WHAT’S RUINING MEDICINE

- Regulations
- Payers
- EHRs

and more...

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CHRONIC & TRANSITIONAL CARE:
GET PAID AND IMPROVE PATIENT OUTCOMES
How to defeat physician burnout

Y ears ago, when I practiced family medicine, I was so burned out I felt crispy. I stumbled through a maze of challenges, self-doubt and shaming before emerging at the other end, satisfied with what I created, grateful for what I was doing and financially stable.

For doctors in burnout’s clutches, the best recipe for recovery comes from within, not from a mythical knight in shining armor who appears from nowhere. Your satisfaction and happiness are your responsibility.

Here are some steps to take control and move beyond burnout:

START WHERE YOU ARE
First, if you’re feeling burned out, admit you’re unhappy. Not in a “woe-is-me” way. More of a “Yeah, I’m here and I’d rather be elsewhere. Let’s start planning.”

You paid a lot of money and gave a lot of time to become a physician. You accumulated debt and gave up much of your personal life during medical school and training. In business those are known as sunk costs. You’ve incurred them, and they’re not coming back. They’re not relevant to your future.

GATHER EVIDENCE
If you were working up a patient, you’d order tests, which we call assessments in coaching. Do the same for yourself:

Start with your values. If you’re working at an organization whose values aren’t aligned with yours, you’ll never be happy. I have several Road to Resilience Values Decks, which I used with dyads, teams and teaching. I like this option because they’re two decks in one. One side has values. The other side has discussion questions, such as “How does recognizing my top value make a difference in my life?”

Discover your strengths. Determine whether your strengths are being well-utilized in your current situation. The VIA Institute on Character in Cincinnati offers a free strengths assessment at viacharacter.org.

Take a test that measures your skills. I recommend Nicholas Lore’s book, The Pathfinder and his Career Testing Program. After debriefing my results, I learned why I had a hard time with anatomy, and with rote memorization of my lines. That is not my strongest skill. I also learned that I am highly rated in creativity.

ASSESS YOUR OPTIONS
Draw three columns. In the left column enter what you’re considering. Becoming a consultant? Moving into research? Pharma? Becoming a professor? A high school science teacher?

In the middle column, enter the advantages for each option. For example, becoming a consultant may mean you’re saying “yes” to “I choose my hours.” In the right column, enter the disadvantages, or what you’re saying “no” to. Becoming a consultant may mean you’re saying “no” to regular income and financial security as you build your consulting practice.

No option will give you everything you want. If you’re like most people, you’ll focus on the negatives. Reconsider what’s important and what’s not. It’s critical to consider financial and personal consequences.

CONSIDER A COACH
High performing and high potential executives in business often engage coaches to work with them as thought partners and guides. Progressive medical organizations such as Mayo Clinic, The Cleveland Clinic, and others recognize the value in providing coaches.

“Coaching done well may be the most effective intervention designed for human performance,” Atul Gawande, MD who has written brilliantly about the medical profession, said in a 2011 New Yorker article.

In addition to Gawande, Bill Gates, Eric Schmidt and John Noseworthy, MD, all have coaches. Shouldn’t you?

Margaret Cary, MD, MBA, MPH, PCC, is a Washington, D.C.-based physician and coach for practicing physicians and med students. Send your comments to medec@ubm.com.
CMS finalizes 2019 rules

CMS has issued its final 2019 rule for both the Physician Fee Schedule (PFS) and the Quality Payment Program (QPP), which includes the Merit-based Incentive Payment System (MIPS).

"Today’s rule finalizes dramatic improvements for clinicians and patients and reflects extensive input from the medical community," CMS Administrator Seema Verma said in a statement. "Today’s rule offers immediate relief from onerous requirements that contribute to burnout in the medical profession and detract from patient care. It also delays even more significant changes to give clinicians the time they need for implementation and provides time for us to continue to work with the medical community on this effort."

Under the final QPP rule, MIPS-eligible clinicians will be required to use a 2015 Edition certified EHR as of Jan. 1, 2019. CMS says this change is necessary so patients can more easily access their data and information can more easily be shared among doctors and other providers. But Ana Maria Lopez, MD, MACP, president of the American College of Physicians, has concerns, especially with the short implementation timeline. "Rushing implementation of these upgrades to meet a reporting deadline can have serious patient safety risks and is a major expense and burden, particularly to small practices," Lopez said in a statement.

CMS also added an additional low-volume threshold exemption to MIPS for next year. To be excluded, providers or groups need to meet at least one of the following conditions:

- Have $90,000 or less in Medicare Part B allowed charges for covered professional services.
- Provide care to 200 or fewer Part B-enrolled patients.
- Provide 200 or fewer covered professional services under the PFS.

The minimum period for each performance category remains unchanged, so quality and cost stay at 12 months while improvement activities and promoting interoperability remain at a continuous 90-day period.

However, the weighting to the final score of the cost and quality categories have both changed. Cost increases from 10 percent to 15 percent of the total score, and quality drops from 50 percent to 45 percent.


Slideshow spotlight

Physicians weigh in on the DPC model

A survey of direct primary care physicians revealed some interesting insight on physician burnout and restoring joy in medicine.

To view, visit bit.ly/physicians-weigh-in-on-DPC.

Interpretation of the data

REVENUE CYCLE MANAGEMENT

- What changes to E/M coding could mean for physician practice finances
- Billing bots can streamline revenue cycle management
- Treat revenue cycle management as a strategic process

For more, visit bit.ly/practice-RCM.
I am writing to comment on the “First Take” article in the June 10, 2018 edition of Medical Economics. I largely concur with the author’s perspective and am grateful for the discussion. I am old fashioned, being in my late sixties. I remember the time when physicians and pharmacists commonly spoke on the phone, particularly when there were questions or concerns about a prescription. And yes, sometimes it was simply a matter of deciphering my handwriting, but also good clinical discussions often ensued that promoted the safest and best outcomes for our patients. Both physicians and pharmacists are foregoing their professional responsibilities by going along with administrators or regulators that do not necessarily have the patient’s benefit foremost. While there are natural differences in public health vs. clinical medical care, the differences in my experience most often result in a win-win for everyone. Since financial and regulatory forces are dominating the scene, I no longer witness the same “win-win” results. In the current arrangement there are clear losers. I believe not only patients but physicians and other healthcare professionals suffer as a result of overbearing financial and regulatory forces.

Besides complaining and groaning about it, recently I took action. For the first time in my career, I reported a pharmacist to our Washington State’s Quality Assurance Commission. He failed to call me. I called him and despite acknowledged expertise and a longstanding relationship with the patient, he refused to fill the prescription, even a day’s worth to allow the patient to seek service elsewhere. Given the co-morbid conditions this patient deals with and limited access, I considered this quite unprofessional in terms of putting a patient at undue risk of harm.

I am curious as to how the authority that evaluates pharmacist professional care will respond. I am hoping at the very least it will give pharmacists pause to refuse to fill a prescription properly and professionally written. I want pharmacists to have the autonomy and authority to refuse to fill a prescription when they believe it is likely to harm a patient or represent an undue risk to other members of the community. I also want them to have room to disagree with a physician.

Another option might be for us to refuse to use pharmacies that have these policies in place or who employ pharmacists that behave unprofessionally, at least in our opinion. We can simply inform patients that we cannot professionally support pharmacies that do not collaborate with us or behave in ways inconsistent with professional medical care. Within my EHR I control where prescriptions go. Historically, I left it up to the patient. But the times they are a changing.

J. Kimber Rotchford, MD, MPH
PORT TOWNSEND, WASH.

“Both physicians and pharmacists are foregoing their professional responsibilities by going along with administrators or regulators that do not necessarily have the patient’s benefit foremost.”
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Physicians enter gun violence debate

Should physicians have a voice in the ongoing debate about gun control? The National Rifle Association (NRA) doesn’t think so.

Last month, the NRA responded to a recent American College of Physicians paper outlining the College’s recommendations for reducing firearm-related injuries and deaths by tweeting that “Someone should tell self-important anti-gun doctors to stay in their lane.”

The tweet, which came only hours before the Thousand Oaks shooting in California, prompted a social media backlash from numerous physicians. Using the hashtags #Docs4GunSense, #Docs4GunResearch, and #ThisisOurLane, physicians took to Twitter to share their clinical experiences with gunshot victims and to advocate for action to reduce gun violence.

Physicians on guns, in their own words

“Be careful what you ask for, you may get it.”

“Physicians should not be this intrusive in patients’ lives. It doesn’t impact overall health.”

“Physicians need to be not only part of the debate but leading the discussions and research.”

“Control of assault & military weapons must be a priority of American medical professionals.”

“We should be addressing the epidemic of gun violence in our society and we should be studying and learning how to promote gun safety and reduce gun violence.”

“I don’t have a problem with people having guns. I have a problem with dangerous people having guns and with people using/ storing guns in an unsafe manner. This affects the health and safety of my patients. As a physician, I AM involved, whether I want to be or not.”

“We see the damage every day: lost parents, jailed parents, children playing with guns or caught in the crossfire, adolescent suicide. We HAVE to be in the conversation.”

Medical Economics surveyed our audience of primary care physicians to get their opinion on this debate. Here are the results.

- **Q: Should physicians be involved in the gun debate?**
  - No: 33%
  - Yes: 67%

- **Q: Is it proper for physicians to ask patients about guns in their homes?**
  - No: 30%
  - Yes: 70%

- **Q: Do you believe more research needs to be conducted on the health impacts of gun ownership?**
  - No: 41%
  - Yes: 59%

Source: Medical Economics web poll, results as of November 26, 2018.
INTERNALIST Alison Guile, MD, is part of a five-provider practice in rural Plattsburgh, N.Y. The practice serves about 5,000 patients, who are mostly geriatric and tilting toward lower socioeconomic status.

Roughly 10 years ago, Guile says, she was getting extremely stressed by her job. There were several reasons, but a big one was “all the psychosocial components to good health that we weren’t able to address” because of a lack of resources.

It was around that time that Champlain Valley Physicians Hospital, through its Adirondacks ACO, began hosting a shared care management team to focus on transitional and chronic care management for internal medicine and family medicine practices.

Guile, who has been with the Adirondacks system for 23 years, calls embedded care managers one of the best ideas the ACO has ever had. Her practice has an embedded RN as a care manager, and “It feels like she’s part of the practice,” Guile says, even though the care manager is paid by the ACO.

The most valuable work the care manager does is diabetes education, and she’s working on her CDE certification, according to Guile. Between the care manager’s home and in-patient visits, “It’s really a return to what physicians used to do before we had the siloing of care,” Guile says.

