When it comes to your liability insurance,
One size doesn’t fit all.

Let’s face it ...

Physicians and their practices are busy enough as it is. They don’t need the additional stress of searching for the right policy.
That’s why ISMIE works with physicians and practice leaders to create customized coverage. Learn more at ismie.com/perfectfit.
MALPRACTICE GUIDE
6 ways to better protect yourself
One of my goals is to inspire others to get engaged in improving the healthcare bureaucracy, which in turn will benefit physician well-being.

I am not going to tell you that the way to prevent burnout is to practice yoga, mindfulness, or laughter therapy—even though these are excellent stress reduction and resiliency techniques. Some of the contributors to physician/clinician burnout are having to deal with layers of bureaucracy and regulations that interfere with our ability to take good care of our patients.

What must we do to bring about positive changes? One answer is simple: advocacy.

Physicians know how these factors impact our patients’ lives. When policies harm patients—such as time-consuming prior authorizations—we need to speak out and get involved; we need to advocate for change.

Early in my career, I did not realize the importance of advocacy and knew nothing about how to engage in system change. I was busy taking care of my patients, continuing my medical knowledge, and teaching learners. As the systems in which we practice medicine have changed, getting engaged in advocacy has reduced my stress and distress.

I find it energizing that I am speaking out for the betterment of my profession, my patients, and work environment. It is not effective to sit back and let those who have not walked (or practiced) in our shoes tell us these regulations or policies are necessary. My voice and the voices of my patients and colleagues need to reach the ears of those in a position to make better laws, policies, regulations, and work environments. That is what advocacy can do. I am confident we can make change happen in our own organizations, and at the local, state, and national level.

Since advocacy takes time, how is this possible? We all have too little time in our workplace these days.

First, “many hands make light work”—the more of us who are involved, the less time it takes to impact change. Second, if we want better systems, regulations, and policies, we must be at the table and part of the conversation and decision making.

Third, it can make a difference to reducing burnout and disengagement. So here are five tips for effective advocacy:

1/ Join a medical professional society advocacy group; get educated on the issues.
2/ Get on a committee at your organization that can work on system improvements.
3/ Write a resolution for your state medical society to advocate on an issue that matters to you.
4/ Invite your elected representatives to visit your workplace.
5/ Use the “take 5” approach. Take 5 minutes to call, email, or write a letter to your elected officials on a specific topic. Remember: Keep it simple and specific.

Access to physicians and healthcare should not be a partisan issue—it is a human issue. Each person is unique and our responsibility is to care for that individual.

Our advocacy will continue to change or build systems that allow us to practice with fulfillment, joy, and professional satisfaction.

Carrie Horwitch MD, MPH, is an outpatient primary care internal medicine and HIV care specialist physician in Seattle. Her column represents her own opinions and not those of her employer.
COVER STORY

Malpractice guide
6 ways to protect yourself & your practice PAGE 10

7 Connect with patients
Focus on really seeing what your patients need, writes Stephanie DeLeon, MD

14 Coding case study
Review our clinical scenario. Can you pick the right codes?

15 Association health plans
The pros and cons of these insurance arrangements

17 Cybersecurity
Understanding two-factor authentication

20 Selling your practice
How to increase its value and get the best deal possible

23 Drop your payers
Rob Lamberts, MD, on the benefits of going insurance free

26 Affordable insulin
9 ways to help patients improve access to this vital medicine

30 Drive down costs
Where to start when cutting practice expenses

31 Cryptocurrency
Are bitcoin and other digital currencies worth investing in?

34 What patients wish you said
10 examples of ways to improve patient experiences

36 Telehealth policy
Understand the rules that shape remote patient visits

LAST WORD

Time to fight facility fees
Arbitrary fees charged by hospitals make healthcare worse for patients and physicians, writes Marni Jameson Carey. PAGE 40

IN EVERY ISSUE

Interactive
Your voice
Vitals
Our advisers
Funny bone
ISMIE’s customized coverage means that your medical professional liability insurance policy is always the perfect fit. No matter your specialty, tenure, full or part-time status, or practice setting, we ensure that you are safeguarded with protection, quality, service, and value. Discover why nearly 10,000 policyholders choose ISMIE at ismie.com/perfectfit.
Overcome cost barriers to patient prescriptions

What can a physician do if a patient is non-adherent due to the cost of prescription medications? There are a number of ways a physician can work with their patients to best overcome cost barriers, and different ways a practice can integrate these processes into their workflow.

Prescribing generics is the first way to help patients afford their medications. Walmart’s Four Dollar Generic List is a great resource for physicians to utilize. There are also apps for physicians that will allow them to compare effectiveness and side effects of generic medications to their name brand counterparts.

Additionally, there are many apps that patients may find useful. Some of the top-rated apps available on computer and mobile devices are OneRX, GoodRX, and LowestMed. These apps help patients find discounts on their name brand or generic prescriptions, compare prices at different pharmacies, and will work to include their insurance plan so the user can see what the cost will be based off their coverage. They offer a lot of the same benefits, but GoodRX seems to be the app with the most features. It has reminders built in to refill prescriptions, shows where the $4 generics are, and can even find pharmacies that have some generics for free.

For patients who have a Medicare Advantage health plan or a Part D prescription plan, CMS offers medication therapy management in which patients receive one-on-one counselling sessions with a pharmacist at no cost. During these sessions the pharmacist reviews how to take each medication and checks for duplications or negative drug interactions.

Even with all of these resources, some patients may still not be able to pay for their medications. For them, a patient-assistance program (PAP) may be an additional option. Pharmaceutical companies have funded PAP programs to help cover patients’ copayments, coinsurance, and deductibles.

For patients who have a Medicare Advantage health plan or a Part D prescription plan, CMS offers medication therapy management in which patients receive one-on-one counselling sessions with a pharmacist at no cost. During these sessions the pharmacist reviews how to take each medication and checks for duplications or negative drug interactions.

Even with all of these resources, some patients may still not be able to pay for their medications. For them, a patient-assistance program (PAP) may be an additional option. Pharmaceutical companies have funded PAP programs to help cover patients’ copayments, coinsurance, and deductibles. Medicare.gov lists information for many of these programs, and each is specific to a certain medication.

MORE ONLINE  To read more, visit bit.ly/Rx-tools-for-docs.

Video Spotlight

Early mentoring to stem the doctor shortage

Ira Rubin, MD, and his son, Zachary, a pediatric resident, explain how mentoring young people—as they do at their Mini Medical School—can foster tomorrow’s physicians.

MORE ONLINE  To watch, visit bit.ly/Rubin-mentoring.

Bloggers

“As the population ages, and develops more chronic conditions, services that help support patients between the traditional physician consult will be essential to effective care. Chronic care management can be part of the solution.”

—Jeffrey Dlott, MD, on the need for more time with older chronic condition patients

“It is time for a revolution throughout primary care voicing the words of Howard Beale played by Peter Finch in the 1976 film Network, ‘I’m mad as hell and I’m not going to take it anymore.’”

—Joseph E. Scherger, MD, MPH, on how physicians can avoid burnout

MORE ONLINE  Visit the Blog section at MedicalEconomics.com
or the last 10 years, insurance companies have been conducting, "home visits," which I call "home invasions." They hire a third-party company to send a mid-level provider—a nurse practitioner or physician’s assistant—to the home of a patient with phone notice. They send the physician’s office a letter saying that they are going to “gather healthcare data,” on their patient and will forward a report. This process was started and motivated by CMS, who pays insurance companies to gather data, to supposedly improve care. But does it? No, it actually worsens it.

These home invasions are generally unwarranted, unwelcome, and ultimately useless in the grand scheme of medical care. The insurance companies want to gather data to reduce their exposure to risk, raise rates, and get paid by federal government programs for millions of subscribers. The insurance companies themselves have a ton of conflict of interest, as only they stand to gain by this government and insurance industry-funded procedure, not patients or physicians. Another concern is that these invasions become patients’ yearly wellness visit. Instead of getting a wellness visit with a personal physician, the visit is usurped by an employee of the insurance company. Not only does the insurer collect data, but avoids a claim from an independent physician who might otherwise handle the wellness visit. The insurer can essentially divert the money CMS pays for these visits for their own data mining operation. The report gives a physician’s office much of the historical information they already have and an inadequate physical exam. In some cases, the mid-level providers find or detect a problem and, because they say they are not in a “care capacity,” don’t act on the problem, putting patients at more risk than before.

One of my elderly couples was harassed by phone by their Medicare “advantage plan” HMO insurance company designees to perform this home invasion. After asking questions and finally saying “no,” the phone agent badgered them into accepting a visit. The mid-level practitioner came and took a history and a set of vital signs and a cursory physical exam. The patient later told me that the nurse detected a blood pressure of 180/110 and failed to instruct them to seek immediate medical care. As a physician I found this out a week later when the patient came in for routine follow-up and his BP was still elevated.

These government- and insurance-directed home invasions are unwarranted, unsafe, and may obfuscate the medical care that a patient is receiving. Patients can and should refuse insurance company representatives coming to their house for any medical history or exam purposes. Physicians should also reject the concept vocally and with action. In my office, I shred the reports, as I will not, and cannot be responsible for someone else’s unsolicited shoddy work.

Craig M. Wax, DO
MULLICA HILLS, N.J.

Gold Humanism Honor Society member Valerie Gribben, MD, won first place for her essay “The One Question to Get to the Heart of a Patient’s True Concern.” Read it in Medical Economics

We support keeping providers independent so they can focus on quarterbacking their patients care. Check out Marni Jameson Carey’s article in @MedEconomics for an in-depth look at the impact of facility fees and the impacts they have on independent providers.

Aledade, Inc.

Facebook.com/MedicalEconomics MedicalEconomics.com
Physician productivity and pay declined in 2017, new report says

Physicians compensation and productivity generally rises. But a new report from the American Medical Group Association (AMGA) shows that productivity declined and pay stagnated in 2017.

What happened to pay, productivity
The report suggests that because compensation is still heavily linked to productivity, a decrease in productivity has dragged down pay.

What the data shows
Primary Care

<table>
<thead>
<tr>
<th></th>
<th>2017-2018 Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compensation</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>1.1%</td>
</tr>
<tr>
<td>Pediatrics &amp; Adolescent - General</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

Three explanations
The reason productivity, measured in work relative value units (work RVUs), has declined is the daily life of a physician is becoming increasingly complex and buried under challenging technology and administrative burdens, according to Fred Horton, MHA, AMGA’s president.

These challenges include:
- Electronic health records
- Increasingly complex patients who require more face-to-face time
- Various administrative and compliance requirements

More compensation data
Find exclusive physician survey data and analysis of physicians compensation levels and trends in the exclusive Medical Economics 89th annual physician report. Read it here: http://www.medicaleconomics.com/business/drowning-paperwork
“You don’t care if she lives or dies, do you?”

Her grandmother’s words surprised me, not because we were having a disagreement over the next steps of needed care, but because her granddaughter’s death wasn’t even on my radar.

Her granddaughter was an older teenager, admitted with what I was sure were non-epileptic seizures and functional neurologic symptoms. In doing our due diligence, the team was moving forward with a lumbar puncture, which the family was demanding be done under full sedation. We were at an impasse, one in which I was unwilling to increase the risk of what I deemed a questionably needed procedure while her family was unwilling to subject her to any more pain than what they already perceived her to be in. I regretted even discussing the lumbar puncture.

My offers of anxiolytics and child life distraction were rejected, and now we stood in the hallway after her grandmother had asked me to leave the room. As a relatively new attending, this level of disagreement was new to me. In that moment, I was beyond frustrated with the patient and her family.

