new person would generate enough money to pay his or her salary.

If the work isn’t easily quantifiable, compare staffing levels to practices with similar revenue levels (staffing data is usually available through professional organizations). If the staffing level is below that of similar offices, it might indicate additional help is justified. If the staffing level is higher, take a closer look at workflows and search for waste in the way the staff is working.

For example, maybe the staff is incurring a lot of overtime pay because the practice has extended its hours and nurses, front desk staff, and X-ray technicians are all working until 7 p.m.

“The extended hours may be necessary for the practice, but plan on the extended hours and set up staggered shifts so you don’t run into overtime issues,” says Hertz. An employee might work 9 a.m. to 5 p.m. one day, then 11 a.m. to 7 p.m. on another.

In some cases, providers’ hours may have shifted, but staff hours have not. “Look at your provider schedule,” says Howard. “If two of your four providers are off on Fridays, why do you have a full staff those days?”

He advises thinking about who really needs to be doing the work in a practice. Do RNs handle work a medical assistant could do? Can routine work be outsourced? “There are companies that can do appointment verification—it doesn’t have to be done by the front desk,” says Howard. “They can do it more efficiently than what you could do with one or two staff members.”

When considering a new position, calculate the costs and benefits to determine whether it’s worth adding. For example, if a scribe costs $30,000 per year, but hiring one allows a doctor to see 10 additional patients per week and the doctor works 44 weeks per year, that’s 440 additional patients generating revenue. If the average revenue per patient visit is $150, that equates to $66,000 in new revenue, netting the practice $36,000 in profit, says Hertz.

Nurse practitioners and physician assistants should be evaluated the same way, says Howard. If a nurse practitioner bills at 85 percent of what the physician would be reimbursed but is paid half to a third of what a physician would earn, a practice has to consider that option if it is looking to expand or already has the space available. The additional revenue is worth the expense.

Cut Expenses and Maximize Revenue

Expenses aren’t necessarily bad, but a practice should look at their return. “The issue is to take your expenses and maximize their ability to generate revenue,” says Hertz. A practice may spend more in overhead than a similar practice, but if the overhead generates more revenue, then it’s well worth it. “It’s not just pure dollars, but how you leverage it to create more money,” he adds.

Office space needs to be closely scrutinized, because it can be a large expense—usually between 8 percent and 15 percent of revenue, says Howard, who notes that exam rooms often are underutilized.

“Think creatively on where you are spending your time,” he says. “If you have three extra exam rooms, maybe you don’t need another partner, but allow another physician to come in and use the space.”

Coding can represent both expense and revenue. It costs money to have it done right, but doing it wrong can result in missed revenue. Howard says it’s imperative that practices not only ensure their evaluation and management coding is accurate, but also in line with industry benchmarks.

“What is sometimes lost on small practices is knowing where providers fall within their peers in their specialty,” says Howard. If a practice falls on the high end of the curve, there may be some compliance risk. The provider falls on the lower end, it may be an indicator that visits are being coded too low and the practice is losing revenue.

He also recommends practices have a third-party service conduct some chart audits to ensure compliance and appropriate billing levels to assure the practice is maximizing its revenue.

Collection practices are worth reviewing, because patients are responsible for an ever-greater share of their healthcare payments and are notoriously less reliable than insurance companies when it comes to paying on time. “If you are only getting $100 a visit and $20 of that comes from the patient, you can’t ignore it,” says Howard. “Most practices are not as focused on this as they should be.”
LEVEL OF CARE COMPARISON CHART

Experts say that practices should compare their E/M codes with those of their peers. The codes are compiled by CMS and can point to both compliance risks and potential lost revenue.

If a physician codes at a lower rate than the Medicare average, it may be an indication of under-billing. Codes used at a higher rate may mean the physician is overbilling.

Below are some sample numbers from an internal medicine doctor compared to Medicare averages:

<table>
<thead>
<tr>
<th>New patient code</th>
<th>Sample internist usage</th>
<th>Medicare usage</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>1.9%</td>
<td>0.4%</td>
<td>Coding rates are similar</td>
</tr>
<tr>
<td>99202</td>
<td>23.2%</td>
<td>5%</td>
<td>This IM may be overusing this code compared to the average</td>
</tr>
<tr>
<td>99203</td>
<td>42.2%</td>
<td>29.4%</td>
<td>This code may also be overused</td>
</tr>
<tr>
<td>99204</td>
<td>27.8%</td>
<td>48.9%</td>
<td>This code is well below the average, so this may be an indication this code is being underused</td>
</tr>
<tr>
<td>99205</td>
<td>4.9%</td>
<td>16.3%</td>
<td>Coding rates are similar</td>
</tr>
</tbody>
</table>

In this example, new patient codes 99202, 99203 and 99204 should be reviewed. 99202 and 99203 are being used at a much higher rate than average, while 99204 is well under the average, which could result in missed revenue.