Guile adds that shared staffing has boosted her quality of life: “It’s enormously helpful from a standpoint of physician stress to be able to unload these tasks to someone who can handle them.”

THE STRUGGLE
While many primary care physicians struggle with issues around transitional and chronic care management simply because they don’t have staff who can handle these important tasks, shared services by way of independent practice associations (IPAs) and other healthcare organizations have given many individual practices capabilities they otherwise wouldn’t have.

When the Adirondacks ACO’s care management team was started in 2011, says Karen Ashline, the ACO’s associate vice president, “Our primary care docs were feeling like they couldn’t get everything done.” There was little continuity of care and not enough follow-through in areas like diabetes education—and the price was paid in heavy ED use and high rates of hospital readmissions.

The care management team now comprises 14 RN’s, two LPN’s and four community resource advocates, who together support 24 provider sites and focus on the highest-risk patients, according to Ashline. Larger practices get an assigned care manager, while smaller practices share one.

Initially the program focused on managing diabetes, hypertension and coronary artery disease, but now it includes any chronic disease, including behavioral health, substance abuse, pediatric obesity, COPD and congestive heart failure.
“Part of what made our arrangement work was that the hospital system was able to support hiring the team that was needed to share across small practices,” Ashline says.

The hospital is responsible for hiring, salaries and benefits, IT, malpractice coverage and centralized office space. In their region, she says, an RN care manager is typically paid $60,000 to $85,000, depending on experience, plus benefits. “If one RN care manager can work across even two small practices, it is much more affordable.”

MORE MODELS

Though primary care practices’ experiences with shared services are broadly similar, the types of organizations offering them vary.

In San Jose, Calif., the county-owned Santa Clara Valley Medical Center undertook a pilot project to embed a transitional care manager in an outpatient family medicine clinic, specifically to help high-risk, high-cost (HRHC) patients. This resulted in reduced ED visits and hospital admissions in a group of 50 HRHC patients, as well as cost savings and better patient outcomes.

Analiza Baldonado, NP, has been a transitional care manager at SCVMC for about five years, as the pilot program was disseminated throughout the county hospital system. She describes some of the typical tasks for a transitional care manager as arranging for a public health nurse to assess a patient at home, educating patients regarding their post-discharge situation or making appointments for lab tests.

In addition, if a patient is having difficulty getting an appointment with their primary care physician, transitional care staff will see if there’s a way to squeeze the person into the physician’s schedule.

Baldonado emphasizes the complexity of patients’ situations and the diverse skill sets needed, saying, “It’s different every time. . . . It takes a village to manage a high-risk, high-cost patient.”

John Paul Pham, MD, a family physician at a clinic in the SCVMC system, values his practice’s access to complex care nurses who track hospital discharges and schedule post-discharge appointments.

He says that typically a patient gets a follow-up call from a nurse about a week after discharge, then roughly a week later has an appointment (for 30 minutes instead of the usual 15) with his or her primary care physician. These actions are required for payment under the TCM codes. The transitional care team also has pharmacists who conduct medication reconciliation at hospital discharge.

“It’s enormously helpful from a standpoint of physician stress to be able to unload these tasks to someone who can handle them.”

—ALISON GUILE, MD, INTERNIST, PLATTSBURGH, N.Y.

The system is good at identifying weak points in patient care, such as transportation or housing issues, in which case the complex care nurses coordinate with social workers, Pham says, adding that the process increases communication between the inpatient and outpatient teams and reduces preventable readmissions. “I see less patients falling through the cracks.”

Better communication with the patient and their family also increases buy-in for things like medication adherence, he adds.

For independent physicians, being part of an IPA can provide the entree to shared services for transitional and chronic care management.

The Greater Rochester (N.Y.) Indepen-
dent Practice Association (GRIPA) encompasses about 350 primary care physicians in about 160 practices; overall, roughly half of its physicians are independent. GRIPA’s care management program began in 1998, and the staff now consists of five nurses, 3.5 pharmacist full-time equivalents and two social workers, says Jeanette Altavela, PharmD, BCPS, the vice president of care management and pharmacy services. The shared care management staff has reduced hospital readmissions and ED visits and, by having pharmacists on the team, has decreased the cost of drugs, which has also boosted medication adherence.

Mark H. Belfer, DO, GRIPA’s chief medical officer, recalls a patient believed to have COPD who’d been admitted to the hospital seven times in one year. Eventually, a home visit by an RN care manager determined that the walls of the patient’s home had black mold, a well-established cause of respiratory problems. The patient did not in fact have COPD, and once the mold was removed, the readmissions stopped. “That’s care management at its best,” Belfer says.

GETTING IN ON SHARED CARE MANAGEMENT
In theory, accessing shared services for transitional or chronic care management should be possible without joining an IPA or having a relationship with a health system. And there are specific CPT codes for care management, such as 99495 and 99496 for transitional care management and 99487, 99489 and 99490 for chronic care management. However, if such grassroots, practice-to-practice arrangements do exist, they appear to be well under the radar.

“It is difficult for small practices to pay for a robust care management services team for their practices,” Altavela says, while in contrast GRIPA provides the care management team free to physician members.

When starting to implement shared services, Belfer advises, be aware that these might be new for many providers. "When our program started, it was important to work with our providers to ensure we were care managing the patients with the highest need.”

Ashline’s advice is to be clear with physicians about the role of shared personnel. For example, a care manager is not “an additional nurse for my practice,” but instead has a very different role.

Guile concedes that some physicians are less enthusiastic about shared services and care management than she is, often because of concerns over turf. “There are people who need to be convinced that this is the logical way to go,” she says.

Once shared care management services are up and running, however, they seem to leverage providers’ time and efforts and to improve patient care, while also being cost-effective.

“When our program started, it was important to work with our providers to ensure we were care managing the patients with the highest need.”

—MARK H. BELFER, DO, CHIEF MEDICAL OFFICER, GRIPA

For patients who received care management, in-patient visits decreased by 45 percent and ED visits by about 15 percent. “Savings have been in the tens of millions over the last five years,” Altavela says. “The savings we generate well exceed the cost of the program.”

THE HOUSE CALL, EVOLVED
Across these various models for shared-service delivery in chronic care, one theme that stands out is the huge benefits that home visits can bring. Home visits have become more frequent at GRIPA over the past five years, to a point where about 70 percent of high-risk patients get them, says Altavela. “There’s nothing like a home visit to find out what’s going on.”
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CMS began reimbursing physicians for obesity counseling in November 2011, when they introduced Healthcare Common Procedure Coding System (HCPCS) code G0447, Face-to-face behavioral counseling for obesity, 15 minutes. This code reimburses at about $25, and is for patients with a BMI of 30 kg/m² or greater.

According to CMS, therapy for obesity consists of:

1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m²);
2. Dietary (nutritional) assessment; and
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

Additionally, the NCD states that the intensive behavioral intervention for obesity should be consistent with the 5-A framework that has been delineated by the USPSTF:

Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.

Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.

Agree: Collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior.

Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.

Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing help and support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Medicare will pay for G0447 up to 22 times in a 12-month period, counted from the date of the first claim. The valid ICD-10 codes will be Z68.30 Z68.39 Z68.41 Z68.45. Check with your local Medicare Administrative Contractor (MAC) for clarification on the ability to bill more than one unit per visit. Medicare coinsurance and Part B deductible are waived for this service, and the service.

The patient must be competent and alert at the time of counseling, which may be provided by primary care physicians, advanced practice nurses and physician assistants. These services also can be performed by auxiliary personnel when incident-to guidelines are met.

For Medicare beneficiaries with obesity, CMS covers one face-to-face visit every week for the first month and one face-to-face visit every other week for months two through six. A weight loss reassessment needs to be performed at six months, and those patients who have lost at least 3 kg during the six months will then be eligible for once a month visits for an additional six months.

In order to bill this code, the time must be documented in the medical record. The physician cannot bill for more than a 15-minute interval. If more time is spent with the patient, the total time should be noted in the record.

This service must be provided by a primary care physician or other primary care practitioner. The place of service is also specific for this therapy to be performed. It must take place in a physician’s office, outpatient hospital clinic, an independent clinic, or a public health clinic.

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Ind. Send your coding questions to medec@ubm.com.
Dealing with EHR buyer’s remorse

The options available when doctors want to change systems

by KEITH LORIA Contributing author

It’s no secret that dissatisfaction with EHR systems has been a major concern for physicians. In fact, several recent surveys report as much as a 25 to 30 percent unhappiness level among doctors and practices.

This presents a real challenge. Physicians usually will have signed a vendor contract that requires them to remain with the EHR system for an agreed upon period of time, so they likely are stuck with it unless they are willing to lose the money.

David Zetter, a member of the National Society of Healthcare Business Consultants (NSCHBC), explains contracts are proprietary to each EHR vendor, and while each is different, there are usually no escape clauses.

“The issue is not whether you can drop the EHR, because you can at some point, but you still paid for it and you are not going to get those monies back,” he says. “The EHR company is not going to refund the price of the purchase unless you can truly prove that they breached their own contract terms, which usually is difficult to prove.”

Generally, EHR contracts are a minimum of two years because of how long it takes to get everything set up, after which they then convert to a month-to-month contract.

WHY DOCTORS WANT OUT

Russell Libby, MD, founder, president, and medical director of the Virginia Pediatric Group, Fairfax, Va., notes that EHRs have been built around reporting and billing needs, so they create distractions rather than complementing the patient encounter.

“Physicians end up spending excessive time fulfilling program expectations rather than their clinical inclinations—this can be very frustrating,” he says, adding that EHR companies lack customer service and flexibility.

Zetter says the main reasons most physicians are unhappy with their EHRs are because they did not thoroughly compare and test drive the various models, and the implementation process is almost always done incorrectly. Before contracting with any system, he recommends obtaining names and numbers of those that utilize it and asking pointed questions about what the issues were with the installation and implementation.

Lansing Urgent Care in Lansing, Mich., wanted to expand its business, but as the clinic grew, their EHR system did not scale with them. The clinic soon found itself being bogged down by workflow inefficiencies, which significantly increased costs.

Catherine Matthews, CEO and owner of the facility, says even though the sales pro-

HIGHLIGHTS

- When looking for an EHR, physicians need to consider capabilities such as easy appointment scheduling, monitoring patient workflows in real-time, and easy access to patient history.
- Study your contract. Some agreements specifically provide a mechanism for dispute resolution.
cess was terrific, once the deal was signed and the system went live, the customer service for the EHR was lacking.

“When we had issues, we had a hard time getting calls returned,” she says. “We knew we needed a new and efficient EHR solution and went looking for a company that would have a true partnership with us, was open to our ideas, and helped to support us throughout our tenure as a customer.”