I have the insight to know I struggle to compassionately communicate and empathize with patients with this disease process, perhaps in large part due to my inability to fully comprehend and effectively treat it. This makes me more diligent and intentional with my interactions with these patients and their families, so to be at such a broken place with this particular family felt even more like a failure.

I remember very intentionally focusing on my body language, posture, and tone in an attempt to fake what I did not feel. I did care about this patient; I cared that she understood her diagnosis, partnered with me to seek treatment, and participated in discussions about risks and benefits of further testing and interventions.

But I did not care if she lived or died because that wasn’t part of the playing field we were on together.
And so when her grandmother asked me that question, I stopped explaining, stopped justifying, stopped talking. I stood (probably with my arms crossed, because I might not be that good at hiding my feelings when I’m caught off guard).

In the silent stare that followed, I saw her grandmother’s worry. She really did think her granddaughter was dying and that I had no compassion for what they were going through. And that, despite all my frustration, was enough to cause a paradigm shift so that I could really see her granddaughter for the first time.

She became more than just the story my residents had presented that morning. She became the cheerleader who was always at the top of the pyramid, until she wasn’t good enough one day. The straight-A student who felt enormous pressure to be the first in her family to have enough scholarships to go to college. The typical teenager who was peer-pressured by a boyfriend to do something she didn’t feel ready for. The mature but still-so-young woman who felt responsible for everyone in her family since her own mother chose drugs over her children.

In medical school, we are taught to see diseases; we review signs and symptoms, pair them with a few key social history points, and assimilate it all into a named disease process. We’re taught those diseases have people and lives associated with them, and some of us probably do a pretty good job at integrating it all together. For the rest of us, it takes work and effort to see the patients, lives, and people behind the illnesses we’re treating. Because, let’s face it—it’s easier to focus on the disease and treatment.

It’s much harder to delve deep into the muddy waters that are our patients’ lives. But only with that vulnerability do we form the bonds that really make us great physicians.

As for my patient, when I stopped talking, I started creating the opportunity for a different conversation. And that conversation led to an unsedated lumbar puncture with child life distraction. And it ultimately led to my original suspected diagnosis, which the family much more readily accepted.

Whether that occurred because we had all the necessary testing or because I opened a different conversation, I’ll never know. I still pride myself on being able to develop great working relationships with patients and their families, and I think communication is one of my strengths.

But now, when I’m faced with a challenging situation, instead of focusing so much on my body language and tone, I focus on really seeing my patient. And seeing my patients has never led me wrong.

Stephanie DeLeon, MD, has practiced pediatric medicine for nine years in Oklahoma City, Okla. She knew that she wanted to be a pediatrician from a young age. “I have always been drawn to science and pathophysiology, and I want to make a difference in the lives of others. I didn’t have any physician role models growing up, so I would say this was a calling I’ve always had,” DeLeon says.

Her advice to young physicians is simple: “Choose a path that you love, that makes you want to go to work every day. Because the days are long and the work is difficult, but if you truly love what you do, the satisfaction runs deep.” This advice rings true for DeLeon every time she witnesses her young patients transition from feeling ill to running out the door to go home.

When not practicing medicine, DeLeon enjoys crafting, photography, and reading (she highly recommends her latest read, All the Light We Cannot See by Anthony Doerr). She also enjoys spending time on the beach with her family in Destin, Fla.
One doctor’s mission to spread treatment around the world

What do the summits of Everest and Kilimanjaro, a small cancer clinic in Ghana, and Alaska’s historic 1,000-mile Iditarod Trail all have in common? For most people, they’re remote “bucket list” destinations with a mystique of adventure or danger. For radiation oncologist Dr. Larry Daugherty, they’re all places that have either improved his life, or given him a chance to improve the lives of others.

Rising to the top in the medical profession demands a long, steep climb through years of education and specialized training. For Larry Daugherty, the professional metaphor also happens to be literally true in his off time. He’s been an avid climber for much of his life, scaling peaks in Russia, South America, and Europe. It turned out that a friend in the same year of residency shared his mountaineering passion and they started planning climbs together.

“When we were climbing away from our clinic, we started to carry Tibetan prayer flags with us. It just started as a gesture to our patients — to bring them a flag that we had taken to the top of a mountain with their name on it.”

He and his friend never planned to start a nonprofit around it, but the idea caught on. Before long, others began hearing about the flags and wanted to know how they could dedicate one to someone they knew whose life had been touched by cancer.

In 2010, they started Radiating Hope to help improve access to cancer treatment services in developing countries. Supporters can dedicate flags, take part in climbing adventures around the world, and make direct donations toward radiation oncology equipment.

Today, Dr. Daugherty works in Anchorage, Alaska at a multidisciplinary cancer center where he is the only radiation oncologist. Having worked locum tenens during his residency, he knows the benefits a locums doctor can bring to a practice and he often has a locums physician work in his place while he is out having adventures or working with his non-profit.

He says, “One of the things that brought me up to Alaska was the opportunity to race in the Iditarod. I take time off to go out mushing, mountain climbing, or fishing with my kids. When I was looking at this job, the ability to take time off worried me because I’m essentially working by myself. It hasn’t been a problem at all being able to have locums as an option to come in and cover for me.”

Dr. Daugherty loves his work and says there’s nothing he’d rather do. “There’s never a question when I go home at night whether I made a difference in the world. I always feel like I did.” So far, he’s managed to make a difference in 14 countries, as well as in many communities around the United States — and there’s no telling where the positive ripple effects will go from there.

Learn more about locum tenens at locumstory.com
MEDICAL MALPRACTICE insurance is one of the greatest expenses physicians face during their careers. A primary care doctor can expect to pay hundreds of thousands of dollars in premiums over the decades.

But knowing what to look for in a policy is a mystery for many physicians, as well as a time-consuming chore that rarely gets the attention it deserves. And buying the wrong type or incorrect amount of insurance—or buying it from the wrong carrier—can be extremely costly.

Physicians who take the time to understand how to buy malpractice insurance will not only save money, but ensure that they’ve got the right type and amount of liability coverage.

TYPES OF INSURANCE
Policies typically cover expenses incurred while defending and settling malpractice suits. These can include attorney fees, medical damages, arbitration and settlement costs, court costs, and punitive and com-
“If I had to go out on my own [to shop for malpractice insurance] there is no way, as a physician, I could figure it out.”
—VIRGINIA KLADDER, MD, INTERNIST, PARTNERSMD, RICHMOND, VA.

Pensatory damages. Liabilities incurred from criminal acts or sexual misconduct usually are not covered.

There are two basic types of malpractice insurance: claims-made and occurrence. A claims-made policy provides coverage only if the policy is in effect both when the incident took place and when a lawsuit is filed. Occurrence policies cover any claim for an event that took place during the period the policy was in effect, even if the claim is filed after the policy lapses.

Because a claim can be filed years after an event and after a claims-made policy expires, these policies often include a “tail” that extends coverage for a set number of years beyond the expiration date. If it’s not part of the original policy, tail coverage can be bought separately.

Tail coverage offers protection when a physician is changing jobs or carriers or retiring. Sometimes, the cost of tail coverage will be covered by a previous employer to protect itself or can be negotiated with a new employer. Occurrence policies generally don’t require tail coverage, but are not available in all states.

If buying a claims-made policy, be sure that the beginning date for coverage is accurate and matches the date on the prior policy to ensure there are no coverage gaps between policies, says Jennifer Richard, ARM, RPLU, vice president of sales and mar-

Medical malpractice terms you need to know

- Annual Aggregate Limit (claims made): Maximum amount carrier will pay for all claims arising from incidents that occurred and were reported during a given policy year.
- Annual Aggregate Limit (occurrence): Maximum amount carrier will pay for all claims arising from incidents that occurred during a given policy year.
- Claims-Made Coverage: The most common type of professional liability coverage, it provides protection for claims that occur and are reported while the policy is in effect (coverage period).
- Limit: Maximum amount paid under terms of a policy. Most policies have two limits: a per-claim limit and an annual aggregate limit.
- Mature Premium: A step rating system used to set premiums for claims-made policies. The mature premium is the fee a policyholder will pay during the year the policy matures, generally the fifth through seventh year. The first level premium is substantially lower than a mature premium because it is designed for policyholders that are new to practice and therefore have no claims history.
- Nose Coverage: Also know as retroactive coverage or prior acts coverage. Supplemental insurance that covers claims from events that occurred before a policy went into effect, but were not reported. The period that is covered is stipulated in the supplemental policy.
- Occurrence Insurance: A type of policy under which the insured is covered for any incident that occurs (or occurred) while the policy is (or was) in force, regardless of when the incident is reported or when it becomes a claim. Occurrence insurance for medical liability coverage is rarely offered today because of the difficulty in projecting long-term claims costs.
- Tail Coverage: Supplemental insurance that covers incidents that occurred during the “active” period of a claims-made policy but are not brought as claims against an insured party, nor reported to the insurer, by the time the claims-made policy has ended. Tail coverage is purchased from an insured’s previous claims-made carrier and is generally 125 percent to 250 percent of the prior year’s premium.
Operations

Medical malpractice insurance

A BREAKDOWN OF MALPRACTICE COSTS AND CLAIMS

Internal Medicine

7.8%
percent of internists face a claim annually

2.4%
percent of claims results in a payment to a plaintiff

$311,524
*Median indemnity payment is $292,000; average is $311,524

$10,000 to $30,000
*Malpractice insurance costs from $10,000 to $30,000 a year

Family Practice

5.2%
percent of physicians face a claim annually

1.3%
percent of claims results in a payment to a plaintiff

$255,000
*Median indemnity payment is $130,000; mean is $255,000

$8,000 to $50,000
*Malpractice insurance costs from $8,000 to $50,000 a year, depending on location, specialty, size of practice and claims history

Source: Capson Physicians Insurance Co.

How much coverage?
The appropriate amount of coverage can vary by state, specialty, and contractual arrangements with hospitals and other healthcare organizations, says Richard. Some states require providers have minimum levels of coverage, but a physician can still need more.

In general, carriers’ standard coverage limits are $1 million per claim and $3 million aggregate, which is the most the policy will pay in a year for all claims. However, certain states require different limits based on medical malpractice caps on damages. States with more litigious climates might require more.

Richard cites the example of Virginia, which does not have a statutory requirement for medical liability insurance. However, the state has a medical malpractice cap of $2.35 million (which eventually will increase to $3 million). For that reason, hospitals require physicians to carry at least that amount with an aggregate that is three times higher ($2.35 million per claim/$7.05 million aggregate).

Some states have patient compensation or catastrophe loss funds, which provide an additional layer of coverage over the primary policy limits, says Eric Anderson, vice president of marketing and commu-

How to find a malpractice insurance carrier perfect for your needs

Continued on page 37
Empower Change | Address the Opioid Crisis

LabCorp offers options that provide unparalleled clinical value for monitoring patients who are prescribed controlled substances including opioids, antianxiety medications, and stimulants, as well as other psychoactive medications such as antidepressants, hypnotics, and muscle relaxants.

LabCorp offers choice in test options for individual patient’s needs:

**LabCorp MedWatch®: Monitor**
Customizable drug monitoring test options focused on many commonly prescribed pain medications and illicit drugs.

**LabCorp MedWatch® ToxASSURE® and ToxASSURE® Select**
Broad-spectrum drug profile offerings that analyze a range of compounds to assess medication use.