Physician numbers courtesy of MGMA, calculations courtesy of AAPC.

Not only should physicians ensure their practices are collecting any money due at the time of visit, they also need to invest in ways of making it easier for patients to pay their bills, such as through an online portal, says Howard.

“’There are good tools out there that can help automate tasks like insurance verification and automate payments and help with patient throughput,’ he says. ‘If you are trying to make it in the tough world of small private practice, you have to embrace different models and efficient technology and services that are out there. You have to also be a doctor of technology.’

BENCHMARKING IS KEY

Practices need to benchmark their financial performance to survive, says Hertz. “But don’t benchmark to the industry average,” he says. “Do you get up in the morning and say, ‘Gee, I hope I can be an average doctor today?’ Push to see how good you can be.”

Internal benchmarking should include monthly revenue and expense levels so practice physicians can make year-to-year and month-to-month comparisons. “Look at the trends,” says Hertz. “Are they going up or down and why? Learn what the numbers are telling you.”

But physicians should also benchmark their practice externally so they know how they compare. “You may be doing better than you did last year, but if your numbers are way off what others are doing, you may have a serious problem,” he notes.

Howard says software tools are available for around $1,000 that can provide practices all the financial analysis they need. Tools such as Qlik, Birst, and Tableau, tie into existing software databases to generate dashboard reports that can help doctors make better financial decisions.

“Look at this as a challenge and an opportunity to have fun with it instead of getting frustrated and agonizing about it,” he says.

—KEN HERTZ, FACMPE, PRINCIPAL CONSULTANT, MGMA
As every medical practice knows, it can be hard to stay on top of ongoing expenses. Most of the time, physicians are too busy taking care of patients to be able to spend time reviewing medical supply pricing and other costs.

Typically, the first time a practice signs an agreement for products or services with a vendor is usually the last time those prices are assessed. Implementing an annual review of expenses is critical to ensure the practice isn’t wasting money.

Start with the easy stuff
First, is the practice part of a buying group (group purchasing organization or GPO)?

If not, you are likely paying more than you need to on items such as medical and office supplies, medications, and vaccines. There are many GPOs to choose from so start with your medical association or local chapter to determine which they recommend.

Next, salary and benefits
Consider using a professional employment organization (PEO). These organizations become the employer of record; so while the practice maintains the management of employees, the PEO bundles up payroll, HR services and compliance, workers compensation, employer liability insurance, and healthcare benefits under its entity. The practice pays either a flat rate per employee per month or a percentage of payroll.

While it might seem more expensive, one of the biggest benefits (and cost savings) is access to healthcare benefits that are priced for a much larger entity. Additionally, many “perks” are included, such as gym memberships, life insurance, and short- and long-term disability plans.

Determine if the practice is routinely paying overtime, and shop around for new payroll companies. Finding more efficient payroll systems can reduce time and create efficiencies too, so look for price plus efficiency when evaluating options.

Take a look at services
How much are you paying for your bank charges? For credit card processing? For phone and internet?

Ask your bank for a better deal; it can produce nice savings. A recent client saved $4,500 a year in fees by switching to a new bank, but also gained process efficiencies with free remote deposit and online access to all their accounts through a single sign-on system.

Shop around for better credit card rates too. The least expensive and most customer-friendly credit card processor that we’ve found is Payment Pros (and we’ve reviewed scored of companies to determine that, through one of my companies, Independent Practice MSO).

You can also approach your current vendor and ask them to reduce their fees—there is not much they can do regarding the credit card company rates but they can reduce monthly fees and per transaction costs.

Call your phone company and ask them what special offers they have. If they are not willing to extend those deals to existing customers, tell them that you will be happy to switch to a new company for a better deal. Every time we’ve used that approach, we’ve received a better offer.

Multi-year contracts
Review your multi-year contracts, such as those you have with EHR companies. While there may not be much that you can do to reduce the rates you pay during that term, know when your contracts are up for renewal and ask for better pricing for any renewals.