There was a moderate amount of work involved with switching, but the new company helped migrate the data and supplied an on-boarding team to lead the urgent care through the various steps of setting up their tool, customizing it, training the staff, and going live.

Pradeepa Selvakumar, MD, once worked as a hospitalist at Marin General Hospital in Greenbrae, Calif., and experienced multiple problems with the EHR system the facility was using. However, the hospital was unable to cancel or recoup the contract.

“As part of the IT committee, we lodged multiple complaints and appealed directly to the EHR vendor at their headquarters without any resolution,” she says. “We needed a collaboration solution and used a third-party software to pull information from the EHR and then worked with the [software company] to create what we needed.” This modification served their needs better.

Now, she is an internist with San Mateo Primary Care, San Mateo, Calif., and utilizes an EHR that is part of a larger hospital system, and says that also comes with some challenges.

“A legal way out? Corinne Smith, JD, a member of Clark Hill Strasburger’s healthcare law team in Austin, Texas, says a remedy may lie within the terms of the EHR vendor contract.

She says in rare cases, a provision for early termination without cause can be added, but a physician would have to demand it. Normally, these require 90-120 days’ written notice to the vendor.

“If you don’t have an early termination provision in the agreement, it is worth trying to negotiate an early termination,” Smith says. "Typically, the vendor does not want to continue supporting a disgruntled practice and they may be willing to negotiate an early exit. It can be in both parties’

“The EHR company is not going to refund the price of the purchase unless you can truly prove that they breached their own contract terms.”

—DAVID ZETTER, HEALTHCARE CONSULTANT
best interest to end the relationship without acrimony."

If this doesn’t work, Smith says a physician or practice should pull out the EHR contract and examine the terms and review key provisions.

"Is there a breach that could be grounds for termination? If so, then the practice can provide written notice of the breach consistent with the requirements of the contract," she says.

"Sometimes a written letter and threat to terminate the agreement is all that it takes to get action. It is critical that the notice letter comply with the requirements in the agreement for termination for breach."

Some agreements specifically provide a mechanism for dispute resolution. Typically, the agreement either provides for mediation process prior to pursuing litigation or it will call for arbitration, Smith says.

"If the contract has a clause for mandatory arbitration, the dispute will not be settled in a court of law," she says. "Arbitration requires the parties to submit their dispute in writing to a third-party arbitrator."

Smith says if the vendor is non-responsive to complaints or concerns and the issues relate to the product’s certified capabilities, contact the Office of the National Coordinator for Health Information Technology.

However, even if there are issues, she advises never to stop making payments on the contract.

"The legal obligation to pay exists under the written agreement regardless of whether you are satisfied with the vendor," she says. "If you withhold payment, you may be hit with a collections suit and fines for late payment."

In the rare case that physicians are able to get out of a contract with an EHR vendor, extra fees should be expected, Zetter says. And because all systems are different, physicians making a switch should expect fees for data transfer.

"It is worth trying to negotiate an early termination. Typically, the vendor does not want to continue supporting a disgruntled practice and they may be willing to negotiate an early exit."

—CORINNE SMITH, JD, CLARK HILL STRASBURGER, AUSTIN, TEXAS

BARRING AN ESCAPE
Since physicians may not be able to get out of a contract, they are going to have to find a way to make it work.

Libby says in some cases, the best way to find a resolution is to engage with the EHR company you are working with.

"That often involves investing time and money, but there may be solutions available," Libby says. "Some might be surprised to know that there are some EHR providers who are willing to work with doctors to make the systems more functional and affordable."

A good way to start, he says, is to designate a "super-user" in the practice who understands the inner workings of the system and can present the issues the practice is experiencing to the EHR company.

"When we aren't getting solutions, we might feel that we're asking the wrong person at the EHR company when in fact the issue is that we don't know how to define the problem well enough to even ask for help fixing it," Libby says. "It takes time and investment to gain that knowledge—sometimes it means going to user conferences and on-site headquarters trainings."

Still, sometimes, no real potential for improving the functionality of the system exists. In those cases, physicians must step back and decide whether switching providers is the right path.

Libby says in some extreme circumstances, physicians may join a group or be acquired by a third-party who can provide a better EHR.

Another idea, Libby suggests, is visiting other practices that have made the same system work for them.

"Finding out what they're doing right could be immensely helpful and sharing knowledge and experience is important," he says.
I am a solo physician that took over a busy primary care office several years ago. In addition to this undertaking, I am a wife and mother of three young kids. The process of taking over and gaining patient trust has required an overwhelming amount of work and time. Like many other physicians, I have heart-warming stories of success and meaningful moments that have shaped me.

An experience that stands out occurred with a patient that was only slightly known to me. She was an elderly woman who would come in sporadically—only when she had a concern. She refused to schedule any preventative visits and did not have any significant medical issues that required regular appointments. She came to see me one summer after a slip and fall that occurred at home, because she injured her lower back and wrist. The day I saw her, I performed X-rays of her hand and lumbar spine. While the wrist X-ray did not show anything significant, her lumbar spine X-rays revealed a compression fracture. I ordered an MRI of the spine that confirmed the fracture and referred her to a specialist.

An ensuing work up occurred for her osteoporosis as well as treatment for her fracture. Along the way, she was lost to follow-up, despite our calls, as she decided to visit one of her children out of state. Several months later, she appeared on my schedule for a follow-up and came in with her daughter.

When I entered the room and introduced myself to her daughter, I quickly knew something was amiss. The atmosphere was very cold and they informed me they had come to confront me about a serious error I had made in her care. I was shocked as they started questioning me, inquiring whether I actually read the reports I signed. I assured them I did, as I scrambled to navigate results in her electronic chart. They just sat and watched me as I discovered what they were referencing—one sentence, in the middle of a two-page MRI report, that described an aortic aneurysm; a finding that never made it to the conclusion summary of the report. I was devastated.

Once I absorbed the situation, I acknowledged what had happened and apologized to them sincerely. I proceeded to sit and listen to the events that occurred after the patient traveled out of state. Her back pain had worsened because the aneurysm had expanded, requiring surgical repair. During that time, she was diagnosed with other chronic medical conditions as well. These records never made it to me, despite their requests to forward them, so I was entirely unprepared for what was happening.

Her daughter then proceeded to express the anger she felt toward me, and my patient expressed her deep disappointment as well. Once they finished expressing their concerns and frustrations, I took time to address what occurred.
I started, again, by apologizing. I expressed my tremendous relief that her outcome was good. I also explained this was not the result of haste and carelessness, but rather a mistake. I attempted to explain reasons for why I thought this had occurred, but accepted responsibility for my role in her care and the missed diagnosis. Speaking from the heart, I relayed to them that I fully grasped the gravity of potential mistakes I could make on a daily basis; I reminded them that I am only human—while I strive to provide the best care, occasionally I can expect to make a mistake. The experience was humbling and painful, but I am thankful for it nonetheless.

As physicians, we spend countless hours outside of the hospital/office working and following up on patient care, because we are dedicated to our oath. We all make sacrifices that our patients may never be aware of in order to provide the best care possible. To have that dedication questioned, or to make a mistake despite such great effort, is deflating and discouraging.

Had the patient never come to talk to me, as difficult as it was to experience, I would have not had the opportunity to learn, evolve, and improve so that I can provide better care for all of my patients. This experience will forever serve as a reminder to me of the human side of medicine and the importance of developing strong patient relationships. Much to my surprise, the patient elected to continue her care with me and is still part of my practice today.
Five reasons to say no to payer contracts

A payer contract is more than a mere fee schedule. There are several other factors to consider when deciding to keep or terminate a payer contract. Oddly enough, the fee schedule was a secondary consideration in most payer agreements I have terminated through the years. Here are five reasons to consider terminating or renegotiating an agreement.

1. Overfl owing appointment schedules
   If you have more patients than you have room for or time to see, you have leverage with any payer who makes up five percent or less of your revenues. Let the payer who pays least and the payer who is the biggest pain know that they need you more than you need them. Make your issues with them—be they lengthy credentialing, a high denial rate, and/or low fees—their issues. These are the issues that must be addressed to your satisfaction if you are to remain in their networks.

2. Credentialing issues
   There are opposing incentives when it comes to credentialing new providers. The sooner a practice can get a provider credentialed, the sooner it can bill and get paid. Conversely, the longer it takes a payer to credential a provider, the more money they save since the practice may not bill for services delivered by un-credentialed providers. If your state does not have credentialing regulations that include a timeline, your practice could lose thousands of dollars due to credentialing delays. My recommendation is to make it an issue with your payers. Share your expectations in advance of bringing in a new provider and let your provider representative know their performance will be part of your next renegotiations.

3. Arbitrary down-coding
   Some payers have been sneaky in automatically or arbitrarily down-coding E/M services. Level 5 services are down-coded and paid at level 4 prices, and level 4 services get the level 3 treatment. Think about it this way: Level 4 office visits (new and established) generally pay 45-55 percent more than their level 3 counterparts! I don’t see this often, but when I do, I call the payer right away. I consider such behavior egregious and would be willing to terminate an agreement over unwarranted down-coding.

4. Excessive denials/higher accounts receivable
   Some payers deny more claims than others. Ask your staff to show you the first pass denial rate for your payers—that is, what percent of initial claims submitted to each payer are denied. Ceteris paribus, a payer who denies more claims is cutting into your bottom line since a denied claim requires additional work by your billing department.
   While looking at denial rates, take the extra step to look at why claims are being denied. You may find patterns—incomplete/incorrect registration, for example—that can be improved internally.

5. Authorization
   Another burden that payers distribute is the authorization process. It costs the practice more to do business with a payer who needs an authorization for seemingly everything. Unless a payer can prove that my practice has much higher utilization of a procedure or test than our peers, I fight to make the authorization go away since the authorization process’s only result is costing us more money.

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The costs and benefits of in-house lab testing

by RAY PELOSI Contributing author

In-house testing laboratories can be profitable for physicians and give patients an enhanced care experience, too. Not only can they generate their own revenue stream within a practice, they can also provide a competitive edge that could translate into the higher physician ratings that help attract new patients.

In addition, doctors who already have an in-house lab may want to expand their testing because health insurers and employers are creating financial incentives and policies that encourage patients to be quality-conscious shoppers for lab tests that they believe offer them the best value for the money.

Reimbursement, Regulation and Sound Management

But before physicians decide to set up their own testing labs, they should consider factors that will impact their potential to limit costs and increase their return on investment, after they have absorbed the initial cost increases involved in planning and opening up the lab.