**Medication Assisted Treatment**
- Test options for Suboxone® medication assisted treatment
- LabCorp collaboration with The Recovery Platform, a valuable monitoring tool to help physicians address and manage the ongoing opioid crisis

**LabCorp is a full-service laboratory that provides exceptional customer service, patient care, and consultative technical expertise:**
- Comprehensive test menu, including comorbidity testing
- Extensive managed care network
- Technical support hotline

Urine drug testing is a critical component in patient care and may help achieve optimal outcomes when used in conjunction with patient risk assessment. Laboratory testing that is not considered medically necessary may result in coverage denials.

For more information, please contact your LabCorp representative, or consult the LabCorp Test Menu at [www.LabCorp.com](http://www.LabCorp.com).
Coding Insights

CODING CASE STUDY: Hypothyroidism and Radiculopathy

CHECK OUT THE FOLLOWING SCENARIO AND SEE IF YOU CAN CHOOSE THE CORRECT CODES.

Clinical Scenario

History of Present Illness
New patient presents for follow up of radiculopathy, hypothyroidism. She’s had pain in her neck, upper back and shoulders for 10 years. She has long history of depression.

Physical Exam

General Appearance: normal, NAD, delightful; BP 140/90
Peripheral Circulation: no cyanosis, clubbing, edema. No varicosities or spider veins
Auscultation: S1 & S2 within normal limits, regular rate and rhythm.
Palpation: no thrill or palpable murmurs, no displacement of PMI
Carotid arteries: pulses 2+, symmetric, no bruits
Abdominal aorta: no enlargement or bruits; difficult to assess because of obesity
Pedal pulse: Right dorsalis pedal pulse present 2+
Left dorsalis pedal pulse present 2+

Musculoskeletal

Gait and Station: normal, able to ascend and descend table without assistance.
Shoulders are without overt deformity; no erythema, warmth or edema. There is pain with movement; ROM of the shoulders without crepitus or popping.
She has neck pain and then also numbness (dormido) in the left hand 4th and 5th digits. Mostly positional.
Muscle strength normal; reflexes somewhat diminished in upper extremities; no sensation loss.
Psychiatric: Loses interest in normal daily activities, feels hopeless at times, lacks productivity at work. Has not tried therapy.

Assessment and plan

Chronic cervical radiculopathy
Will order x-ray of cervical region; she can try her linaments and also the patches like salon pas and aspercreme that contain lidocaine 4% - apply 12 hours on and 12 hours off

Congenital hypothyroidism
TSH; will contact patient with results

Major depressive disorder, recurrent,
Continue Lexapro; ambulatory referral to psych for therapy; we will monitor progress at next visit

High blood pressure
Blood pressures should be less than 130/80; document regular BP checks at home and bring with you at next visit

Diagnosis Codes

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Indiana. Send your billing and coding questions to medec@ubm.com.
What association health plans mean for physicians and their patients

by KEITH LORIA Contributing author

n June, the U.S. Department of Labor expanded access to health coverage options for small businesses and their employees through Association Health Plans (AHPs).

AHPs allow small businesses and self-employed workers to band together by geography or industry to obtain healthcare coverage as if they were a single large employer, thereby providing, according to the Trump administration, more choice, access, and coverage. However, AHPs generally do not cover as much as other health plans, which could spur frustration and concern among both patients and doctors as they learn what an AHP actually covers.

The American College of Physicians, for one, opposes the introduction of the new plans. “As a physician, I know from experience how crucial it is that patients have access to insurance plans that meet full healthcare needs,” Ana María López, MD, FACP, ACP’s president, said in a statement after the ruling. “This rule will do the opposite.”

Proponents of the new rule argue that it will provide small employers the same opportunity for coverage available to large employers with self-insured plans. “Many of our laws, particularly Obamacare, make healthcare coverage more expensive for small businesses than large companies,” U.S. Secretary of Labor Alexander Acosta said in a statement.

A HISTORY OF ASSOCIATION PLANS

Kevin Lucia, MHP, research professor and project director at Georgetown University’s Health Policy Institute, notes that since the 1990s, congressional proposals to create federally certified AHPs have been opposed by a broad spectrum of stakeholders, including the National Association of Insurance Commissioners. Opponents point to a history of association health plans that is rife with insolvency, fraud, loss of consumer protections, and market segmentation.

“Prior to this rule, under federal law, it was only in the rarest instance that an association of small employers could make the claim that they were so tightly connected that they were actually a large employer for the purpose of sponsoring a health plan, and that was the Obama Administration’s stance,” Lucia says.

Once established, AHPs may offer market coverage locally or nationally, provided the plan applies to members of a shared industry or profession or geography.

Lucia explains that for states, AHPs are important because they are trying to maintain a significant competitive market for insurance. However, if companies gravitate...
toward plans that have fewer protections or have a regulatory advantage, it leaves other in the insured market vulnerable to higher premiums.

IMPACT ON PHYSICIANS
Under the new AHP rule, Lucia says, it will be easy to form an AHP and market large group coverage to members.

He believes this may lead to AHPs offering less comprehensive coverage because these arrangements will not be required to offer coverage that is as comprehensive as what’s required under current law.

“Some AHPs will offer comprehensive plans that work to the [advantage] of their members, but one way you get the cheaper premiums is by offering fewer benefits, which means providers face more consumers with skimpier coverage.”

—KEVIN LUCIA, MHP, RESEARCH PROFESSOR AND PROJECT DIRECTOR, GEORGETOWN UNIVERSITY’S HEALTH POLICY INSTITUTE,
Tech Talk

The fine print on two-factor authentication

It seems like common sense that greater security would aid the fight against hackers, but physicians must be aware of the drawbacks before implementing these systems.

Hacking remains a constant threat, but with each security lapse, we learn something important about the shortcomings of our current data protection methods.

In October 2017, for example, hackers exposed the personally identifiable information (PII) of 18,470 patients at the Henry Ford Health System in Detroit after stealing employees’ emails. With only a single layer of authentication protecting the data, the thieves could easily break into the system.

This isn’t uncommon: Verizon’s data breach report found that 81 percent of all breaches are caused by stolen or weak credentials. And the healthcare industry is particularly vulnerable: In 2017, the number of data breaches totaled 328 worldwide, costing an estimated $1.2 billion.

To put that into perspective, consider that the second-most vulnerable industry—technology—experienced only 48 breaches in the same year.

To protect patients’ health records, many organizations have turned to two-factor authentication to maintain data security.

The goal is to go beyond passwords and add something unique to the user—making it harder for thieves to spoof.

To meet HIPAA authentication requirements, each factor must be one of the following: a password or security question, a signature or biometric (e.g., fingerprint, voice print, or iris pattern), or a mobile number to receive SMS codes. If a hacker can obtain a password but access also requires an SMS text code, the thinking goes, the organization’s data should remain secure.

However, two-factor authentication isn’t a guarantee against all security breaches, and even though two methods are better than one, neither is truly foolproof. So when implementing two-factor authentication, be wary of these shortcomings:

1/ Text codes are convenient but susceptible

SMS text codes are one of the most popular authentication methods because of their convenience. Our phones have become an extension of ourselves, and it wouldn’t take long to realize it was missing. But if it is stolen, cybercriminals are instantly closer to infiltrating your healthcare organization.

“Healthcare remains one of the most vulnerable industries. Follow the strictest precautions possible, even after implementing two-factor authentication.”

2/ User fatigue is a real problem

In some cases, thieves don’t even need the physical phone. There have been reports of hackers tricking mobile carriers into rerouting calls and texts to another number, after which they change passwords on accounts that use the number as a security backup.

The mobile market doesn’t have much incentive to increase security, either. Two major networks dominate the market, and the industry has remained one of the slowest to conform to two-factor authentication standards. This means that even if an employee receives the code, hackers could still exploit the network’s vulnerability.

One solution is to use a time-sensitive code that expires after being sent, shortening the window of time thieves have to hijack the SMS service. You can also add an additional layer of security with 2D codes—square bar codes that read both horizontally and vertically—that hospital employees scan with an app, such as Google Authenticator, before generating the text.

To protect patients’ health records, many organizations have turned to two-factor authentication to maintain data security.

The fine print on two-factor authentication

It seems like common sense that greater security would aid the fight against hackers, but physicians must be aware of the drawbacks before implementing these systems.

Hacking remains a constant threat, but with each security lapse, we learn something important about the shortcomings of our current data protection methods.

In October 2017, for example, hackers exposed the personally identifiable information (PII) of 18,470 patients at the Henry Ford Health System in Detroit after stealing employees’ emails. With only a single layer of authentication protecting the data, the thieves could easily break into the system.

This isn’t uncommon: Verizon’s data breach report found that 81 percent of all breaches are caused by stolen or weak credentials. And the healthcare industry is particularly vulnerable: In 2017, the number of data breaches totaled 328 worldwide, costing an estimated $1.2 billion.

To put that into perspective, consider that the second-most vulnerable industry—technology—experienced only 48 breaches in the same year.

To protect patients’ health records, many organizations have turned to two-factor authentication to maintain data security.

The goal is to go beyond passwords and add something unique to the user—making it harder for thieves to spoof.

To meet HIPAA authentication requirements, each factor must be one of the following: a password or security question, a signature or biometric (e.g., fingerprint, voice print, or iris pattern), or a mobile number to receive SMS codes. If a hacker can obtain a password but access also requires an SMS text code, the thinking goes, the organization’s data should remain secure.

However, two-factor authentication isn’t a guarantee against all security breaches, and even though two methods are better than one, neither is truly foolproof. So when implementing two-factor authentication, be wary of these shortcomings:

1/ Text codes are convenient but susceptible

SMS text codes are one of the most popular authentication methods because of their convenience. Our phones have become an extension of ourselves, and it wouldn’t take long to realize it was missing. But if it is stolen, cybercriminals are instantly closer to infiltrating your healthcare organization.

“Healthcare remains one of the most vulnerable industries. Follow the strictest precautions possible, even after implementing two-factor authentication.”

2/ User fatigue is a real problem

In some cases, thieves don’t even need the physical phone. There have been reports of hackers tricking mobile carriers into rerouting calls and texts to another number, after which they change passwords on accounts that use the number as a security backup.

The mobile market doesn’t have much incentive to increase security, either. Two major networks dominate the market, and the industry has remained one of the slowest to conform to two-factor authentication standards. This means that even if an employee receives the code, hackers could still exploit the network’s vulnerability.

One solution is to use a time-sensitive code that expires after being sent, shortening the window of time thieves have to hijack the SMS service. You can also add an additional layer of security with 2D codes—square bar codes that read both horizontally and vertically—that hospital employees scan with an app, such as Google Authenticator, before generating the text.
Remember that two-factor authentication is not people-proof and security threats are constantly evolving.

An excess of confidence leaves your employees more likely to fall for a crafty scheme, especially now that phishing attacks are sneakier than ever. For example, a hacker recently compromised LinkedIn’s two-factor authentication measures by sending seemingly authentic emails to users. Those who opened the link were sent to a fake login screen, where they completed the two-factor authentication process. Hackers could observe and record the session’s cookies, then use them to act as authenticated users.

The trick worked because the only difference between LinkedIn and the email’s origin was an L in place of an I in the URL. Details like this are easy to miss, so make sure every employee carefully examines the origin of any unsolicited or unexpected email—even if it seems authentic.

Two-factor authentication is a significant step toward protecting your organization, but it doesn’t change the fact that healthcare remains one of the most vulnerable industries. Follow the strictest precautions possible, even after implementing two-factor authentication, and utilize additional features to help build up the security it already provides.

Recently revealed that fewer than one in 10 users have enabled the free two-factor authentication measures it offers. Hospital staff members are constantly pressed for time, and the idea of taking extra steps, even if they’re for a good reason, won’t sound appealing. As a result, they’ll be keen on finding ways to get around their own two-factor authentication to save time—making mistakes or ignoring some of the processes altogether. This can cause technical errors and bog down the tech help desk, giving hackers a weak link to exploit.