Much like the phone carriers, they would prefer to work at a discount to keep you than lose you to a competitor. Even if you think you’d never switch EHR vendors, they don’t know that, right?

Susanne Madden, MBA, is founder and CEO of The Verden Group, a healthcare practice consulting firm. Send your financial questions to medec@ubm.com.
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Transitional care management (TCM) is also a payer target for auditing, which means practices need to focus on following the rules when billing this service. Consider the following common TCM denials and how to avoid them:

**Reason for denial:** The practice doesn’t call the patient within two business days of discharge.

**How to avoid it:** Join a health information exchange to receive daily admission discharge transfer (ADT) feeds and discharge summaries, says Samantha Sizemore, chief operating officer at Holston Medical Group PC in Kingsport, Tenn. Then work with the EHR vendor to incorporate this information into the system so staff can view it easily. Consider hiring a patient navigator who can monitor these discharges and reach out to patients in a timely manner to schedule a post-discharge appointment. In small practices with few TCM billings, nurses, medical assistants, or even administrative staff can also perform this task, she adds.

"The idea is to get the patient engaged in the outpatient setting as quickly as possible," says Shelton Hager, MD, CPC, a primary care physician at Holston who bills TCM approximately five times a month.

**Reason for denial:** The practice doesn’t document the initial call to the patient.

**How to avoid it:** Develop an EHR template for the follow-up telephone call to the patient, says Sizemore. This template should include the date of discharge, time, and date of the follow-up phone call, and a summary of the conversation. Work with the EHR vendor to automatically pull information from this template into the template for the transition of care (TOC) office note, she adds.

The TOC office note should also include checkboxes to remind physicians of the key components of the TCM code (e.g., review the discharge summary, establish or re-establish referrals to community services, and provide patient education). "These are the components that auditors will be looking for," says Hager.

**Reason for denial:** The patient is not seen within seven or 14 days of discharge.

**How to avoid it:** Save one or more appointment slots per week for hospital follow-up appointments, says Sizemore. Another option is to double book or have the patient see a different provider in the practice, she adds.

**Reason for denial:** The patient is readmitted or dies within 30 days of discharge.

**How to avoid it:** One option is to hold the TCM claim for 30 days and manually review ADT data before billing to ensure the patient hasn’t died or been readmitted. Another option is to bill TCM at the time of service under the assumption that the patient won’t die or be readmitted. If the patient is readmitted or dies within 30 days of discharge, Medicare will automatically recoup the TCM payment; however, practices can refile the claim using an E/M code based on the documentation. "If you don’t refile it, then you forfeit the payment for the TCM service altogether," says Sizemore.

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**CPT code** | **Description** | **2018 national average Medicare payment**
---|---|---
99495 | TCM with moderate medical decision complexity and a face-to-face visit within 14 days of discharge | $167.04
99496 | TCM with high-complexity medical decision making and a face-to-face visit within 7 days of discharge | $236.52

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"The idea is to get the patient engaged in the outpatient setting as quickly as possible."

— SHELTON HAGER, MD, CPC, PRIMARY CARE PHYSICIAN, HOLSTON MEDICAL GROUP, KINGSPORT, TENN.
TIME-BASED E/M BILLING

It may be easier to bill an E/M code based on time alone because physicians don’t need to count bullet points in the E/M guidelines to level a service. However, doing so can also put a practice’s revenue at risk if physicians report time-based E/M codes frequently, says Michael Strong, CPC, bill review technical specialist at SFM Mutual Insurance Company in Bloomington, Minn. These codes should be the exception rather than the rule, and physicians shouldn’t use time-based E/M codes to circumvent proper documentation or medical necessity, he adds. Strong provides these tips to avoid denials:

1. **Use time as the controlling factor only when a physician spends more than 50 percent of the visit counseling the patient or coordinating care.**

Counseling and coordinating care include the face-to-face time with the patient and/or family member spent obtaining a history, performing an exam, or counseling the patient. They do not include the following services:

- Administrative tasks for which payers do not reimburse (e.g., documenting in the EHR, dictating, refilling prescriptions, or completing workers’ compensation applications)
- Arranging for additional services
- Communicating with other professionals or the patient via written reports and telephone
- Reviewing records and tests before or after the face-to-face visit

Physicians should clearly document how much time they spent performing the counseling and coordination of care and what they did specifically, says Strong. “If you don’t describe it, the payer doesn’t know whether you met the criteria,” he adds.