The diagnoses that an in-house lab provides are becoming more popular with patients because they can get test results and begin a treatment regimen right away. Another factor to consider is the availability of more value-based reimbursement options connected to clinical and financial results.

“With many contracts now tied to quality, you’ll get a higher reimbursement, depending upon the quality of care delivered,” notes John Daly, MD, chief medical officer for COLA, the national accreditation agency that helps clinical laboratories meet federal and other regulatory requirements.

At the same time, increasing government oversight is requiring in-house labs to understand and master evolving regulatory procedures and requirements.
The Protecting Access to Medicare Act (PAMA) aligns CMS lab reimbursements with the average commercial payer reimbursement for diagnostic lab tests. Given that PAMA will cut reimbursement rates for many routine lab tests by 30 percent over the next three years, the resulting financial risk to open an in-house lab could become too high for some practices, particularly in rural and sparsely-populated areas.

“It’s great if you’re a physician who can just directly bill your patient and you don’t have to worry about insurance. Then there’s no problem. But many physicians do have to interact with insurers or Medicare or Medicaid, and as a result of PAMA and insurers following suit with what the government does, it’s harder to maintain a physician-owned lab and be profitable” says Lisa Emiliusen, a group manager with Mayo Medical Labs, in Rochester, Minn.

Indeed, PAMA’s impact will extend beyond the Federal government to insurers “because contracts are set as a percentage of Medicare reimbursement in many instances,” explains John Daly, MD, chief medical officer for COLA, the national accrediting body that advises labs on how to meet regulatory requirements. “So we haven’t seen the end of this yet.”

Saying this is an across-the-board drawback, though, is premature, because to some degree, what happens to in-house labs under PAMA will depend upon the particular test performed. The American Association of Clinical Chemistry reports that Medicare payments for some commonly performed waived tests, such as HbA1c and specimen cultures, will go up during the next three years, while those payments will fall for many other high-volume tests, such as complete blood counts. The same report states that the labs that are best able to survive PAMA are those “that are operationally efficient, financially fit, and strategically diverse.”

For instance, labs that capture their volume and payment data by contract and not just by payer – as PAMA reporting requires – can better negotiate contracts and collect what they’re owed. Greater efficiency can flow from the staffing level necessary to conduct the tests and measures such as workflow automation and device-agnostic connectivity suites that directly upload lab results to the EHR in real time.

For instance, doctors in rural and low-population areas should be aware that the Protecting Access to Medicare Act, or PAMA, that went into effect this year could devastate in-house labs in these locales by cutting reimbursements for many routine tests by 10 percent in 2018 and 30 percent over the three years ending in 2020.

Once the decision is made to have an in-house lab, the most important action doctors can take in order to make the lab financially and clinically sound, whether the practice has one or multiple physicians, is to hire a professional lab manager who is obsessive about details, meticulous about record-keeping, and scrupulous about lab conditions.

“If the lab manager goes in some morning and their machine doesn’t pass controls, they better shut the lab down and not let us run any tests,” says John L. Bender, MD, senior partner and CEO of Miramont Family Medicine, in Fort Collins, Colo. “I don’t want to hear that the machine failed controls and we ran tests all day and might have given people results that were erroneous.”

**TEST VOLUME, AFFORDABILITY AND THE BREAK-EVEN POINT**

Bringing tests in house gives the doctor the revenue that otherwise would go to the referral lab.

As well, an in-house lab removes costs associated with outsourcing the tests; in effect “you now control the costs of the testing (i.e., the markup on the test) that’s performed on behalf of your patient care,” says Lisa Emiliusen, DFSS, an experienced healthcare contract negotiator and lab consultant who is a group manager with Mayo Medical Labs, in Rochester, Minn.

In the absence of an in-house lab’s quick results, a physician who believes it’s important to treat the presenting condition as
soon as possible may otherwise order interventions—drugs, diagnostic procedures, or even surgery—that the lab test data could show are unnecessary.

That's not just a patient cost burden; those costs also can come back to the practice.

With all the reimbursement changes happening today, Emiliusen stresses that “having things that are capitated, where doctors will get one reimbursement fee for an entire episode of care, they’ll want to do as much as they can for the least cost possible, because they’re only going to get reimbursed one fee in some cases.”

Whether doctors get only one payment for an episode of care may depend upon how they’re reimbursed by their payer mix, and if it’s an inpatient procedure or surgery in their office or an outpatient visit, which could leave them vulnerable to absorbing the expense of some procedures. (Typically, the hospital will pay for the inpatient testing associated with the procedure as long as it’s part of the overall care of the patient.)

So if doctors can avoid taking some procedural steps with the help of an in-house lab test diagnosis, they can lower their risk of incurring unreimbursed costs.

But in order to determine if an in-house lab is affordable, the practice needs to know how many patients have chronic ailments and what those maladies are. Then it must develop a menu of lab tests that are customized for those conditions and an estimate of how often it will need to run those tests—an approach that not only is patient-centric but also can keep unit test costs down by generating economies of scale from high-frequency test volumes.

Practices also need to know how many of the tests the practice ordered for patients were actually performed by offsite labs, so that it can measure total patient adherence rate to prescribed treatments. These complementary steps will show doctors which tests have the greatest clinical value when brought in-house and yield quick results that can enable them to make nimble treatment adjustments within minutes.

In the view of Patrick Bowman, MBA, who helps health systems plan their clinical diagnostic laboratory strategy as director of Health Systems-Lab, at McKesson Laboratory Solutions, in Philadelphia, Pa, a well-planned in-house lab with the right test menu and the right instruments to carry it out can be a revenue producer by producing reimbursements that are greater than expenses.

“To understand the real impact of moving the lab tests in-house, the practice should look at how many of those tests it ordered for its patients and how many of those tests were actually done by offsite labs, with a goal of measuring total patient adherence rate,” Bowman says.

Models that project revenue on the basis of test volume will show if a lab is affordable. At the heart of this calculation is the break-even point, which is the number of tests a lab must run to recover the costs of administering the tests.

“By and large, a physician who is not doing laboratory medicine doesn’t know much about laboratories. But technical consultants do know, so you can avoid mistakes and wind up with a much better quality laboratory if you have them working with you.”

— JOHN DALY, MD, CHIEF MEDICAL OFFICER, COLA

When test volume exceeds test costs, the tests becomes profitable. Bender points out that if the break-even for his practice is three tests a day on a cell counter, and he and two other staffers in his clinic are doing 10 such tests each day, then it makes sense to do that test.

“If the break-even is three tests a day but it’s a test that we only order every third day, then I should definitely not do that,” he suggests.

LABOR SAVING EFFICIENCIES AND PERSONNEL EXPENSES

For labs, like most businesses, personnel are the biggest expense, and most labs will need to have at least one certified lab technician.
"That’s why it’s important to automate as much as possible,” says Tim Dumas, president of TLD Consulting, in Raleigh, N.C., who advises medical practices on the financial feasibility of in-house lab testing. A comprehensive laboratory information system (LIS), whose software captures, manages and stores patient data, is central to the automation process, according to Bowman. A lab can go paperless with software capability that handles the data and monitors all analyzers, runs quality control, and connects to the EHR.

The best way to control personnel expense, though—and reap the primary cost benefit accruing to an in-house lab—is for doctors to “include workforce efficiencies in their workflow,” advises Bender.

For example, before Bender had an on-premises lab, it took his medical assistants 20 minutes over a three-day period to perform all the steps involved in ordering blood work for a patient. Today, the whole test takes just 10 minutes within a single day when performed by the on-staff medical assistant.

“What if I told you every time I took a cell count, a CVC, I lost a dollar, because the CVC costs me $8 but I only get paid $7?” he asks. “You’d tell me ‘You can’t make up that volume.’”

While bringing tests in-house is the primary way a practice can earn more money with its own lab, the efficiency at Bender’s clinic that cuts the CVC testing time in half allows his practice to more than compensate for losing money on the test itself. This is done by eliminating several high-wage hours from an employee’s week, “not to mention the competitive advantage it gives me in the marketplace, where I can say ‘Well, even at the urgent care place you don’t get these tests back right away. Here, you do.’”

But it’s important to figure out exactly how much labor time you’re saving in this way.

Doctors also can create cost efficiencies by partnering with other independent physicians in a common lab, or offering their in-house lab services to doctors who don’t have a lab. And auto-verification modules can deliver workflow and cost savings with enhanced connectivity and intelligence to an existing LIS.

“When executed correctly, these auto-verification modules can drastically reduce lab technician time and, in some cases, reduce or eliminate any potential overtime,” reports Bowman.

**BEST PRACTICES**

It’s important to engage a technical consultant to set up the lab and provide ongoing management oversight.

“By and large, a physician who is not doing laboratory medicine doesn’t know much about laboratories,” says Daly. “But technical consultants do know, so you can avoid mistakes and wind up with a much better quality laboratory if you have them working with you.”

Once the lab is in place, the technical consultant can help resolve any problems with equipment or tests. Periodically, the consultant can review quality control procedures and the proficiency testing of samples on which the lab’s accreditation depends, as well as educate office staff on quality control measures.

It’s also smart to work with lab equipment suppliers who can save practices money by covering the cost of interfacing their instruments into the LIS or the EHR. That’s money not spent on coders or programmers who might otherwise be required.

“Sometimes it’ll take 40 hours to get a test built into a laboratory information system, so the supplier can help you mitigate that cost,” says Emiliusen.

Ultimately, making a POL work is about doing the necessary homework.

“As long as a practice is performing ample clinical, operational and financial diligence, creating a lean and efficient strategy, there is no reason why their POL won’t bring ample value to the practice in the short and long-term,” says Bowman.
During the 2016 fiscal year, the Medicare fee-for-service improper payment rate reached an estimated 11 percent or roughly $40.4 billion. This improper payment rate does not measure fraud, but rather payments that did not meet Medicare coverage, coding or billing rules.

These billing errors represent a significant depletion of available Medicare funds, and as a result, healthcare providers share the responsibility of ensuring the accuracy of submitted claims.

The Centers for Medicare & Medicaid (CMS) cites five major categories of improper billing:

- no documentation,
- insufficient documentation,
- lack of medical necessity,
- incorrect coding, and
- other.

Insufficient documentation makes up nearly 64% of improper payments, while the other four categories account for the remaining 36%. They serve to highlight changes healthcare professionals can make to ensure accurate payment rates.

Fraud defined

While Medicare fraud contributes to improper payments, not all improper payments constitute Medicare fraud. While Medicare fraud is done intentionally, erroneous billing results in the same consequences—overpayment—even though unintentional.