To reduce fatigue, personalize two-factor authentication with adaptive risk assessments that analyze each user’s IP address, location, device, and credential behavior every time he or she signs in. The second authentication will only be triggered if an anomaly indicates a potential risk rather than every time an employee signs in.

3/ Trusted devices create liability

When you label devices as “trusted” within your network, they only require two-factor authentication periodically. If access to the trusted device is compromised, two-factor authentication loses its value. The device doesn’t need to be stolen to be compromised, either. Organizations often forget to update their trusted devices list when employees leave or when devices are lost. As long as those devices remain trusted, they’re a huge liability.

In addition to routinely updating your list of trusted devices, you can encrypt and password-protect them for added security. You might even consider placing a time limit on how long devices are considered trusted. Limiting who can view sensitive information by implementing role-based access to patient records and protected health information is another way to protect data.

4/ You’re never fully protected

Once you see improvement in user engagement and lower security risks, it’s easy to become overconfident in your security measures.

Trusted devices create liability

When you label devices as “trusted” within your network, they only require two-factor authentication periodically. If access to the trusted device is compromised, two-factor authentication loses its value. The device doesn’t need to be stolen to be compromised, either. Organizations often forget to update their trusted devices list when employees leave or when devices are lost. As long as those devices remain trusted, they’re a huge liability.

In addition to routinely updating your list of trusted devices, you can encrypt and password-protect them for added security. You might even consider placing a time limit on how long devices are considered trusted. Limiting who can view sensitive information by implementing role-based access to patient records and protected health information is another way to protect data.

4/ You’re never fully protected

Once you see improvement in user engagement and lower security risks, it’s easy to become overconfident in your security measures.

Trusted devices create liability

When you label devices as “trusted” within your network, they only require two-factor authentication periodically. If access to the trusted device is compromised, two-factor authentication loses its value. The device doesn’t need to be stolen to be compromised, either. Organizations often forget to update their trusted devices list when employees leave or when devices are lost. As long as those devices remain trusted, they’re a huge liability.

In addition to routinely updating your list of trusted devices, you can encrypt and password-protect them for added security. You might even consider placing a time limit on how long devices are considered trusted. Limiting who can view sensitive information by implementing role-based access to patient records and protected health information is another way to protect data.

4/ You’re never fully protected

Once you see improvement in user engagement and lower security risks, it’s easy to become overconfident in your security measures.

Trusted devices create liability

When you label devices as “trusted” within your network, they only require two-factor authentication periodically. If access to the trusted device is compromised, two-factor authentication loses its value. The device doesn’t need to be stolen to be compromised, either. Organizations often forget to update their trusted devices list when employees leave or when devices are lost. As long as those devices remain trusted, they’re a huge liability.

In addition to routinely updating your list of trusted devices, you can encrypt and password-protect them for added security. You might even consider placing a time limit on how long devices are considered trusted. Limiting who can view sensitive information by implementing role-based access to patient records and protected health information is another way to protect data.

4/ You’re never fully protected

Once you see improvement in user engagement and lower security risks, it’s easy to become overconfident in your security measures.

Trusted devices create liability

When you label devices as “trusted” within your network, they only require two-factor authentication periodically. If access to the trusted device is compromised, two-factor authentication loses its value. The device doesn’t need to be stolen to be compromised, either. Organizations often forget to update their trusted devices list when employees leave or when devices are lost. As long as those devices remain trusted, they’re a huge liability.

In addition to routinely updating your list of trusted devices, you can encrypt and password-protect them for added security. You might even consider placing a time limit on how long devices are considered trusted. Limiting who can view sensitive information by implementing role-based access to patient records and protected health information is another way to protect data.

4/ You’re never fully protected

Once you see improvement in user engagement and lower security risks, it’s easy to become overconfident in your security measures.

Trusted devices create liability

When you label devices as “trusted” within your network, they only require two-factor authentication periodically. If access to the trusted device is compromised, two-factor authentication loses its value. The device doesn’t need to be stolen to be compromised, either. Organizations often forget to update their trusted devices list when employees leave or when devices are lost. As long as those devices remain trusted, they’re a huge liability.

In addition to routinely updating your list of trusted devices, you can encrypt and password-protect them for added security. You might even consider placing a time limit on how long devices are considered trusted. Limiting who can view sensitive information by implementing role-based access to patient records and protected health information is another way to protect data.

4/ You’re never fully protected

Once you see improvement in user engagement and lower security risks, it’s easy to become overconfident in your security measures.
VOTED #1 EHR IN THE NATION
Practices sell regularly, many for a good price with minimal fanfare. At least half of all practices offered for sale never sell, however. Not every practice has value, nor does every seller try to sell their practice properly. This low sales rate is not peculiar to medicine—it’s similar for most small businesses according to business broker industry reports.

The more profitable your practice, the easier it usually is to sell, and the more it is worth to a buyer.

**WHO BUYS PRACTICES?**

Hospitals have been the top practice acquirers since Obamacare started, and often the easiest purchasers to sell to.

Unfortunately, hospitals usually will only pay the fair market value of your practice’s assets, and nothing for its intangible “goodwill” value. Hospitals do this to avoid government charges that they violated the law by “paying for referrals.” They likely will offer you good-paying employment and benefits; often more than you can earn on your own.

Venture capital and private equity groups pay top dollar for leading group practices in some specialties, but they are extremely selective and their terms may be onerous.

I find that graduating residents and fellows are rarely the buyers of practices. Many get 50 to 100 job offers prior to finishing their training, mostly from large and hosp-
tal-owned groups. These job offers are inundating them and not just more preferable, but easier than taking on a new practice.

Dissatisfied employed physicians re-entering private practice, and physicians relocating to be nearer to their or their spouse’s family are the primary candidates for buying a practice. They have a choice of joining another group, starting their own practice, or buying your practice. You therefore are not competing just with other practices for sale but also with employment in groups and start-ups.

Your most likely buyers are already practicing in your area, since they don’t have to move or re-license, and they have a strong reason to be there. In many cases, the most likely buyer might be your competition.

For a seller, putting a practice up for sale not only can result in financial reward, it can also dispose of the ongoing expense of custodianship of a career’s worth of patient records. This can easily run into the tens of thousands of dollars, so sometimes it’s even worth it to pay a buyer (like a colleague in your call group) a nominal amount to take over your practice.

Check your state laws or guidelines with your malpractice insurance carrier or state medical association regarding medical record custodianship laws.

**TIPS TO HELP YOU SELL**

If you are considering the sale of your practice—even if you are just early on in the thought process—here are some initial steps.

**PLAN AND PIVOT**

Plan at least a year ahead if possible, but also be ready to sell to the first candidate on short notice, and maybe stay employed by them during the transition. That candidate might have been looking for a while, and now your opportunity pops up and they respond.

There is no guarantee there will ever be a second candidate.

**MAINTAIN BUSINESS AS USUAL**

Don’t slow down your practice in advance. Growing practices are more attractive than stagnating ones.

**DON’T RULE OUT A MERGER**

Consider merging your practice with a local group in lieu of a sale to a unknown single buyer, with a higher compensation for one to three years in lieu of a sale price.

**KNOW YOUR VALUE**

Overpricing is the number one reason why businesses don’t sell. Get a professional appraisal—both to price the practice correctly and to convince a buyer of its value—using a medical practice expert that can demonstrate compliance with the Uniform Standards of Professional Appraisal Practice (USPAP).

---

3/ **Sellers often demand help from buyers.**

This may mean that the seller stays onboard for some time after the sale in order to introduce established patients to the buyer and help ensure minimal attrition. “If you just try to substitute the buyer for the seller without any transition, that might freak the patients out,” says Nechay. To avoid doing that, sellers often continue to work full time for a while, then ease off to part time for a period that may range from a couple of months to a few years.

4/ **Getting a good deal means more than just the purchase price.**

“Sellers need to look at the whole deal structure in its totality,” says Nechay. Often, sellers no longer wish to work full time but neither are they ready to abruptly stop practicing completely because they still enjoy working. In many such cases, Nechay has seen that a buyer will pay a seller to continue working part-time, which makes things more comfortable for the seller. “Focus on the transition plan and what they are going to pay you after the sale,” he says.

5/ **Deals often devalue after a death.**

A medical practice is more valuable when the person who built it is still around and able to help with the transition. This suggests that doctors ought not to work until they die, because that approach leaves the doctor’s family with a much less valuable entity to sell. Nechay has seen situations where a physician’s ability to practice has been abruptly cut short either by death or by a major health setback. “The family may bring in a locum tenens to take care of patients and to try and reduce attrition. We’ve done deals where we’ve sold practices under these circumstances. It’s very difficult and the value is going to drop.”
Learn what EBITDA stands for, and use a multiple of it in your pricing strategy.

**HAVE YOUR FINANCING AT THE READY**

Get your business pre-qualified for a 100 percent bank loan at the asking price for a qualified buyer, which reduces low-ball offers. Both the buyer and the practice must qualify for the loan.

If you pre-qualify the practice to support a loan for the asking price, the seller then only needs to get the buyer qualified when they appear.

On the other side of the coin, if the buyer qualifies, and the bank then refuses to loan because the practice doesn’t qualify, that’s a bad thing to learn later. Get qualified in advance.

**POLISH UP YOUR ONLINE PRESENCE**

Most purchase candidates now come via internet searches. Prepare a proper professional promotional package, including a dedicated search engine optimized website separate from the practice’s business site.

You should also have a regular website for the practice and be on LinkedIn and Facebook.

**MAKE A GOOD FIRST IMPRESSION**

Clean up the office—and your desk—to make them appear modern and attractive. Fresh paint, carpet, and furnishings are inexpensive and create quality “staging.” Perhaps ask a local real estate broker for a referral to a stager.

**ASSEMBLE YOUR EXPERT ADVISERS**

You have to assume the buyer will engage competent advisers to evaluate your practice, so engage competent counsel yourself including an experienced medical practice broker, certified public accountant, and business attorney.

Many can be found through the National Society of Certified Healthcare Business Consultants (NSCHBC.org) and HealthLawyers.org.

**GET YOUR NUMBERS IN ORDER**

Make sure your last one to three years’ accounting and statistics conform to standards like those developed by the NSCHBC or Medical Group Management Association This will give the buyer and their advisers more confidence in your data and operations.

**REMEMBER, YOU AREN’T ONLY COURTING A PHYSICIAN**

Be prepared to convince the buyer’s spouse and children to live in your community, with a tour of local homes with a real estate agent, visiting schools, malls, local attractions, etc.

**PITCH A PROGRESSIVE PURCHASE**

Consider offering the buyer a chance to work for one to three years at reduced income, then purchasing the practice for the value of the hard assets, “without goodwill.”

Your offer to sell then will look more competitive with employment. An offer document can cover all the relevant information to help an investor to make his or her investment decision.

**GET A COMMITMENT ON PAPER**

Get everything in writing to avoid future misunderstandings or litigation. You can work with your lawyer or broker to list everything required for due diligence. The seller must assemble this for the buyer’s review.

**DON’T ZERO IN ON A PROFIT**

In this current down market for practice value, sell for reasons of personal lifestyle—like reduced administrative hours, retirement, or disability—not for anticipated financial gain for equity to fund retirement or something else.

The practice is built to create continuing income, already harvested through work years, not for future equity.

**KEEP AN EYE ON D.C.**

Consider waiting until after the 2020 elections to sell, as hopefully the medical environment will have stabilized at that point, with any luck improving practice fiscal value.