2. **Choose the code that most accurately describes the services rendered.**

For example, one of the following CPT codes might be more applicable than billing a time-based E/M code, says Strong:

- 99401-99404 (individual preventive medicine counseling and/or risk factor reduction intervention)
- 99406-99407 (smoking and tobacco use cessation counseling)
- 99408-99409 (alcohol and/or substance [other than tobacco] abuse counseling)
- 99411-99412 (group preventive medicine counseling and/or risk factor reduction intervention)

3. **Bill psychotherapy separately from the E/M service.**

When physicians perform psychotherapy in addition to an E/M service, they should report the E/M service as well as an add-on code for the psychotherapy (i.e., 90833, 9036, or 90838), rather than using time as the controlling factor for the E/M code and forgoing the psychotherapy code, says Strong. Physicians also can’t use time-based billing for the E/M service when they report it with a psychotherapy add-on code. Instead, select the E/M code based on the history, exam, and medical-decision making, he adds.

“If you don’t describe it, the payer doesn’t know whether you met the criteria.”

— MICHAEL STRONG, CPC, BILL REVIEW TECHNICAL SPECIALIST AT SFM MUTUAL INSURANCE COMPANY, BLOOMINGTON, MINN.
When used appropriately, modifiers help physicians collect revenue to which they're entitled because they convey to payers that the claim should bypass billing edits that are designed to prevent improper payments. However, when practices use these modifiers to bypass edits inappropriately, they could be at risk for recoupments resulting from post-payment audits, says Angie Clements, CPC, physician coding auditor at MedKoder LLC in Mandeville, La.

It all comes down to documentation, says Clements. "Documentation has to support everything you do. Payers are looking at the documentation to support everything they pay," she says.

Here are some do's and don'ts when applying these three common modifiers:

**Modifier -25**

**DO** apply it when the E/M service goes above and beyond the usual pre- and post-operative work associated with a procedure that has a global fee period. Documentation must clearly explain why the additional E/M service was necessary and why it went above and beyond what's typically required for the procedure, says Clements.

For example, a patient falls and has a laceration to the forehead that's deep enough to require sutures. In addition to the laceration repair, the physician performs an exam and neurological assessment to rule out a concussion and orders additional testing. The E/M code for the office visit may be separately reportable using modifier -25 provided all documentation requirements are met, says Clements.

**DON'T** apply it automatically just because a non-physician provider performs part of the treatment. As always, documentation must justify why the E/M service is separately reportable, says Clements.

**DON'T** apply it when a patient presents for a scheduled procedure. For example, a physician performs an E/M service and asks the patient to come back in a few days for an injection if symptoms worsen. If the patient returns, the physician should only bill the CPT code for the injection—not an additional E/M code with modifier -25, says Clements.

**Modifier -26**

**DO** apply it when a physician performs the professional component only. For example, CPT code 71045 denotes a single-view chest X-ray. If a physician performs the professional component only, they should report this code with modifier -26.

**DON'T** apply it when there is a more specific code. For example, CPT code 93000 denotes a routine electrocardiogram (ECG)
with at least 12 leads, including the tracing, interpretation, and report. If a physician performs only the interpretation and report (without the tracing), they should report CPT code 93000—not 93010 with modifier -26.

**DON'T** apply it when another physician already interpreted the test. Physicians can count their own interpretation toward their medical decision-making but not bill separately for the professional component of the test, says Clements.

**Modifier -59**

**DO** apply it as a last resort. Consider these other options first: -RT (right), -LT (left), or -50 (bilateral procedure). Payers may also accept modifiers -XE (separate encounter), -XS (separate organ or structure), -XU (unusual non-overlapping service), or -XP (separate practitioner). For example, a physician performs an injection in the right and left knees. Report CPT code 20610 with modifier -50 not -59.

**DO** apply it when there’s a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury. For example, a physician trims a callus and trims a toenail on the same toe. The toenail, bed, and surrounding tissues are considered the same anatomical site, says Clements.

**DON'T** apply it if National Correct Coding Initiative (NCCI) edits prohibit doing so. For example, physicians shouldn’t report a biopsy and excision of the same lesion using modifier -59. They should only report the removal, says Clements. An exception to this is when a physician biopsies the lesion, waits for the pathology results, and then excises the lesion during the same session. In this case, they can report both procedures using modifier -59. If there isn’t any documentation to support the decision to excise the lesion after pathology results were obtained, payers may recoup reimbursement during a post-payment audit, she adds.