Medicare fraud is more than simply submitting false claims or making misrepresentations to obtain payment that would not otherwise occur. Medicare fraud can occur in any size institution ranging from solo practices to large institutions. Fraud can be committed by a wide range of individuals from the patients to the physicians. Medicare fraud committed by the provider includes:

- billing for appointments that the patient failed to keep,
- billing for services not provided,
- upcoding,
- billing for unnecessary services or items.

Fraud vs. abuse

Medicare abuse includes practices that directly or indirectly result in unnecessary costs to the Medicare program. Abuse includes practices inconsistent with providing a patient with medically necessary services that meet professionally recognized standards. Medicare abuse can be committed in many of the same ways as fraud.

Improper payments from erroneous billing can also occur in many forms. These include insufficient documentation such as treatment plans, physician's orders and progress notes. Other forms of improper payments stem from policy changes, data entry mistakes, failure to meet statutory coverage requests or medical necessity requirements, or incorrect coding.

By ensuring the proper documentation is in place, physicians can decrease the risk of improper payments. Incorrect coding that results in improper payments are similar to the coding errors that lead to Medicare fraud. Though deterrence is difficult to quantify, there is empirical evidence that investigating and prosecuting healthcare fraud has resulted in reductions in improper claims to Medicare.

Compliance keys

The Office of Inspector General (OIG) and CMS suggest that individual and small group practices who accept Medicare implement compliance programs to avoid both erroneous and fraudulent claims. The OIG suggests that such a program would not only reduce the risk of improper claims and an external audit but improve the quality of care.

Essentially, a compliance program allows errors to be identified and resolved internally before claims are submitted. Since every practice is unique, there is not one compliance program that fits the needs of every practice. Instead, the OIG has developed seven guidelines that can help to establish the basics of a compliance program. These guidelines include:

- implementing written procedures,
- designating a compliance professional,
- providing training for employees,
- developing effective communication,
Writing policies and procedures is an important step in establishing a compliance program, but these policies need to be enforced and regularly updated in order to be effective. This is where having a designated compliance professional becomes beneficial. The role of the compliance professional is to remain up to date with new requirements and ensure this information is effectively communicated to all necessary employees.

**Training & education**

In addition to a compliance professional, employees should receive proper education and training about current Medicare billing requirements. CMS and OIG offer web-based educational resources on Medicare coding, fraud and abuse, office management, provider compliance, and payment policy.

The specific type of training conducted should be based on the needs of the practice and could be provided by an outside source as well. Training may also be available at local community colleges for billing and coding. After initial training is completed the OIG recommends that training sessions continue to be provided at least once a year for employees involved in billing.

**Conduct self-audits**

Once a compliance program has been established it is imperative to conduct self-audits to assess its efficacy.

If a self-audit has never been performed the OIG recommends that a baseline audit be completed which reviews the claims submitted during the three months following the implementation of an initial compliance program. This will provide insight about how effective the initial compliance program is and where any potential problems exist.

After the first baseline audit is completed the OIG recommends that self-audits continue at a minimum of once a year to ensure the compliance program is still being followed and is effective. During these yearly audits the OIG recommends at least five to ten medical records per physician.

The American Institute of CPAs recommends a minimum sample size of eleven per item type, assuming the expectation of no errors. The claims examined could be from a random sample of all Medicare claims or chosen specifically based on potential risk areas that have been identified. The OIG recognizes four potential risk areas for all providers. These include coding and billing, reasonable and necessary services, documentation, and improper documents.

During the self-audit there are generally six areas that the CMS recommends examining. These include: availability of documentation, adequacy of documentation, acceptability of documentation, allowability of service, appropriateness of service, accuracy of payment. If an error is detected during the self-audit a prompt response is necessary and the action taken will depend on the error.

The OIG also recommends that any risk areas identified be addressed in the written procedures. After an audit is completed the error rate, error count and total amount paid for all potential errors should be documented. This allows practices to track their progress and determine if the compliance plan is effective.

**Source:** CMS

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**TYPES OF IMPROPER PAYMENTS**

<table>
<thead>
<tr>
<th>MISTAKES</th>
<th>Result in errors</th>
<th>Such as incorrect coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>INEFFICIENCIES</td>
<td>Result in waste</td>
<td>Such as ordering excessive diagnostic tests</td>
</tr>
<tr>
<td>BENDING THE RULES</td>
<td>Result in abuse</td>
<td>Such as improper billing practices (like upcoding)</td>
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The types of improper payments in Figure 1 are strictly examples for educational purposes, and the precise characterization of any type of improper payment depends on a full analysis of the particular facts and circumstances. Providers who engage in incorrect coding, ordering excessive diagnostic tests, upcoding, or billing for services or supplies not provided may be subject to administrative, civil, or criminal liability.

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Jonathan Montrose, Courtney McClure, Hannah Rector are osteopathic medical students and Janis Coffin, DO, FAAFP, is a professor in the department of family medicine at Kansas City University of Medicine and Biosciences in Joplin, Mo. Send your practice management questions to medec@ubm.com.
even when we spend a great deal of time with our patients or do something really important for them like making a critical diagnosis, or heck, maybe even saving their lives, patients may leave their visit feeling unsatisfied. This can be intensely frustrating for us since we try our best to care for the patient and simply cannot understand what went wrong.

More importantly, feeling unable to make patients happy leads to physician burnout. Doctors who receive negative feedback from patients may begin to feel a lack of accomplishment in their work, or a sense that what they are doing doesn’t matter. They may also begin to develop negative feelings towards patients, which can cause cynicism and detachment.

The good news is that there is a simple way to improve patient satisfaction—and in return, to improve our own satisfaction as physicians. And no, it doesn’t mean giving in to every patient demand for antibiotics or pain medications. The key is learning how to help patients feel heard and understood, which we can do using psychology.

WHAT LEADS TO PATIENT DISSATISFACTION?
The biggest cause of dissatisfaction occurs when patients leave the office without feeling that their doctor really listened to them.

Unfortunately, sometimes doctors unknowingly give that impression to their patients. Although we may be listening, it may not always be obvious to our patients as we click away on the keyboard and scroll through computer screens. And with the increasing demands of EHRs, computerized physician-order entry, and mandatory check-boxes, we can become so distracted by our role as data entry clerks and paper pushers that we sometimes lose our focus.

By bringing our attention back to the patient—at least at the beginning of the visit—we can dramatically improve patient satisfaction. The bonus is that when we focus on building relationships with our patients, we will find that we get the information we need from them more quickly, and our office visits become more efficient.

SHOW EMPATHY
The key to patient satisfaction is learning how to show empathy—that you understand their concerns, and you care. Most doctors do care about their patients, but not all are naturally good at projecting empathy to make patients feel cared about and understood.

The simplest way to show empathy is to start with a smile. Even if you don’t feel happy, smile anyway. Psychology shows us that emotions are contagious, so when you smile at patients, even a brief smile, they will automatically smile back. This alone will make them feel more welcome and happier.

Next, engage with the patient in a small physical way. Shake hands. Touch them on the shoulder or elbow. This type of expressive touch has been shown to improve interactions between physicians and patients.

Sit down at the same level as the patient and look them in the eye. Spend just a few moments making small talk before you start scrolling around on the computer—this helps to build a bond that may help the patient to open up more quickly when you begin discussing health issues. You can ask about the patient’s family or hobbies, upcoming holiday plans, or even just chat about the weather.
When you start to talk about the patient’s medical concerns, really listen to the patient, and demonstrate that you are listening by giving the patient your full and complete attention. This can be very difficult with the EHR—but at least during the patient’s introductory statements, don’t even look at the computer!

As the patient begins to describe concerns or symptoms, avoid interrupting so the patient feels completely heard. Use active listening techniques, such as eye contact, leaning forward, and verbal cues (“yes...” “go on...” “uh huh...”), to show you are listening. Repeat back what the patient says to you, so to demonstrate you heard and understood what was said.

Now, I know what you are thinking. “I can’t possibly sit there and listen to everything that the patient has to tell me! I will be there all day!”

First, you may be surprised at how quickly your patient finishes talking if you simply let them talk without interrupting. Studies show that the average patient finishes talking in 92 seconds, and most patients will be done within two minutes.

Also, keep in mind that you don’t have to act today on everything that the patient is telling you. You must simply acknowledge that you have heard the patient’s concerns and say that you understand.

**USE EMOTIONAL MIRRORING AND VALIDATION**

Imagine you are seeing a patient with a chief complaint of abdominal pain. As you are addressing the abdominal pain, the patient then says: “Oh, by the way, Doctor, I’m also having this really weird pain in my foot.”

If you ignore this “add-on” complaint, even if you cure their main issue of abdominal problem, the patient may go away complaining of that “no-good doctor” who didn’t do anything to help them (because you didn’t deal with their foot pain). On the other hand, if you take the time to deal with their foot pain, now you are running behind for your next patient, who is going to be upset with you. It’s a no-win situation!

But there is a solution! You can quickly help the patient feel heard and understood without taking much time by using the psychology technique of emotional mirroring and validation.

Here’s what you do: Simply repeat back the concern that the patient has stated, check for clarification (making it clear that you understand), and show empathy by acknowledging the patient’s concern. Then redirect the patient back to the main problem at hand (in this case, the abdominal pain).

Start by restating the patient’s concern:

**Doctor:** “You say that you are having a really weird pain in your foot?”

**The patient may respond:** “Yes, it comes and goes. It’s not there right now, though.”

**Keep in mind that you don’t have to act today on everything that the patient is telling you. You must simply acknowledge that you have heard the patient’s concerns and say that you understand.”**

Again, repeat the patient’s words and ask for clarification.

**Doctor:** “So, the pain comes and goes, but it’s not there right now, is that right?”

**Patient:** “Yes, it isn’t bothering me right now.”

Show empathy by validating the patient’s concern.

**Doctor:** (with an expression of genuine concern) “Pain that comes and goes can be frustrating—I’m sure that must be uncomfortable when it happens. But since your foot is not hurting right now and your stomach is, let’s focus on that area. We can make another appointment to discuss your foot pain.”

The key to this technique is repeating back what the patient says when validating so that they feel heard and understood, even if you don’t act medically on the information offered right at that moment.

Emotional mirroring and validation can be especially useful when dealing with emotionally charged situations or difficult patients, which we will explore more in the next article in this series.

Rebekah Bernard, MD, is a family physician and author. Send your comments to meded@ubm.com.
How telehealth technology can boost revenue

Digital changes in consumerism are spilling over into healthcare, and driving the way physicians communicate with their patients, says Kathy Ford, president and chief product officer at Rhinogram, a telehealth platform in Chattanooga, Tenn.