Keith Borglum, CHBC, CBB, is a licensed and certified business broker, appraiser, author, and member of the National Society of Certified Healthcare Business Consultants (NSCHBC.org) specializing in outpatient medical practices for over 30 years. He is a regular contributor to Medical Economics and many medical association journals. He is the author of The Medical Practice Valuation Workbook.
here’s a great deal of misunderstanding and even misinformation about direct primary care (DPC). It is often confused with higher cost “concierge” or “boutique” practices, and hence is seen as elitist, unaffordable, and consequently something that has only a future as a niche version of care.

So let me clarify things by once again stating what DPC is:

1 **Primary care that excludes third-party payments.** No money is accepted from insurance companies or other third-party payers. Payment comes either from the patient or by an employer who offers the care to its employees.

2 **Payments are made on a monthly, quarterly, or yearly basis,** with that charge usually being under $100 per patient per month (generally in the $50 per month range). Some offices charge a small copay for office visits, but most do not.

In my office, we charge between $35 and $70 per month, depending on age. There are no charges for office visits.

Both of these differences are a huge departure from the status quo of medicine, and both have a huge effect on the quality and cost of the care given. All of those effects would be too much to explain in depth in a single article, so this month I will focus on the implications of direct patient payment, and next month will discuss the monthly payment.

Before moving on, let me address a common misconception: DPC is not meant to replace insurance, nor does the model in any way encourage patients to drop their insurance. People need a way to pay for the high-cost areas of care, such as surgery and hospitalizations. DPC doesn’t try to address paying those costs, but instead focuses on decreasing their need by focusing on health and prevention.

While that may sound like typical preventive medicine jargon, it really is in the best interest of the DPC practice to keep patients healthy and reduce the need for catastrophic care.

Using automobile insurance as a parallel, health insurance has done the equivalent of paying for oil changes, tires, and other car repairs in addition to covering collision and liability. But the consumer is already motivated to do those things and will pay out of pocket to maintain their car so as to avoid needing to use their automobile insurance at all. Additionally, paying for tires, oil changes, etc., allows these things to have artificially set prices which are unreasonably high (since it’s covered by insurance) and so the cost of routine maintenance goes up.

So, what are the implications of rejecting insurance payment?

**THERE IS AN INCREASED FOCUS ON REDUCING THE COST OF CARE.**

My patients are paying me, so I am very conscious of trying to give them their money’s worth. If I can give them value (a concept that has become foreign to healthcare), patients are happy with my care and will continue to stay in my practice.

It’s in my business’ best interest to do this, so we do a number of things to save patients’ money:

- We offer very low-cost lab testing (using “client billing”), saving people 75 percent or more on labs.
- We dispense medications in the office (legal in most states), also saving people 75 percent or more, and offering a huge convenience to the patient.
- We find the lowest cost for procedures, X-rays, and specialist services. While many of these are covered by insurance, most people have higher deductibles, so the lower cash prices are very valuable to them (not to mention the value to the uninsured).

None of these give significant direct income to the practice, but they all
make patients much more reluctant to leave. In truth, these things end up being our biggest marketing tool, as patients frequently brag to friends and family about their doctor “who saves me money.”

THE RESULT OF THIS WORK HAS HAD THREE KEY BENEFITS:
There is an increased focus on customer service.

It is fairly easy to exceed expectations in the area of customer service, as people have an increasingly low expectation for the service they get at the doctor’s office. It’s normal to have to wait an hour or more to be seen, and then get only a few minutes of the doctor’s time (if a doctor is seen at all). This results in, at best, frustration. At worst, people avoid care they should be getting.

In our practice, the patient has a much different experience:

- Patients seldom have to wait more than 10 minutes to be seen.
- Appointments are, on average, 30 minutes per patient.
- Most days begin with multiple slots open for same-day urgent visits.
- Care is often done via text message or phone, reducing the need for coming to the office at all.

Much of these changes hinge on the use of monthly payment for care (eliminating the economic motivation for unnecessary care). But a premium is placed on patient experience in the office, and again this is done because it’s in the best interest of the business.

“I remember asking myself: ‘What would medical records look like if their only purpose was patient care?’ This was a radical question at the time.”

PATIENT RECORDS ARE FREED FROM THE CODING NIGHTMARE.
I remember asking myself: “What would medical records look like if their only purpose was patient care?” This was a radical question at the time. Records long ago become the domain of a ridiculously complex payment system that requires submission of data and over-documentation to justify billing codes. It was hard to imagine not having to think about evaluation and management codes, Meaningful Use or the Medicare Quality Payment Program, or other “pay-for-performance” factors when charting.

But that is what happens when insurance is eliminated. I now document for care, leaving out parts of the note (what I refer to as “computer vomit”) that get in the way of patient care.

I am daily reminded of the depth of this change, as I get records from specialists, previous primary care physicians, and hospitalizations. Most health records hide important clinical information in an avalanche of insurance documentation compliance.

PATIENTS TRUST THEIR DOCTOR MORE.
This may be a subjective one, but it is very important. Patients are increasingly suspicious of the motivations of their physicians, wondering if the care they get is focused on them or if it is done for increasing revenue or following insurance company rules. They question the doctor’s motivation when that doctor is financially rewarded for increasing the cost of care. The dichotomy between the needs of the patient and the business interests of the practice sows mistrust and undermines the doctor-patient relationship.

My patients don’t have to question this. I am rewarded for minimizing the cost of care, for getting them healthy, and for helping avoid unnecessary cost. So, I am not questioned nearly as much when I don’t prescribe an antibiotic or when I recommend physical therapy instead of pain medication. People know I am on their side because they pay me to do so.

Overall, this has resulted in a much better relationship with my patients, has increased my satisfaction in practicing medicine, and has improved the quality of care I can give.

Rob Lamberts, MD, is a board-certified internist and pediatrician who runs Dr. Rob Lamberts, LLC, a direct primary care practice in Augusta, Ga. He also recently gave a TED talk on the DPC model (bit.ly/DPC-TED-talk). Have questions about DPC? Email medec@ubm.com.

READ MORE  Why facility fees are bad for physicians and patients  PAGE 40
healthy vitals

ProAssurance has been monitoring risk and protecting healthcare industry professionals for more than 40 years, with key specialists on duty to diagnose complex risk exposures.

Work with a team that understands the importance of delivering flexible healthcare professional liability solutions.
The quest to find affordable insulin for patients

9 strategies physicians can use to help their patients with diabetes improve access to this vital medication

by ILENE MACDONALD Contributing author

HIGHLIGHTS

► To help streamline the prior authorization process, have staff research the most common insurers that cover their patients and create a preferred formulary list for physicians.

► Some drug manufacturers offer assistance to patients who don’t have prescription drug coverage and who meet certain income and eligibility requirements.

Near every day, Justen Rudolph, MD, has a conversation with a diabetic patient who is upset about the rising cost of insulin.

Just recently, the internal medicine specialist spoke with an 86-year-old patient who was very concerned about the price of the life-saving medication and worried because she was unable to get enough test strips covered under Medicare rules and guidelines.

It’s a discussion physicians are having more and more often with their diabetic patients—especially those who are uninsured or underinsured or have hit the “donut hole” in the Medicare Part D program—as a result of the skyrocketing prices of insulin. “We’ve seen retail costs go up 250 percent in the last 10 years,” says Rudolph, director of St. Vincent Diabetes Center in Billings, Mont.

As a result, some patients who can’t afford insulin will underuse it to stretch out the medication, Rudolph says, a dangerous practice that can lead to serious, long-term complications, including kidney failure, blindness, and lower-limb amputations. A study published in July in Diabetes found that one in four patients at Yale Diabetes Center reported cost-related insulin underuse that was associated with poor glycemic control.

“It’s a horrible situation,” says Hayward Zwerling, MD, FACP, an endocrinologist at the Lowell Diabetes & Endocrine Center in North Chelmsford, Mass. Zwerling says 90 percent of his patients use insulin, so he personally spends much of his time on the websites of health insurance companies trying to determine which type of insulin they will cover and how much it will cost his patients. But the information isn’t always up to date and he frequently finds out later from patients their prescription isn’t covered.

So what can physicians do to ensure their patients are able to find affordable insulin? Consider these strategies that internal medicine physicians, endocrinologists, and physician practices have used to ensure their diabetic patients get the insulin they need:

1 SEND PATIENTS TO WALMART
Walmart sells one of the most affordable insulins on the market, a godsend for uninsured patients or those with high-deductible health plans, says David M. Nathan,
MD, director of the MGH Diabetes Center and Clinical Research Center in Boston. The retailer sells ReliOn, its store-brand version of Novo Nordisk’s Novolin for $25 a vial and in many states doesn’t require a prescription. Nathan says it’s an older generation of insulin that many doctors are unaware of because drug manufacturers spend more money advertising newer, longer-acting insulins.

Jeremy A. Greene, MD, PhD, associate professor of history of medicine at the Johns Hopkins University School of Medicine, who also practices internal medicine at the East Baltimore Medical Center in Maryland, says many of his patients with Type 1 diabetes depend on the insulin Walmart sells even though it is short-acting and thus requires more than one dose a day. The problem, he says, is that the retail chain could discontinue the program at any time and patients need to live near enough to a Walmart to be able to purchase the medication.

2 USE A WEBSITE TO FIND THE BEST PRICES FOR MEDICATION

Yul D. Ejnes, MD, MACP, an internist at Coastal Medical Inc. in Providence, R.I., is a fan of GoodRX.com. The website has a tool that allows patients and physicians to find out the cost of a medication within their geographical area, which pharmacies have it, and it will even link to a discount coupon for the prescription if available.

“[GoodRX is] a wonderful tool for that situation where a patient is going to have to pay out of pocket,” he says.

3 CHECK WHETHER THE DRUG COMPANY HAS DISCOUNT CARDS OR COUPONS

For patients with commercial insurance, Coastal Medical will also check to see if manufacturer coupons are available for insulin, according to Sarah Thompson, PharmD, the practice’s director of clinical services. If available, a coupon can lower the cost of the patient copay to $20 or in some cases to zero she says.

However, patients who don’t have insurance or are covered by Medicare and/or Medicaid can’t take advantage of discount cards or coupons due to a federal rule, notes Rudolph.

“It makes zero sense to me. People on fixed incomes who need the help the most are the ones who can’t use discount cards,” he says.

4 LOOK ACROSS THE BORDER

Insulin is far less expensive in other countries. Irl B. Hirsch, MD, professor of medicine at the University of Washington Medical Center-Roosevelt in Seattle, Wash., says his patients can take a two-hour drive to the Canadian border and purchase insulin for a tenth of what it costs in the U.S.

But realistically that option is available only to those who live near the border with Canada or Mexico, because it’s illegal to mail insulin internationally. But Hirsch says that his patients can buy insulin at a Canadian pharmacy and take it over the border as long as the insulin is for their use or for a family member.

5 EXPLORE PATIENT ASSISTANCE PROGRAMS

Some drug manufacturers offer assistance to patients who don’t have prescription drug coverage and who meet certain income and eligibility requirements. In some cases the patient may receive medication at no cost, explains Thompson. She says Coastal Medical’s pharmacy technician team helps patients who can’t afford their insulin with the application process.

Ejnes also recommends that physicians suggest that patients explore the website Needymeds.org to find out what programs may be available to help them afford insulin. Patients who are computer literate can do a lot of the legwork themselves to see if they meet the income requirements, he says.
HAND OUT SAMPLES

Pharmaceutical companies typically provide physician practices with samples of newer medications they want to sell.