**3 tips to use modifiers correctly**

1. **Make sure the practice management system incorporates NCCI edits to prevent appending modifiers that aren’t allowed or necessary.**

2. **Ask coders to validate cases with a history of high denial rates before sending claims to the payer.**

3. **Learn what modifiers do—and don’t—apply to the procedures physicians perform most frequently and what’s required from a documentation standpoint.**

**APPEALING DENIED CLAIMS**

When it comes to appealing denials, knowing payer policies and regulatory requirements is critical. “Being smarter than your payers is the key to successful denial management,” says Michael Strong, CPC, bill review technical specialist at SFM Mutual Insurance Company in Bloomington, Minn. Consider these tips to ease the appeal process:

1. **Give payers what they want.**

   “Look at the remark codes, and address those specific edits,” says Strong. “Don’t hand them back the same medical record. They’re just going to deny it again.” For example, missing information is a common reason for claim denials. Payers often look for lab or operative reports and won’t pay the claim until they receive this documentation, he adds.

2. **Ask for exceptions.**

   Payer policies aren’t set in stone, and payers may be willing to make exceptions for diagnostic procedures such as labs or x-rays...
3 TIPS TO AVOID DENIALS

Provide payer-specific training for billing staff members.

Develop this training internally, or work with a local consultant who can incorporate the practice’s denial trends and payer audit trends.

Why it helps:
Reduces denials related to prior authorization and medical necessity.

Boost staff confidence.

Help billing staff view themselves as patient advocates who contribute to patient care.

Why it helps:
Reduces denials related to data entry.

Build a relationship with the clearinghouse.

Ask billing staff to contact the clearinghouse to obtain information about what’s denied in the local region for the same specialty. Most clearinghouses can provide this information—it’s just a matter of scrubbing and disseminating the data. The same is true for practice management vendors.

Why it helps:
This data can be more specific than the denial remark codes that payers provide, and it can help practices address denials proactively.

when patients have an abnormal or uncommon presentation, says Tammy Tipton, owner of Appeal Solutions Inc. in Oklahoma City, Okla. For example, she says, many clinical guidelines are more applicable to adult patients and may not be relevant to pediatric patients.

3. Cite regulatory information in the appeal letter.

This includes Medicare Local Coverage Determinations and National Coverage Determinations as well as the Affordable Care Act (ACA), says Tipton.

The ACA, for example, expanded access to external reviews—something that payers don’t necessarily want providers to know, she says. This expansion allows providers who are authorized to appeal on a patient’s behalf to request an external review after they’ve exhausted all internal reviews with a payer. Providers can obtain this authorization by asking patients to sign an assignment of benefits and authorization release, including the ability to pursue appeals on the patient’s behalf.

“I feel strongly that you get a higher quality of review with an external appeal because it’s unbiased, and reviewers are accessing the latest clinical guidelines when making decisions,” she adds. “You also get more detail as to how and why the payer is making certain decisions.”

Also, be prepared to cite the Employee Retirement Income Security Act (ERISA). ERISA allows providers with authorization to appeal on a patient’s behalf to:

- Ask for the specific internal criteria on which a payer is basing a denial. This information goes beyond the denial reason code and can help providers craft a compelling argument to fight the denial, says Tipton.
- Ask the payer to provide the credentials of the reviewer. Demand peer review (i.e., that a physician in the same specialty with the same credentials review the appeal), says Tipton.
- “The more specialized the treatment, the more critical a peer review is to the review process,” she adds.
- File appeals within 180 days. This may go beyond a payer contract allowing only 30 or 60 days, says Tipton.

“You have to understand all of these regulations, be willing to cite them in your appeal, and demand compliance,” she says.

Is the practice’s write-off policy too strict?

The last thing practices want to do is write off a claim that has the potential for payment, says Tammy Tipton, owner of Appeal Solutions Inc. in Oklahoma City, Okla.

Here are three tips to help avoid unnecessary write-offs:

1. Review all write-offs.

Does the practice write off claims that should have been appealed? For example, some practices write off contractual adjustments (i.e., the amount they agree not to charge the patient per the contract terms with the insurance company) without realizing that there was an actual denial that staff could have appealed successfully, says Tipton. “Assess these adjustments, follow your collection policy, and appeal if the benefit calculation does not appear to be in compliance with the expected payment,” she adds.