“We are all now conditioned to a certain level of services, based on Amazon and Starbucks and other online tools we all use every day,” Ford says.

As a result, physicians looking to improve their revenue cycle should optimize the way they communicate with patients through telehealth platforms. “If I have something wrong, I don’t want to go wait in a physician’s office for 45 minutes only to find out that I could have just taken an aspirin,” Ford explains.

Real-time communication

Patients want the ability to communicate in real time or close to it through some form of messaging, be that text or instant messenger, or a telehealth call. “If I can get a response almost in real time, I’m going to stay loyal to that provider. And I’m going to tell my friends about that provider,” she says.

Communicating with patients is a key part of keeping them healthy. “Practices need to use more contemporary ways to make sure their patients are staying healthy, staying out of the ED, and certainly preventing readmissions,” Ford says.

Virtual check-ins

One way to do this is through virtual check-ins, either through a messaging function within a telehealth platform, or video visits with patients that can save time and avoid unnecessary office visits.

“This hopefully drives down overall healthcare costs and allows those practices to use those appointment slots for higher acuity patients, or new patients,” she says.

Using telehealth to communicate with patients provides them additional access, as well, which, Ford says, drives a better patient experience.

“A better patient experience means better patient engagement. It means improved reputation management, which are all drivers to bottom line performance.”

Multi-tasking potential

Telehealth messaging also allows for multiple contacts with patients, rather than a single phone call in which the physician’s time is completely tied up. “[The physician] sends a message, waits for a response, and meanwhile can send another message. So the ability to communicate with multiple patients in a shorter amount of time is an overall office efficiency,” Ford says.

This frees staff up to focus on higher-value activities, she says.

Additionally, physicians can use telehealth platforms to send text messages, which, she says, have a 98% open rate as compared to the 20% open rate for an email.

More efficient workflow

It can also help the practice avoid phone calls. “Calling people to tell them what their obligations is or to remind them that they have an outstanding bill is also time-consuming and inefficient,” she says.

She believes that telehealth is one of the ways that physicians can be competitive in their markets, particularly for specialty clinics and services where there’s more competition for the patient population.

Moreover, Ford explains that telehealth’s additional capabilities offer other services such as mobile bill pay and explanation of benefits that support increased revenue for physicians. “Using these technologies is going to drive revenue cycle improvement,” she says.
WHAT’S RUINING MEDICINE
At the end of every year, *Medical Economics* publishes a list of the top challenges facing physicians. This list is generated by surveying our physician readers.

For this year’s list, we decided to recast the question. Instead of asking what challenges physicians face, our editorial staff wanted to hone in on what issues annoy and frustrate doctors and get in the way of what’s truly important: Treating patients and running practices.

And so we asked physicians in a poll: “What ruining medicine for physicians?”

In our list of the nine issues ruining medicine for physicians, the goal is not to dwell on the negative aspects of working as a physician. Instead, we wanted to show our readers that they share common challenges when dealing with the vexing issues facing primary care in today’s complex healthcare environment. Each piece also offers practical solutions that physicians can start using in their practices today.

What’s ruining medicine for physicians?

1. **44%** Paperwork and administrative burdens  [PAGE 52]
2. **41%** Difficulty using EHRs  [PAGE 53]
3. **26%** Government regulations  [PAGE 54]
4. **24%** Prior authorizations  [PAGE 55]
5. **19%** Replacing primary care physicians with NPs/PAs  [PAGE 56]
6. **18%** No negotiating leverage with payers  [PAGE 57]
7. **15%** Rising practice staff and overhead costs  [PAGE 58]
8. **15%** Imbalance in primary care vs. specialist reimbursements  [PAGE 59]
9. **12%** MOC costs and requirements  [PAGE 60]

A NOTE ABOUT BURNOUT In our original survey, we included “physician burnout” as one of the issues ruining medicine. That garnered nearly 25 percent of responses, good enough for 5th on our list. But after further consideration, the editors and our medical advisers decided that burnout did not really fit, as burnout was a result of the challenges on our list. So we decided to leave it out. *Medical Economics* knows that addressing burnout is a top priority for physicians. We couldn’t agree more, and will offer detailed coverage of physician burnout, including practical solutions, in upcoming issues of *Medical Economics*. Stay tuned.
It’s no surprise that physicians chose paperwork and administrative burdens as the top issue ruining medicine. Earlier this year, in the 2018 Medical Economics Physician Report, 79% of doctors said it was the top challenge they experience in practice.

Much of this burden is a result of changes in the last several years, notably the advent of value-based care. Kevin Riddleberger, MBA, co-founder and chief strategy officer at DispatchHealth, which delivers mobile urgent care to homes, says paperwork or administrative duties is not the best use of clinicians’ time and resources, and directly impacts patient care and increases physician burnout.

Kyle Varner, MD, an internist at the Tripler Army Medical Center in Hawaii and author of White Coat Cartels, laments that he spends more time in front of a computer documenting his time with patients than he actually spends with patients.

“This is not because I am trying to create a good record of the care—it is because I have to play semantic games so that the hospital gets paid,” he says.

Then when records come in from another hospital, often he must sift through hundreds of pages of data to find the important information he needs, saying it is hidden in a pile bureaucratically mandated auto-populated junk that no one wants to read.

Another challenge is dealing with insurance companies that try to convince him to prescribe certain drugs over others, citing a longer authorization process and lots of paperwork for his preferred choice in many cases.

“So, instead, I often adhere to their guidelines, which may not have the patient’s best interests at heart,” Varner says.

He cites the example of trying to get a Medicaid patient on sacubitril/valsartan (Entresto), a drug used to treat heart failure.

“I can expect to spend at least 45 minutes filing paperwork and I can expect to get multiple phone calls when I do this,” he says. Because of the extra time needed, he feels Entresto isn’t prescribed as much as it should be, blaming the indirect incentives created by third-party payers.

C. Nicole Swiner, MD, with Durham Family Medicine in Durham, N.C., says physicians are often in a tug-of-war between what is right for their patients’ care, what the patient’s insurance will cover and what the pharmaceutical companies will allow them to prescribe.

“Specialists are also still valued more than primary care providers, yet PCPs are underpaid and overwhelmed with work,” she says. “I or my staff members spend the majority of our weeks on the phone and doing paperwork (often denied and resent to do again) on our patients’ behalf for better care.”

Even students and residents can’t escape busy work. Internal medicine residents spend just 12 percent of their time with patients and 40 percent on computer-related tasks or administrative tasks, according to a study out of The Johns Hopkins University School of Medicine.

Ways to overcome the challenge

1. **Have patients pay cash for medications:** Varner frequently suggests that patients whose insurance company requires prior authorization take this route because it will simplify the process. “This is usually substantially cheaper than they think,” he says. For example, when one of his patients was told by Medicaid that he couldn’t have Linezolid without a pre-approval process, Verner got the patient a coupon so he could get the medication for just $50.

2. **Rely on technology:** Riddleberger says the future of healthcare operations and clinical delivery will improve thanks to enhancements to technology that will decrease paperwork and administrative burdens. Some of what’s expected to help are increased machine learning, natural language processing and artificial intelligence in day-to-day care delivery.
2 Difficulties using EHRs

Physicians largely dislike their EHR systems and feel they are stuck with the ones they have, even when they are unhappy with it.

The Medical Economics EHR Report, published in October, found that 70 percent of physicians would like to switch systems but don’t because of high costs and lack of better options. In addition, about 57 percent would not recommend their current system to a fellow physician.

These problems are leading many physicians to simply quit. The Doctors Company, a medical malpractice insurer, released a report earlier this year which found that 54 percent of physicians plan to retire within the next five years because of burnout, with EHRs being a major contributor.

The report also revealed that 61 percent of doctors believe EHRs have a negative impact on efficiency and productivity and 54 percent feel they negatively affect the physician-patient relationship.

Richard E. Anderson, MD, FACP, chairman and chief executive officer of The Doctors Company, says there are two problems with EHRs. First, they require hours of duplicative and often unnecessary data input. Second, the systems are non-intuitive, vary widely, and don’t communicate with one another.

“An organization should be well-equipped with EHR specialists or equivalent positions to provide training as needed to all staff and providers,” he says. Maiona says every hospital and medical practice’s goal should be to make EHRs a clinically indispensable tool for physicians to deliver optimal patient care. And that begins with improving EHR usability.

“I’ve seen that the physician, EHR usability refers to accessing and acting on patient information with ease. It’s having data presented in a manner that is consistent with the physician’s unique thought process and workflow, and that allows them to intuitively act on that information the fly,” he says. “It also means doing no harm.”

Since hospitals have made huge investments in their EHR systems, Anderson says, they need to find ways to get the most out of those investments.

He says technology such as workflow applications, mobile device access, voice enabling tools and secure messaging apps assist in making things easier for physicians and therefore help in their use of EHRs.

Richard Schuster, DO, a family practitioner at Schuster Family Medicine in Indianapolis, Ind., says the problem with most EHRs is that they are not built to be health or medical records and are essentially billing platforms designed to extract data points.

“EHRs actually reduce physician productivity, and often impede rather than facilitate the care of patients. This is the exact opposite of what we seek when we deploy a new technology.”

— RICHARD E. ANDERSON, MD, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, THE DOCTORS COMPANY

Christopher Maiona, MD, chief medical officer of PatientKeeper Inc., which provides financial applications to streamline physician workflow, says that based on 20 years of conversations as a hospitalist, EHRs generally confound and frustrate physicians.

“Problems include counterintuitive workflows, poor interfaces, bloated clinical documentation, and too many unhelpful alerts,” he says in an e-mail. “It is sad but true that healthcare is the only industry which, in the course of computerizing its operations, has made its most valuable, highly compensated workers—physicians—less productive by increasing their administrative burden.”

THOUGHTS FROM USERS

John Nguyen, MD, chief medical officer at QueensCare Health Centers in Los Angeles, says for EHR use to become easier, providers should welcome feedback and be open to learning.

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When it comes to value-based care, government regulations often get in the way of physicians’ best efforts and that’s a challenge that irks many in healthcare.

Physicians told Medical Economics earlier this year that complying with government regulations was one of the top reasons their practice finances worsened in the last year. Many physicians also cited penalties from pay-for-performance initiatives as a reason.

“Low-risk patients will inevitably lead to higher reimbursement, and those who care for the highest-risk patients will end up being penalized.”

— Kyle Varner, MD, internist and author

Kyle Varner, MD, an internist and the author of White Coat Cartels, says under a value-based care system, physicians and hospitals face a penalty for caring for very sick or very difficult patients, because when reimbursement is tied to outcome, it is really tied to the demographics of the patient population.