Claresa S. Levetan, MD, takes advantage of this practice to give patients drugs at no cost. Levetan, who specializes in endocrinology, diabetes and metabolism, and internal medicine at Jefferson Health Endocrinology in Philadelphia, says it’s not unusual for patients to ask for samples because they can’t afford the out-of-pocket costs.

“Hand out samples and created a preferred formulary list for physicians. This way they can prevent patients from delays due to the need for a prior authorization or step therapy, Thompson says.

However, “part of what makes this difficult is that formularies change frequently. Patients often experience multiple medication conversions, sometimes year after year. This makes medication adherence challenging,” she says.

Elbert Huang, MD, MPH, professor of medicine and director of the Center for Chronic Disease Research and Policy at the University of Chicago, says because each health plan has its own preferred insulin analog, and that plan may change year to year, he talks with his patients about the problem.

If patients agree to use the drug preferred by their prescription drug plan, Huang will prescribe it. For those patients who don’t want to change medications, he explains that he’ll have to go through a prior authorization process that will take time and may not be approved.

EDUCATE PATIENTS ABOUT THE IMPORTANCE OF DIABETES MANAGEMENT

Thompson would like insurers to provide incentives, such as reduced costs for testing supplies or medications, to patients with diabetes if they attend classes or work with a care manager or diabetes educator. “I think programs that empower patients and give them a tangible benefit might be one additional strategy” for patients to better manage the disease, she says.

Levetan also recommends that physicians focus on patients’ pre-diabetes so they can reduce the risk of the disease progressing. This requires physicians to start educating patients who have higher than normal blood glucose levels before they develop diabetes.

But she also suggests educating children about the disease.

“Our healthcare system still hasn’t focused on prevention of disease too well,” Levetan says, noting that the number of children with Type 2 diabetes is on the rise. Teaching children about healthy lifestyles at office visits and in schools could make a big difference in preventing diabetes, she says.
World-Class Educational Program Includes:

**Advanced Hands-On Injectable Training** – Neurotoxin and Dermal Filler Techniques

**Certified Aesthetic Consultant Certification** – Advanced Techniques for Practice Success

**General Education** – All About Aesthetics

CME Credits Available
Live Demonstrations
Financial Strategies

How to drive down practice expenses

It can be difficult to stay on top of ongoing expenses. Because physicians are so busy taking care of patients, the first time a practice signs an agreement for products or services with a vendor is usually the last time those prices are assessed. But implementing a regular review of your expenses is critical. Here’s how to do it.

Start with easy stuff
First, determine if you are part of a buying group (group purchasing organization or GPO). If you are not, you are likely paying much more than you need to on items such as medical and office supplies, medications, vaccines, and other services. There are many GPOs to choose from so start with your medical association or local chapter to determine which one(s) they recommend for your specialty.

Next, salary and benefits
Have you considered using a professional employment organization (PEO)? These organizations become the employer of record; so while you maintain the management of your employees, the PEO bundles up payroll, HR services and compliance, workers compensation, employer liability insurance, health care benefits, and so on under its entity.

You pay either a flat rate per employee per month (Justworks) or a percentage of payroll (ADP) and the PEO does the rest.

While it might seem more expensive than what you pay for payroll cost alone, one of the biggest benefits (and cost savings) is access to health care benefits that are priced for a much large entity than your practice could obtain alone. Additionally, there are often many ‘perks’ included such as gym memberships and life insurance, optional short term and long disability plans that employees can purchase and so on.

You should also determine if you are routinely paying overtime, and shop around for new payroll companies to make sure that you are not overpaying for those services. 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? Shop around for the best deals.

Simply asking your bank for a better deal can produce nice savings. A recent client—single location, four physician group—saved $4500 a year in fees by switching to a new bank, but also gained process efficiencies with free remote deposit and online account access.

Shop around for better credit card rates too. Approach your vendor and ask them to reduce their fees—there is not much they can do on the credit card rates, but they can reduce monthly fees and per transaction costs.

Call the 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.

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

Don’t stop there
Once you get the hang of reviewing pricing, terms and negotiations, look at every expense item on your profit and loss sheet and apply the same methods to each of them. If you set up a system whereby you know what contracts and pricing you have with each vendor, and routinely review those rates annually and / or upon renewal, you will save yourself thousands of dollars in expenses every year.

Susanne Madden, MBA, is founder and CEO of the Verden Group, a consulting firm that helps physicians navigate the business of healthcare. Send your financial questions to medec@ubm.com.
Cryptocurrency, such as Bitcoin, is an alternative currency that lives in the digital world and can be used either as an investment, or to buy real things. Depending on who you ask, it’s either the next big thing, or risky business.

Is investing in cryptocurrency something to avoid, as financial titans such as Warren Buffett have said, or are physicians missing out on a prime investment opportunity if they don’t give it a try? The answer is somewhere in the middle.

Cryptocurrency is definitely not the place to pour an entire retirement savings, nor is it likely that medical practices will be adopting Bitcoin as a standard payment option anytime soon. However, if doctors are interested in the technology supporting cryptocurrency, generally distrust banks, or just want to try a new kind of investment, Bitcoin and other digital coins are worth learning about.

**HOW DOES CRYPTOCURRENCY WORK?**

Though there are now about 2,600 types, Bitcoin was the first cryptocurrency (invented in 2009) and it’s still the most ubiquitous. Consumers can buy and sell Bitcoin and other digital coins, and use this digital currency to pay for purchases. It’s different from traditional currency because there are no bills or coins. Also, cryptocurrency is decentralized.

“When you send cryptocurrency to someone or use it to buy something, you don’t need to use a bank, credit card, or any other third-party type of intermediary to coordinate that transaction. The transaction goes directly from you to the other person (electronically) and arrives securely and almost instantly—all without any middleman involved,” says Mark Grabowski, JD, an associate professor at Adelphi University who teaches courses on Bitcoin and internet law.

The decentralized model is what makes Bitcoin so attractive to many consumers and investors.

“This is the first time in the last 100 years [consumers] have a medium of exchange that isn’t related to government, and we have full control of,” says Ofir Beigel, who runs 99Bitcoins.com, one of the oldest and largest information sites about Bitcoin and cryptocurrency. The lack of regulation is also what makes Bitcoin volatile, subject to both large gains and losses in a short amount of time. “Never invest more than you can afford to lose,” Beigel says. That’s true for buying Bitcoin or other cryptocurrency.
GETTING STARTED WITH BITCOIN

Whether physicians want to spend it or stockpile it as an investment, getting started with Bitcoin requires a Bitcoin wallet, which is a program similar to email that helps someone send and receive Bitcoin.

An investor can either download a free software wallet to their computer or phone, or purchase a hardware wallet, which is a physical device that's virtually unhackable.

"Don't spend money on hardware the first time, because it costs $80 or $90," Beigel says. He advises starting with a small amount and only investing in a hardware wallet once someone gets comfortable with how Bitcoin works and/or are making larger investments.

After downloading a free wallet, a user will receive a Bitcoin address, which is a randomly generated long string of numbers and characters that acts as the user's identifier. The second thing a wallet provides is a private key or seed phrase. This acts as the password to the wallet and should be kept secure.

Once the wallet is set up, the user can begin buying Bitcoins (or more likely fractions of Bitcoin, since a whole Bitcoin was worth $7,364 at press time). Buying from brokers, such as Coinbase—which both Beigel and Grabowski recommend to get started—is the simplest option, but it does cost more.

"You should only buy from trusted exchanges online," Beigel says. Another option is to buy from a trading platform, such as CEX.IO or Bitstamp, which securely connects buyers and sellers. These platforms are a less expensive way to buy Bitcoin, but Beigel says they are more difficult to use, especially for newcomers.

The third way to buy Bitcoin is directly from other sellers. "This is the method I least recommend," Beigel says, because there is a chance of fraud.

In theory, Bitcoin spends like traditional currency. But that doesn’t mean it’s always easy to use. Bitcoin debit cards are available, Beigel says. The consumer loads the debit card with Bitcoin to use for spending, and the merchant gets paid in their own currency (dollars, Euros, etc.).

That’s not highly practical though. Each time a person trades, sells, or uses cryptocurrency, that’s a taxable event, since the IRS considers them an asset, not a currency. "So, if you use your Bitcoin to buy a cappuccino, you’ll need to pay taxes at the capital gains rate in addition to paying sales tax," Grabowski says.

What about other cryptocurrencies?

With so many types of cryptocurrency, how does one choose?

Grabowski recommends that users just getting started should invest conservatively and only purchase established, “blue chip” cryptocurrencies, such as Bitcoin (BTC) and Ethereum (ETH).

“These are the two largest cryptocurrency projects and have a real (purpose). Moreover, you usually need to buy one or the other before you can purchase other cryptocurrencies,” he says. When someone purchases an alternative cryptocurrency or “altcoin,” they are viewing its value in relation to another cryptocurrency (namely ETH or BTC), he explains. “After you gain some experience managing a portfolio with these coins and have had time to conduct research about other coins and study the market, you might foray into altcoins.”
“Cryptocurrency is traded around the world 24/7. So, you may go to bed at night feeling pretty happy about your portfolio only to wake up the next day and see you’ve literally dropped 25 percent overnight.”

—MARK GRABOWSKI, JD, ASSOCIATE PROFESSOR, ADELPHI UNIVERSITY

Grabowski says. It’s volleyed back and forth since Bitcoin’s inception in 2009, and it still fluctuates wildly in any given 24 hours.

“Unlike the nine-to-five hours of the New York Stock Exchange, cryptocurrency is traded around the world 24/7. So, you may go to bed at night feeling pretty happy about your portfolio only to wake up the next day and see you’ve literally dropped 25 percent overnight,” he says.

That said, plenty of smart, experienced investors are betting on the future of cryptocurrency. One reason people are paying attention to crypto is because of the blockchain technology that supports it. The blockchain is the transparent ledger where every transaction is recorded independently; each participant in the network holds an identical copy (versus a central authority holding a master copy). Blockchain is already starting to influence healthcare.

“This technology has many applications beyond cryptocurrency. In healthcare, patients’ records could be encoded and stored on the blockchain with a private key, which would grant access only to specific doctors. This could help ensure that medical privacy laws aren’t violated,” explains Grabowski.

Blockchain technology is the major reason most people who wouldn’t normally be keen on high-risk investments are looking more closely at investing in crypto, including investing in initial coin offerings (ICOs).

Michael Kapilkov, a partner at MMVIII Capital, is an adviser to several ICO startups—meaning he works with companies who create a currency and want to offer coins to the public, the way a company would offer shares to the public. He also advises individuals looking to invest in ICOs.

“When I talk to people, I tell them, you can make a lot of money, but you can also lose a lot, too. It’s high-risk, high-reward,” he says.

At any point in time, there are several dozen ICOs underway, Kapilkov says. There are a few basic things to keep in mind when thinking of investing. He advises that physicians to carefully study the ICO’s whitepaper, or rationale for why the currency exists.

Also, it’s important to understand the “why” behind the coin: Is it solving a problem? Taking a new approach? Compare it to other coins, and check to make sure it has a solid advisory board. Do the people behind the coin have experience? Do they seem trustworthy? Investing is always a gamble, and it’s worth it to do basic research and work with an advisor who understands ICOs and cryptocurrency in general.

The barrier to entry for purchasing, trading, and investing in cryptocurrency is still rather high (given the purchase of a wallet and the details above), but that may change in the coming years. The technology that supports decentralized currency may very well be the path forward for significant innovation in many industries, and there is money to be made there, one way or another.

“You can make a lot of money, but you can also lose a lot, too. It’s high-risk, high-reward.”

—MICHAEL KAPILKOV, PARTNER, MMVIII CAPITAL
Imagine you are a patient rather than a healthcare provider at your practice. Now, complete the following sentence: “I wish my healthcare team would communicate more clearly about…” What was your response?