2. Demand responses from payers. Payers are contractually obligated to respond to appeals within a certain timeframe, and practices should hold them accountable before automatically writing off a denial, says Tipton. Send a letter reiterating the date of the appeal, the contractual obligation, and the payer’s lack of response. Ask the payer to explain why there’s a delay.

3. Be patient. “Many claims that end up in legal review will take more than a year to resolve, so you’re going to have some aged claims. But that doesn’t mean these claims won’t be paid eventually,” she adds.
Physicians have never had a greater need for evidence-based information to evaluate the effectiveness and risks of alternative therapies and treatments. New reimbursement models include financial rewards for the delivery of quality, cost-effective care, which means doctors need tools that explicitly identify the value and risks of particular interventions, based on scientific research and evidence.

With ready access to current information, physicians can maximize their earning potential and diminish the risk of financial penalties, lower health costs, and a better patient experience.

Most physicians still rely on traditional fee-for-service models for the bulk of their compensation. Newer fee-for-service plans, however, often include quality components that incent clinicians to follow guidelines. Physicians subject to Medicare’s Merit-based Incentive Payment System (MIPS) are also motivated to adhere to evidence-based medicine standards. Reimbursements and penalties under MIPS are tied to quality performance, so they are driven to deliver optimal outcomes and cost-effective treatment.

By adhering to evidence-based guidelines, physicians can earn higher rewards while participating in risk-based payment models, such as an accountable care organization enrolled in the Medicare Shared Savings Program, or a Medicare Advantage plan administered by a private insurer.

As reimbursement models continue to add value-based metrics, physicians will demand ready access to evidence-based protocols to guide preventive care efforts, better manage patients with chronic conditions, and minimize unnecessary interventions. Even with aligned financial incentives and well-intentioned clinical practice guidelines, physicians are sometimes slow to employ evidence-based medicine in practice. This is especially true when new evidence challenges conventional wisdom.

Despite strong evidence, physicians often take years to change practice habits. Evidence adoption is further delayed when doctors cannot easily translate population-based guidelines to the needs of an individual patient.

However, physicians now have access to tools to help them evaluate the value of different interventions. Consider the Choosing Wisely campaign, which the American Board of Internal Medicine launched in 2012. ABIM publishes a list that includes specialty society warnings about several hundred tests or treatments that should be avoided under specific circumstances. Physicians able to stay abreast of pertinent details related to their specialty are more likely to select interventions that improve care and optimize resources.

Other sources of evidence-based guidelines include the Cochrane Collaboration, specialty society “journal clubs,” and commercial providers of order sets and care plans. In addition, Right Care Alliance, the NNT, and similar coalitions work to identify and reduce overused healthcare interventions by clarifying the risks and benefits of various tests and treatments.

In order to achieve Triple Aim goals and value-based care objectives, healthcare organizations must leverage available technologies and resources and give their physicians ready access to the most current evidence-based data.

Ross Ellis, MD, is an ABIM board-certified internist and medical director at Zynx Health.
What is on your personal playlist right now?

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

“Luciano Pavarotti and Yo-Yo Ma.”

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

“Anything country.”

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


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

“James Taylor, Gloria Estefan, Billy Joel, Barbara Streisand, and Taylor Swift.”

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

“Lorde, Prince, Sia, Pharrell Williams, Barenaked Ladies, and Amanda Palmer.”

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

“Elton John.”

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

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“Take your expenses and maximize their ability to generate revenue. It’s not just pure dollars, but how you leverage it.”

—KEN HERTZ, FACMPE, PRINCIPAL CONSULTANT, MGMA

“Documentation has to support everything you do.”

ANGIE CLEMENTS, CPC, PHYSICIAN CODING AUDITOR, MEDKODER, LLC

50% Weight given to quality scores for the MIPS 2018 reporting period

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Production Director

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VP, Marketing & Audience Development
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“It’s going to take some time figuring out how to code this one.”

Fighting Back to Defeat Physician Burnout

Professional fatigue is taking its toll on healthcare. It stems from an exhaustive amount of work doctors must do to fulfill the requirements of several laws and regulations. We explore how physicians are battling back to restore the joy in medicine, sometimes by collaborating with patients.

PLUS:

- One doctor’s story of how burnout lead to retirement and the growing importance of work-life balance to the next generation of physicians