“Low-risk patients will inevitably lead to higher reimbursement, and those who care for the highest-risk patients will end up being penalized,” he says.

Richard E. Anderson, MD, FACP, chairman and chief executive officer of The Doctors Company, says the U.S. healthcare system isn’t set up to accommodate new payment models, so the transition from where we are to where we are heading will be long and difficult. In fact, The Doctors Company’s recent “Future of Healthcare” survey revealed high levels of resistance and skepticism among physicians when it came to value-based care.

“Healthcare is different from other industries. Human biology is almost infinitely complex and cannot be fixed on assembly lines,” Anderson says. He believes the patient must be at the center of caregiving and there should be less concern of operating as if in a factory. The survey reflects that many believe endless regulations distract from patient care and waste physicians’ valuable time.

Daniel Stock, MD, a family practitioner in Noblesville, Ind., says the problem with value-based care is that it isn’t the patients’ values that get reimbursed for, but rather whatever the accountant and his chosen “experts” value.

“To make matters worse, governments and insurers think that time spent cutting patients is more valuable than time spent thinking about patients, so they pay a premium for those services, which leads providers to recommend surgery over other treatment,” he says.

The impact has been felt in the need for additional documentation and justification for services and payment. Moreover, each time another level of documentation is added, it takes time away from the patient encounter and from communicating with the patient or other physicians involved in caring for the patient.

Verner believes the best solution is to get the government out of the doctor-patient relationship.

“Healthcare policy should be laser-focused on giving consumers power and choices,” Varner says. “Health savings accounts, healthcare cost sharing organizations, direct primary care and medical tourism are all viable solutions that can contribute to a revolution.”
Prior authorizations

Physicians hate prior authorizations. They find the process insulting, as they argue they know what’s best for each individual patient under their care, and have the medical training and expertise to back up their clinical decisions. Prior authorizations also disrupt a practice’s workflow by creating additional work for staff and physicians to get a treatment or test approved. Physicians also believe that prior authorizations are largely a cynical effort to shape treatment so as to contain costs and boost a payer’s bottom line.

“[Prior authorization] has nothing to do with medical care, it’s all about saving money and putting people through the hassle so they get tired of the hassle.”
—KENNETH KUBITSCHEK, MD, INTERNIST, ASHEVILLE, N.C.

More than three out of four physicians (78 percent) say prior authorizations were the most challenging issue they experienced when dealing with payers, according to the Medical Economics 2018 Payer Scorecard survey. Furthermore, physicians said they and their staff spend upward of 20 hours per week, on average, dealing with prior authorization issues.

“We want to take care of the patients, but we’re taking care of the insurance company,” said Ripley Hollister, MD, a family physician in Boulder, Colo., and a board member of the Physicians Foundation, which advocates on behalf of practicing physicians.

Furthermore, physicians are pessimistic that there’s anything they can do, either individually or collectively, to make prior authorizations go away. Still, there are strategies doctors can put in place to better manage prior authorizations.

Focus staff efforts
Find a staff member that can focus on prior authorizations, Kubitschek said. This person can attempt to monitor formulary changes, track prior authorization requests to detect patterns and eliminate inefficiencies.

Get patients involved
There’s nothing wrong with having patients assist with the prior authorization effort. One way payers get away with prior authorizations, Kubitschek said, is that they often don’t involve patients. Asking patients to call their insurance company to inquire about prescriptions and tests is one way to make patients a part of the process.

Play hardball (when possible)
Do you have a payer contract that’s given you a lot of problems? Consider not re-upping with that payer. Kubitschek said this is not a decision to make lightly, as it affects patients under your care. But sometimes the extra work and headaches are just not worth it.

Go direct pay
One radical solution is to stop accepting insurance at all, and go with a direct primary care model, Hollister said. This requires careful thought and meticulous business planning, and should not be done haphazardly. However, switching to a direct model is an option worth considering.

Advocate
Physicians often are leery about getting involved in politics. But it is one way to bring about change. David O. Barbe, MD, MHA, the former president of the AMA, told Medical Economics earlier this year that physicians can work through their state medical societies and other membership organizations to fight for change.

“These membership organizations exist to serve their members and patients, and they want to hear from practicing physicians about obstacles they face in providing high-quality care,” Barbe said.
The number of new nurse practitioners (NPs) and physician assistants (PAs) continues to outpace the number of new physicians nationwide, causing some concern among primary care doctors. There are more than 248,000 NPs currently licensed to practice in the United States, up from about 120,000 in 2007, according to the American Association of Nurse Practitioners. An estimated 85.5 percent of new graduates have been trained in primary care.

Similarly, the number of physician assistants has grown exponentially, from just four in 1967 to more than 115,000 in 2018, according to the American Academy of Physician Assistants. Slightly more than 30 percent of PAs work in family medicine.

Both professions are projected to grow more than 30 percent by 2026, creating frustration among doctors who fear being replaced by lesser-trained professionals in providing primary care.

“One of the biggest concerns we have is the development of diploma mills—NPs in particular are being churned out of online programs,” says Rebekah Bernard, MD, board member of Physicians for Patient Protection, an advocacy group for physician-led healthcare.

She adds that there is no standardized education for NPs and PAs, so knowledge and training can vary widely among graduates. “The gap in required education is staggering—physicians aren’t allowed to practice until we have trained for about 20,000 hours, while NPs may have 1,000.”

Yet NPs are often promoted by health systems and nursing programs as being “just as good” as doctors and are now allowed to practice independently in 23 states.

The push for more non-physician providers in primary care is coming not just from healthcare organizations looking to reduce costs, but from patients who want more convenient access to providers. These patients often lack respect for the amount of training it takes to be a physician and want instant answers and quick care, and a nurse practitioner at a retail clinic can often provide that, even though it may incur a higher risk, says Bernard.

“The biggest thing with a new NP is they don’t know what they don’t know,” she says. “They don’t have the experience, and really don’t realize how quickly something can go wrong.”

Doctors working for health systems can be assigned supervisory duties over non-physician providers who may or may not have appropriate training, putting physicians who are already short on time in a position of having to assume liability for supervising them.

“There’s no oversight on hiring or how helpful they might be, but doctors are expected to supervise them or they’ll be let go,” says Bernard. “Physicians should be extremely aggressive if doing true supervision and not just sign off on charts. Understand their knowledge base and there should be true collaboration.”

Bernard says collaboration is the key. Laws should limit what NPs or PAs can do on their own, and they should always have to work under the supervision of a physician.

### Number of nurse practitioners licensed to practice

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
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<tr>
<td>2007</td>
<td>120,000</td>
</tr>
<tr>
<td>2018</td>
<td>248,000</td>
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Source: American Association of Nurse Practitioners
Negotiating contracts with payers has always been an unpleasant task for doctors. But it has become even more difficult in recent years, thanks to trends such as value-based care and consolidation among commercial payers.

"The big payers don’t want to negotiate with small practices. They say ‘take it or leave it,’” Rebecca Jaffe, MD, owner of a Wilmington, Del. internal medicine practice, told Medical Economics in 2013.

David Zetter, CHBC, founder and lead consultant of Zetter HealthCare in Mechanicsburg, Penn., notes that until about a decade ago many payers would give small increases to doctors in their networks without asking for much evidence that the providers were improving outcomes or holding down costs. But no longer.

"Healthcare financing is getting tight and payers want to increase their profits,” Zetter says. "In addition, with everything going to value-based, the payers are getting more sophisticated. They’re demanding more information and evaluating providers on a more rigorous basis." Evidence of that, he adds, is the trend of payers narrowing their networks to include only those physicians and practices demonstrating the lowest costs and best outcomes.

For doctors, this new reality means they need to become more sophisticated and proactive in their approach to contract negotiations. A good place to start, Zetter says, is by understanding the payer's perspective. Most contract managers operate with a fixed budget, so increasing one doctor’s reimbursement means reducing payments to another. "There needs to be a win-win situation for it all to come together," Zetter explains.

With that in mind, Zetter says, physicians need to ask themselves, "What can I do for the payer that’s going to make it [raising reimbursements] a benefit to them? Is the issue that my costs are too high? Am I referring patients to specialists that don’t have good outcomes?"

Zetter also recommends that doctors participating in Medicare’s Quality Payment Program obtain their quality and cost data (available at https://qpp.cms.gov/participation-lookup). That information will help level the playing field when negotiating with commercial payers, most of whom have their own data about the doctors in their networks—but may not be sharing it.

"If they have a provider with low costs and good outcomes, and yet are underpaying them compared to other providers in the same specialty, they’re getting a good provider on the cheap," he explains. "So the doctor who’s going to negotiate with them needs to let them see how good a practitioner they are.

"Doing your homework means a better chance of success in getting what you want, versus just saying ‘I want to negotiate a new contract,’ because in most cases now that won’t get you anywhere," Zetter adds.

Along with preparation, regular communication with payers is helpful for ensuring successful negotiations, says Lucien Roberts III, FAC-MPE. The administrator of a Richmond, Virginia gastro-intestinal practice, Roberts has negotiated contracts with many of the country’s largest commercial payers. He makes a point of contacting representatives of his major payers several times a year.

"The big payers don’t want to negotiate with small practices. They say ‘take it or leave it,’”

—REBECCA JAFFE, MD, INTERNIST, WILMINGTON, DEL.
Every business grapples with rising employee and overhead costs, but these increases are particularly distressing for physician practices. Since 2013, the median operating costs for primary care practices rose by 13 percent, according to a 2018 Medical Group Management Association (MGMA) report.

“What I think has made it more acute and painful for physician practices is that earnings have remained fairly flat,” says Susanne Madden, president and CEO of The Verden Group, a practice-management consulting firm in Nyack, N.Y. “We’re not seeing insurance companies increasing payments to providers that keep pace with their burgeoning expenses.”

To combat these rising business costs, practices must balance reducing expenses with driving revenue growth. Here are four strategies that can help practices succeed in the face of financial constraints.

**FIND THE BEST VENDOR CONTRACTS**

Get the best prices for medical and office supplies, medications, vaccines, and other overhead services by taking advantage of discount contracts. These contracts are easy to find with a bit of research and can be secured independently or through group purchasing, but it’s important to stay abreast of what’s available, says Deborah Winiger, MD, a solo family physician in Vernon Hills, Ill. “I was discussing vaccines [with another physician] and he was paying $50 more a dose [than I was] for one shot, and he had no idea.”