Patients have strong feelings about what healthcare teams are and are not getting right when it comes to communicating with them. Understanding patients’ wishes helps healthcare teams create better care interactions and support patients both during and in-between appointments.

Of course, knowing what patients expect when it comes to communicating about their healthcare can be challenging. But when healthcare providers understand what patients want and expect from healthcare interactions, they can do a better job of creating healthcare experiences that satisfy patients.

West, a patient engagement communications provider, recently surveyed 1,036 adults and 317 healthcare providers in the United States to learn more about patients’ communication preferences. Survey findings identified 10 types of communication that patients say are important to them. Their communication wish list revolves around themes of prevention, disease management, and billing transparency.

Patients prioritize routine and preventive care outreach

Patients say they want more support from their healthcare providers between appointments so they can better manage their own health at home. West’s survey showed patients think it is important for providers to make communications more prevention-focused by helping track lab results (77 percent); recommending and scheduling preventive tests and screenings (71 percent); sending text messages and participating in online chat sessions (60 percent); and using automated text, voice, and email reminders to encourage prevention and promote routine health management.

Recommendations for preventive services.

Patients rarely know when they are due for preventive exams or what screenings they need. Worse, many aren’t receiving guidance from their healthcare team. More than one in three patients (36 percent) report their healthcare team does not proactively recommend preventive screenings or they do a poor job communicating which preventive services are needed. Sending automated messages to let patients know they need to make an appointment for an annual exam or preventive screening, such as a mammogram or colorectal cancer screening, is simple and creates awareness about preventive care.

Text Messages. In the past seven years, patients’ interest in texting with providers has doubled. Texting is a widely popular form of communication, so providers shouldn’t be surprised that patients want healthcare professionals to text them. However, many providers have been slow to adopt texting. Nearly one-quarter (24 percent) of patients say they do not receive text messages from their healthcare team. Using patient engagement technology, providers can easily send patients mass or one-to-one text messages about routine care and prevention.

Health management advice. Patients welcome tips and information they can follow at home to maintain their health. A reminder to get 30 minutes of physical activity daily, recipes and healthy
eating tips, or an invitation to join a smoking cessation program are just a few examples of the types of automated communications providers can send patients to encourage prevention and wellness. Although patients say they want to receive automated text messages, voicemails, or emails with prevention-themed advice, 21 percent of patients don’t currently receive these communications from their providers.

**Disease management support is in demand**

Approximately half of adults in the United States face the daily struggle of having to manage a chronic illness, and they don’t want to do it without help from their healthcare team. More than three in four chronic patients say it is very important for providers to give them personalized disease management recommendations based on their specific needs (78 percent) and help them understand their current and target health metrics (76 percent). Sixty-four percent of patients with a chronic illness want to receive medication reminders while 53 percent want providers to administer surveys or check-ins to monitor conditions, assess health risks, and help manage their chronic conditions.

**Personalized recommendations.** Nearly all (95 percent) healthcare providers agree it is important to give patients personalized—not generic—recommendations targeted to their conditions. Fortunately, sending disease-specific communications on a mass scale is easy for providers who leverage their patient engagement technology. For example, staff can send a series of emails with tips and information on lowering blood pressure to all of their patients who have been diagnosed with high blood pressure.

**Information about health metrics and goals.** For patients with chronic diseases, tracking health metrics is the first step to improving and maintaining health. Unfortunately, more than one-third (36 percent) of chronic patients say they don’t get enough information from their providers about health metrics. Patients want more frequent communication to help them understand what their health readings are, or should be. After discussing health metrics during appointments, providers can follow up and send patients automated messages that clearly define goals for metrics like blood sugar, weight, or blood pressure. This guidance helps ensure patients know what range they need to work toward and whether they are within their target levels for optimal health.

**Medication reminders.** Patients with chronic diseases often rely on medication(s) to manage their health, but many struggle with adherence. Clear communication about medication can make a big impact. For example, automated reminder messages can help encourage patients to pick up and take prescribed medications. Medication adherence surveys can be used to identify medication issues, so providers can intervene when necessary.

**Monitoring surveys.** Patients with chronic diseases say they would prefer that their providers proactively monitor their health and alert them of health risks. Survey check-ins give healthcare teams a way to do that. Teams can send patients automated messages with invitations to complete online surveys on their health. These surveys can be used to identify new and worsening symptoms. When survey data show patients are struggling, providers can escalate cases and intervene to prevent avoidable issues.

**Patients want billing transparency.** In addition to health and wellness-themed outreach, patients expect providers to communicate about billing. Seventy-six percent of Americans want providers to give them an easy way to understand and pay their medical bills. And 90 percent of patients say it is very important for healthcare providers to help them understand what is covered by insurance and how much they are responsible for paying.

**Manage expectations.** Not knowing what to expect when it comes to medical expenses is both common and frustrating for patients. Despite wanting to help patients understand what insurance covers, 35 percent of providers give their organization a poor grade for communicating about out-of-pocket expenses. A simple action like sending an automated message prior to appointments to let patients know they need to make a copayment helps manage expectations.

**Make bills easy to understand and pay.** Patients often receive little to no information about the cost of care until they open their healthcare bills. To eliminate confusion and encourage on-time payments, healthcare teams can begin communicating with patients about billing even before bills are mailed. For example, staff can send automated messages following appointments to let patients know what services they should expect to be billed for and when. Implementing automated reminders for upcoming payments is another easy way providers can improve communication about billing.  

Allison Hart is vice president of marketing at West, a technology and communications company. Send your practice management questions to medec@ubm.com.
How policy shapes the telehealth market

In today’s age of advanced connectivity, technology is shaping the delivery of healthcare services. By engaging in telehealth, providers can utilize technologies such as mobile devices, video conferencing, and real-time data sharing to provide healthcare services remotely.

Despite the vast opportunities for healthcare delivery available through technology, legal policy poses a great barrier to telehealth. In the United States, 49 states have some form of legislation relating to telehealth, the Medicaid programs in 48 states and the District of Columbia provide coverage for some form of telehealth, and the Medicare program has its own set of telehealth coverage rules. These state and Medicare telehealth policies vary widely, although there have been attempts to establish more uniform rules.

Location, location
Telehealth policies tend to revolve around where the services take place, who provides the services, and the technology utilized. Typically, a telehealth encounter is considered to occur at the “originating site,” which is where the patient is physically located when receiving telehealth treatment. Medicare typically limits telehealth services to rural or underserved areas, and requires a patient to be at certain specified origination sites, such as a practitioner’s office, a hospital, a rural health clinic or a skilled nursing facility. Like Medicare, a few states also restrict telehealth services to rural and underserved areas. While certain states, such as New York, also restrict telehealth services to certain originating sites, more than half of the states, including New Jersey and California, allow patients to receive telehealth services at any location.

Who provides service?
Medicare and most states, including New Jersey, New York, and California, require a provider to be licensed in the state where the telehealth patient is located, thus requiring the practitioner to follow that state’s professional practice rules and recordkeeping requirements. Over 20 states have adopted the Interstate Licensure Compact that makes it easier for member-state physicians to obtain a license in another member state, and almost 30 states have adopted the Nurses Licensing Compact that allows member-state licensed nurses licensed to practice in another member state.

Several states, including Ohio and Texas, even offer special telehealth certifications to out-of-state practitioners.

Technology matters
The technology used to provide the services also matters. Most states and Medicare require the use of live or interactive technology, such as video conferencing, that permits two-way communication, and limits the use of real-time data sharing to certain specified services. A few states, however, are more relaxed regarding the types of technologies that may be used, and an increasing number of states are permitting physicians to remotely monitor patients with chronic conditions through real-time data sharing technology.

Remote prescribing
New Jersey and California allow physicians to prescribe medications to telehealth patients, except that certain classes of controlled substances may only be prescribed after an initial in-person physician-patient encounter. Contrast that with New York, which does not have any specific telehealth prescription rules.

Ask the right questions
Telehealth and other technology can be useful tools in providing broader access to healthcare services. Telehealth also creates opportunities for providers to expand their patient base and grow their medical businesses by reaching across borders that have historically been barriers. Despite the benefits of telehealth to consumers, laws designed to protect state healthcare providers and patients often stand in the way. As with any other business, the business of telehealth requires providers to understand the rules where they intend to conduct business. Therefore, before a telehealth provider expands into a new state, it is imperative that the provider seeks the right information, asks the right questions, and engages the right advisers in order to ensure compliance with the law.
Communications for Medical Professional Liability Associates, an industry group.

Providers pay into these state-run funds through a surcharge on medical malpractice insurance premiums. If a lawsuit is filed and found to be legitimate, malpractice insurance will cover the injured patient’s costs to a limit set by the state. The rest is paid by the fund.

**WHAT TO LOOK FOR IN A CARRIER**

Carriers must be licensed in each state in which they operate and follow that state’s rules and regulations. While many carriers operate in multiple states, not all do. Patrick Lawn, owner of Physicians Insurance Consultants in Pennsylvania, estimates that there is an average of five to six carriers in each state.

Price is an important factor, but it shouldn’t be the only one, says Lawn, adding that shopping on price alone can lead to hiring an unreliable or financially precarious carrier.

“*You can’t just jump (carriers) for a penny; you’ve got to be able to rely on the carrier,*” Lawn says.

Make sure the policy has a consent to settle clause, which prevents the insurer from settling a claim without permission of the insured doctor, Lawn advises.

The best carriers will act as resources for their clients, offering advice on how to avoid claims and other matters, says Kenneth Hertz, FACMPE, principal consultant at Medical Group Management Association (MGMA). “Partner with them as a resource. They’re the experts. They’re only too happy to help and they can help you stay out of trouble. It’s to their benefit as well,” he says.

He recommends screening potential carriers on a variety of criteria, in addition to price:

- Ask medical colleagues and people in the insurance industry about the carrier’s reputation. How responsive is it? What’s its history on settling claims?
- Check the carrier’s financial security on A.M. Best, which reports on the financial stability of insurers and rates individual companies. Look for a carrier with an “A, Excellent” rating or better and a “Stable” outlook.
- How long has the carrier been in business? Does it specialize in certain fields, such as obstetrics?
- Does the carrier have a local office or counsel? Is it willing to visit the practice and become familiar with the caregivers?

**SHOULD YOU USE A BROKER?**

Virginia Kladder, MD, considers herself fortunate that she’s never had to shop for malpractice insurance. “If I had to go out on my own there is no way, as a physician, I could figure it out,” she says.

The Richmond, Va., internist works for PartnerMD, a concierge practice. Buying insurance for Kladder and 23 other physicians across eight offices in five states is the responsibility of PartnerMD’s Chief Operating
Should you use your own attorney to defend you?

By James F. Sweeney

Operations

Medical malpractice insurance

“Some policies will deny coverage if you have retained your own attorney to handle the case without the carrier’s written permission and the case is adjudicated and/or settled without the carrier’s knowledge.”

—JENNIFER RICHARD, ARM, RPLU, VICE PRESIDENT, PROFESSIONAL RISK ASSOCIATES, MIDLOTHIAN, VA.

Should a physician who’s being sued for medical malpractice use a personal defense attorney instead of, or in addition to, the one provided by the insurer? In most cases the answer is no, according to the experts.

As part of the policy, the insurer provides a defense team with expertise in medical malpractice, a highly specialized area of the law. Attorneys who don’t specialize in medical malpractice would be at a significant disadvantage in preparing a defense, says Patrick Lawn, owner of Physicians Insurance Consultants in Lafayette Hill, Pa. “You want someone who’s an expert,” Lawn says. “A lot of the malpractice attorneys are well-versed in the law, so there’s really no need to spend your own money.”

Private attorneys are at another disadvantage because they do not have a prior relationship with the carrier, which can lead to miscommunication, mistrust, and a disorganized defense, says Jennifer Richard, ARM, RPLU, vice president at Professional Risk Associates, a healthcare insurance brokerage in Midlothian, Va.

Involving a private attorney can even lead to penalties. “Some policies will deny coverage if you have retained your own attorney to handle the case without the carrier’s written permission and the case is adjudicated and/or settled without the carrier’s knowledge,” Richard says. She advises physicians to familiarize themselves with the part of their policy that dictates the carrier’s and physician’s duties when a claim is filed.

The exception would be if the carrier informs the client that a claim is not covered. In that case, “it is good to enlist your own attorney, at your own expense, to protect your potential uninsured interests,” she says. In some cases, if the client insists and the insurer thinks it is to their advantage, the carrier will hire on the client’s attorney for the duration of the case, Lawn says.

Physicians worried that the insurer’s attorney will not adequately represent them should be sure to purchase policies with strong consent to settle clauses, which don’t allow insurers to settle a claim without the insured physician’s permission. However, many consent to settle policies also have a “hammer” clause which an insurer can invoke if a doctor refuses to settle. Typically, it states that if a doctor insists on going to court and is found liable then the doctor is responsible for any damages beyond the proposed settlement, as well as any further defense costs.

Kenneth Hertz, FACMPE, principal consultant with Medical Group Management Association, says he has seen a practice’s private counsel brought in to help settle disputes between members of the practice as to whether to settle a claim. He adds that, even if they are not involved in the malpractice case, a practice’s attorney and the physician’s personal attorney should be kept informed of malpractice proceedings.
Officer Jack Bretcher, who, in turn, relies on insurance broker Professional Risk Associates.

A broker has the depth of knowledge and the experience to know the coverage a practice needs and the best insurers to provide it, Bretcher says.

“They help us keep abreast of what’s out there and what our needs are,” he says, adding that he’s bought extra layers of coverage, including cyber insurance, at the recommendation of his broker.

Even small practices are better off using independent brokers rather than spending the time to research policies and carriers, says MGMA’s Hertz, a former practice manager.

“If you can find a broker who is knowledgeable, it’s a lot easier to hire them to do the legwork, get the quotes, and educate you as a manager,” he says.

RISK RETENTION GROUPS
An alternative to traditional malpractice insurance is a risk retention group (RRG). These are liability insurance companies that require all company owners to be policyholders and vice versa.

All owners/policyholders must be in the same type of business, such as physicians. RRGs can offer lower premiums than traditional carriers and, if they are profitable, the owners are paid dividends, but there are some drawbacks as well, says Hertz. They must be incorporated in at least one state but can operate nationwide, largely exempt from the oversight of other state insurance departments.

Because they were created by federal law, they are not subject to the same level of state regulation as private carriers. They may not have to disclose as much financial information and they are not backed by state guaranty funds in case of financial troubles.

Practices should perform due diligence on RRGs before deciding to join one, Hertz says. Sources of information about them are Demotech and Risk Retention Reporter.

SHOPPING AND UPDATING
Shopping for malpractice insurance can be a time-consuming task, so it’s not surprising that physicians tend to stick with a carrier and policy unless something changes, such as a large increase in premiums or a contentious claim. That complacency can be costly, says Lawn.

“I’ve seen doctors who are looking to save expenses, but they don’t bother [comparison] shopping one of their highest overhead expenses. It makes no sense to me,” Lawn says.

But that doesn’t mean shopping every year, says Richard, who adds that practices should review their policies and compare prices every two to three years.

“Ask carriers about ways to earn discounts, says Hertz, who adds that some insurers will offer discounts of up to 10 to 15 percent if doctors attend carrier-led risk management programs on how to avoid malpractice claims through such things as documentation and better patient communication.

Even if not shopping for a new carrier, physicians should periodically check if their coverage needs updating to account for developments since the policy was purchased. Richard says the following can result in a need for policy changes:

- Adding a provider
- Starting a joint venture or new business
- Forming a new entity
- Changing employers
- Any changes in practice parameters, such as new services or using new equipment

“If you have any questions at all, you should reach out to your agent, as they can guide you through practice exposure changes,” she says.
Imagine that you and your family love going to a local chef-owned restaurant. The service is good. The price is reasonable. The staff is friendly and knows your order. You know the chef-owner personally, and have heard that he often donates surplus food to the local food bank.

Then a large restaurant chain buys up the restaurant. The menu looks exactly the same, but it doesn’t have prices. You go ahead and order the Caesar salad and hamburger that you always get for $12. After you’ve eaten, you get your bill. The meal is now $48. When you ask why, you don’t get a straight answer.

Finally, after some persistence, you discover that the chain-owned restaurant has layered in a facility fee: a charge that adds no value to your dining experience whatsoever, but that allegedly helps the corporate entity maintain its overhead and give an occasional free meal to the poor—so the owners claim.

Facility fee? The facility looks the same. You find the former owner, who looks a little sheepish, and demoralized. He tells you he wishes he never sold out, but the corporation pressured him and paid him a lot of money. And now the corporate honchos are making him prepare twice as many meals a day as an employed chef. He’s burning out.

Quality has suffered. He can’t buy the fresh market ingredients he wants, but must make do with what the company supplies. What’s more, he is contractually forbidden from opening another restaurant within 100 miles. He’s stuck.

You start trying out other nearby restaurants to find a new favorite and learn they’ve all been bought by the same company.

You know where this is going.

**THE WHY OF FACILITY FEES**

Every day, hospitals and health systems are buying independent doctors and turning them into employed physicians. When they do, hospitals tack a facility fee onto the doctor’s fee every time he or she performs a procedure. These fees add zero value, yet the law allows hospitals to charge them to “cover overhead.” These money-for-nothing fees are one reason hospitals can afford to pay doctors more than doctors can earn on their own, and lure them out of independent practice—a trend that is unhealthy for doctors and for Americans.

Because of these fatuous fees, the same treatment that cost $500 in an independent practice, now costs $1,500 or $3,000 after a hospital buyout. A hospital that employs a cardiologist should not get $4,000 for a heart catheterization when an independent doctor performing the same procedure across the street gets $1,100.

A procedure should cost the same regardless of where it’s performed. But our law doesn’t work that way.

**IT’S THE LAW**

Under current federal law, Medicare payments flow differently depending on whether payments go to a hospital outpatient setting (via the Outpatient Prospective Payment System) or to a private physician (through the Physician Fee Schedule). Hospitals get paid more, often several times more, because the system lets them add facility fees.

For example, clinic visits are the most commonly billed service under Medicare. Currently Medicare pays...
$116 for a visit to a doctor in an outpatient hospital clinic, and only $46 for the same level visit to an independent doctor. That difference adds up.

CMS has long advocated for equal payments, or what the agency calls “site-neutrality,” to no avail. The Medicare Payment Advisory Commission has advised year over year that if Medicare stopped paying facility fees our nation could save tens of billions of dollars. This could be a lot more if private insurers followed suit.

Where the facility fees really add up is when they compound. See, hospitals require employed physicians to refer only to other employed doctors, and to order tests only through hospital-owned facilities, regardless of whether those doctors or facilities are the best or most cost effective. Doing otherwise is called “leakage,” an offense that sparks an administrative rebuke, and often a pink slip.

So, when a patient with a knee injury unwittingly goes to an employed primary care doctor, he will be referred to a hospital-owned orthopedist, who will order an MRI from a hospital-owned imaging center, then schedule surgery in hospital-owned outpatient center. Facility fees pile on at every step, so a knee surgery that would have cost the patient $5,000 through various independent practices now costs $35,000. When you figure that only one third of practicing physicians today are independent, leaving the majority employed, you see how facility fees cost us all billions of dollars a year.

For nothing.

“Because of these fatuous fees, the same treatment that cost $500 in an independent practice, now costs $1,500 or $3,000 after a hospital buyout.”

EVERYONE PAYS
Even if you never go to the doctor, you pay for this through higher premiums, higher deductibles, higher taxes, and higher costs of goods and services.

If CMS knows this, why doesn’t the agency follow MedPAC’s recommendations and get rid of facility fees? Because MedPAC advises Congress, CMS can’t change the law. Getting rid of facility fees would literally require an act of Congress.

And, because the American Hospital Association alone spent $22 million in 2017 lobbying lawmakers on behalf of their bottom lines, and because it’s tough for lawmakers to put patients over their own pockets, lawmakers aren’t motivated to get rid of these facility fees. (See how much your lawmaker gets from healthcare special interests on OpenSecrets.org.)

A GAME CHANGER
In late July, however, CMS proposed a policy change to move toward a site-neutral payment system in 2019, which would effectively eliminate facility fees. If the move goes through, Americans would save $760 million in 2019 alone.

This would be a huge positive step toward fixing a badly broken system riddled with perverse incentives. But brace yourself for a fierce fight from hospitals, who aren’t going to give up this gravy train easily.

Meanwhile, facility fees are a farce we all pay for. They need to go away, or at least be made very clear in every state. If Medicare doesn’t fix this, and lawmakers won’t, that leaves it up to doctors and patients. Doctors must first say no when hospitals bribe or bully them to sell out. Second, they need to educate consumers about choosing independent doctors.

If we expose—or even better—eliminate facility fees, hospitals will stop buying doctors. Independent doctors could practice on a level playing field. Patients could get reasonably priced care. Americans would save tens of billions of dollars a year in healthcare costs. And a burger and salad would be $12 again, with better service.

Because CMS can’t and Congress won’t get rid of hospital-based facility fees, doctors and patients must take action.

Marni Jameson Carey is the executive director of the Association of Independent Doctors. www.aid-us.org. You may reach her at info@aid-us.org.

READ MORE Prevent physician burnout by advocating for the profession PAGE 1
### Our Advisers

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

“My father, who is a child psychiatrist and the most patient person I know.”

---

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

“My family doctor growing up.”

---

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

“Steve Jobs, Elon Musk, Warren Buffet, and [University of Texas-El Paso President] Diana Natalicio.”

---

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

 “[Fellow physician] John C. Tapp, MD.”

---

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

“Mrs. Kobida (my 8th grade math teacher), Marie Curie, and my mom.”

---

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

“[Neurologist] David Perlmutter, MD.”

---

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

“My parents.”

---

The board members that contribute expertise and analysis to help shape content of Medical Economics.
“One way [some association plans] get the cheaper premiums is by offering fewer benefits.”

KEVIN LUCIA, MHP, GEORGETOWN UNIVERSITY’S HEALTH POLICY INSTITUTE,

PAGE 15

“We’ve seen retail costs [of insulin] go up 250 percent in the last 10 years.”

JUSTEN RUDOLPH, MD, DIRECTOR OF ST. VINCENT DIABETES CENTER, BILLINGS, MONT.

PAGE 26

“7.8% of internists will face a malpractice claim each year.”

PAGE 10
Advertising in Medical Economics has accelerated the growth of our program and business by putting me in contact with Health Care Professionals around the country who are the creators and innovators in their field. It has allowed me to help both my colleagues and their patients.
“It’s only natural to withdraw a bit once you’ve been sued.”

IN CASE YOU MISSED IT

“Partner with [your malpractice carrier] as a resource. They’re the experts. They’re only too happy to help and they can help you stay out of trouble. It’s to their benefit as well.”

— KENNETH HERTZ, FACMPE, PRINCIPAL CONSULTANT, MEDICAL GROUP MANAGEMENT ASSOCIATION