**EXPAND PRACTICE OFFERINGS**

Ancillary services can improve the bottom line but often require considerable upfront investment. If a practice is not financially ready to add an ancillary service, Madden recommends renting out practice space to complementary specialties and/or offering educational sessions on pertinent topics, such as mental health or nutrition, that patients can attend for a modest fee. These offerings require minimal investment while providing value for patients and a revenue boost for the practice.

**INVEST IN STAFF**

Administrative and clinical staff members play a pivotal role in the success or failure of a practice, and employing non-physician providers leads to increased revenue despite greater expenses, according to the 2018 MGMA report.

Therefore, it pays to hire and retain skilled and engaged employees, even if that means offering them competitive wages and benefits. “You want to make sure you can attract the good ones,” Madden says. “[If you don’t] it hurts you in so many ways—from patient frustration with a person who doesn’t know what they’re doing up front to the physicians not being adequately supported in their clinical work.”

**SOLICIT PATIENT FEEDBACK**

Don’t rely on trial and error to pinpoint which areas of the practice are functioning well and which need improvement, as decisions based on incorrect assumptions can be expensive to rectify. “Ask your patients,” Madden says. “You have a focus group coming through your doors every day that you’re open.” She suggests utilizing check in to survey returning patients on potential practice changes, such as additional appointment times or new services. Similarly, checkout provides the opportunity to inquire about and address any issues patients may have experienced during their visits.

Asking patients what they want from the practice is key to improving patient satisfaction, which increases the likelihood of retaining current patients and acquiring new ones without any additional marketing costs. “My practice has been built on loyalty of patients. A lot of my patients have been with me the whole time, and they refer their friends and coworkers,” Winiger says. “Be good to your patients and be a good physician. That brings patients in and helps the bottom line.”

Increase in median operating costs to run a primary care practice, since 2013

Source: MGMA
Primary care pay has increased by more than 10 percent over the past five years, nearly double the rate of specialist compensation during the same time period, according to data from the Medical Group Management Association (MGMA).

But even with these gains, primary care physicians earned a median income of $257,726 in 2017—compared with a median of $425,136 for specialists.

The discrepancy in reimbursement between cognitive and procedure-based specialties has never been a secret. "Doctors don’t choose careers in primary care for the money or the lifestyle," says Heidi Larson, MD, a consultant with Stroudwater Associates. "We choose it for the relationships with patients and their families," says Larson, who spent the first 15 years of her career in solo family practice in Portland, Maine.

But owning and running a practice on relatively little income exacts a toll on precisely that element of practice, as physicians are forced to spend less time with more patients, she says. "It’s not just about the disparity in reimbursement. It’s about the loss of relationship and face-to-face time with our patients."

It may not be feasible to eliminate the disparity altogether, but Larson predicts that continued movement away from fee-for-service reimbursement and toward global payments will alleviate the strain on primary care practices.

"We need to change the payment model to incorporate care management fees and incentives for quality, cost, and utilization. And I think that’s going to become more obvious in the coming years," she says.

In the meantime, primary care practices can optimize their reimbursement at current rates by implementing team-based care, a staffing model in which all clinicians work to the top of their licensure, Larson says.

The MGMA report reflects an increase in team-based care by noting significant growth in compensation for non-physician practitioners. "In many communities that we visit, nurse practitioners and other advanced practice providers provide immediate care and same-day access," says Nick Fabrizio, a principal consultant with MGMA.

When working with clients to redistribute their workload throughout an established team, Larson tracks measures such as patient experience scores, capacity and access, quality metrics, cost and utilization, and provider satisfaction before implementation of team-based care and again at three, six, and 12 months.

Success in these measures not only ensures clinicians’ and patients’ acceptance of the model, but can also help optimize reimbursement.

For example, high-performing teams can help fill gaps in care by teeing up and ordering routine health maintenance, prescription refills, smoking cessation, advanced care planning, and other items that factor into coding and reimbursement, she says.
Physicians have numerous complaints about maintenance of certification (MOC), with its significant commitment of physician time, effort, and financial expense ranking near the top. In that context, primary care physicians’ perception that much of the information on which they are evaluated is irrelevant to their daily practice amplifies their frustrations.

A recent survey from MDLinx garnered powerful comments from physicians. One respondent wrote: “This is a ridiculous, time-consuming, family-wrecking, practice-interfering, sleep-depriving activity that leads me to want to quit [medicine].”

According to the survey, 62 percent of respondents who took the 10-year exam spent more than three months preparing, while 33 percent of those who chose the Knowledge Check-In exceeded three months of study. Both formats are “open book,” meaning that physicians have access to clinical decision support while taking the assessment.

Meanwhile, 65 percent of physicians who responded to the survey reported that the MOC process added no clinical value to their practice of medicine. Some even argued in their comments that it causes harm. As one respondent wrote: “I found the whole exercise devoid of value, tedious, emotionally taxing, and disruptive. I am a rural physician and travel was required for this exam. MOC significantly contributes to physician burnout and office interruption.”

“It’s clear from the physicians’ responses that preparing for MOC adds to their burnout,” says Sarah Anwar, director of content strategy for MDLinx.

What’s more, the financial requirements of MOC spelled out by the American Board of Internal Medicine (ABIM) and American Board of Family Medicine (ABFM) on their websites do not include costs related to travel or lost practice time.

Although MOC is not required in all states, it’s not unusual for hospitals or insurers to mandate that their physicians participate in the program. And in the age of increasingly consumer-directed healthcare, patients frequently use the American Board of Medical Specialties’ (ABMS) website to verify physicians’ board certification or ABMS MOC, says Marianne Green, MD, a board-certified internist who is a member of the ABIM Board of Directors and the ABIM Council.

From that perspective, physicians may receive a return on their investment in MOC. “But the most important reason [to pursue MOC] is our professional obligation to serve patients as best we can,” says Green, who is also an associate professor of medicine and medical education and senior associate dean for medical education at Northwestern University Feinberg School of Medicine.

Nonetheless, she sympathizes with the plight of primary care physicians. “The challenge of being a primary care physician has risen exponentially in the last few years, given the complexity of what we see in our patients, the amount of things we need to do for our patients, and the evidence explosion of the science,” she says. “I understand why physicians are trying to cut [burdens] where they can, but this is not an area where we can cut. It’s critical that we have external assessments that help us understand what we don’t know.”

ABIM has also made a concerted effort in recent years to ease the MOC process, she says. For example, many physicians don’t realize that ABIM has a relationship with the Accreditation Council for Continuing Medical Education (ACCME), under which physicians can get MOC points by performing certain CME activities, “You can hit a button on the UpToDate site and submit those points for MOC seamlessly,” Green says.

The ABFM has also announced it will pilot a new MOC option in 2019, in which diplomates will receive 25 online questions each quarter. Not only will family physicians who choose the alternative test be able to take it at the time and place of their choosing, but they will be allowed to use clinical references to answer the questions.
When I was in medical school and would go out with my college friends, they would always be surprised that I could tear myself away from studying long enough to go out to dinner, go to a party, or watch a movie. They were expecting me to be buried in books or at the hospital for four years. It became a common refrain, “What are you doing here? Don’t you have to study?” I started to feel self-conscious about being out of the library or anatomy lab, convinced I must not be doing medical school correctly.

Today, one of my patients asked me if I ever get more than two minutes to myself. She’s aware that I have two roles—one clinical and one administrative—and four kids. When I replied that I do take time for myself, she was surprised and somewhat disbelieving. I explained that my to-do list at work and my to-do list at home are so long that I have given up ever completing either one of them. Instead I do what I can and try to let the rest of it go.

Confession: I find it hard to let it go. I’ve written about this previously, but I return to one of the most influential books I’ve read. It has changed how I think about work, rest, family, balance, and personal time. The book, The Power of Full Engagement, outlines how to be your best in all spheres by carefully managing your energy to make sure that you are spiritually, mentally, physically, and socially balanced.

The authors make a solid argument for the diminishing quality of what you do at work, at home, or for yourself when you allow your energy to run down in any area of your life. Within medicine, we know this—physiology, biochemistry, and anatomy all teach us the necessity of rest and renewal.

When I take time for myself (which I do nearly every day), I do not do so to be selfish or because it’s on my to-do list or even because the latest article in a journal or magazine describes the benefits of it. Instead I do it because I know what will happen if I do not. I will get irritable, unproductive, and lose my creativity and resilience. It is self-preservation and a desire to do a great job in all that I do that compels me to seek balance.

I am surrounded by people who make different choices than I do. This could be the medical school classmate that does not take any study breaks or the residency colleague who skips meals in order to do one more thing for one more patient. It can even be the attending physician who stays late to craft the perfect, grammatically-correct note.

I cannot criticize those choices—I understand the pressure to do those things. But I also know myself—I will wind down slowly like a spinning top if I do not balance myself.

For me, skipping a study session for a movie or reading a book before bed is not a luxury that I only allow myself if I get everything else done. Rather, it’s an essential part of how I manage my energy so that I can get anything done.

Jennifer Frank, MD, is a family physician and physician leader in Northeastern Wisconsin. Send your comments to medec@ubm.com.

MEDICAL ECONOMICS ❚ DECEMBER 25, 2018
What is your favorite vacation destination?

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

“Maui.”

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

“San Diego.”

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

“Anywhere warm and beachy, lately it’s Charleston, S.C.”

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

“Roatan, Honduras.”

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

“Somewhere I’ve never been, preferably with a beach.”

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

“Hawaii.”

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

“Montreal.”

The board members that contribute expertise and analysis to help shape content of Medical Economics.
“The EHR company is not going to refund unless you can truly prove that they breached their own contract terms.”

DAVID ZETTER, HEALTHCARE CONSULTANT

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“We all make sacrifices that our patients may never be aware of.”

THERESA M. THOMAS, DO, PRIMARY CARE PHYSICIAN, CLARKTON, MICH.

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44% of physicians surveyed said paperwork is top issue ruining medicine

PAGE 50

“Of physicians surveyed said paperwork is top issue ruining medicine”

PAGE 50

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COMING NEXT ISSUE

Physician reimbursement in 2019

Every year it feels like it gets more complicated for primary care physicians to earn what they deserve. This article will dive into some of the broad trends around payment/reimbursement that physicians will face in 2019, including:

- The latest requirements for value-based care
- Trends involving private payers
- Physician fee schedule and level of care changes
- Coding in 2019: What services do primary care physicians provide that they often don’t seek reimbursement for, but could?

“The paperwork for your treatment is very complex, so we’re getting a second opinion from accounting.”

By Jon Carter, cartertoons.com
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.

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**Medication Assisted Treatment**
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- LabCorp collaboration with The Recovery Platform, a valuable monitoring tool to help physicians address and manage the ongoing opioid crisis

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