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GETTING PAID IN 2020

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n our last issue of 2019, we presented our top challenges that physicians will face in 2020. Near the top of the list was getting paid.

And so we decided, for our first issue of 2020, to tackle this vital issue, and provide our physicians with some guidance concerning the payment trends to come. In lots of ways, 2020 is a transition year for physicians—still in the thick of MIPS and other value-based care initiatives, but also preparing for the new payment models CMS has developed focusing on primary care that go into effect a year from now, in January 2021.

Our coverage in this issues provides physicians with some strategies on how they can prepare for what’s coming. Healthcare reimbursement becomes more complicated every year, and that’s not going to change in 2020. Our goal is to help provide some clarity to this confusing issue.

In addition to our in-depth coverage, we have other great content in this issue, focusing on a variety of topics, including practice management and finance tips, career and physician lifestyle content, legal advice, and strategies for managing patients with chronic conditions. A sample of our content includes:

- How physicians can leverage the value of the annual wellness visit to re-engage lapsed patients, increase revenue and boost outcomes;
- A feature on compassionate collection, to both ensure that practices can collect what patients owe, but in an empathetic way that doesn’t damage the relationship; and
- An article that explores switching EHR systems, focusing specifically on how you can learn that the time is right, and how to go about the process in a way that minimizes disruptions to your workflow.

2020 is going to be a challenging year for physicians, but opportunities abound. We hope our content helps motivate you this year to grow your business, take the next step in your career, improve outcomes for your patients, or whatever other goal you set. Our goal is to help you along the way.

Mike Hennessy, Sr. Chairman and Founder
COVER STORY

Getting paid

Reimbursement trends for 2020  PAGE 4

ALSO INSIDE

MONEY

10  Combination visits  Coding when patients present multiple issues

11  Financial safeguards  Four important steps for financial health

CHRONIC CONDITIONS

12  Improve diabetes care  Reaching patients to boost adherence and outcomes

15  Obesity counseling  How to get paid for weight management services

PRACTICE MANAGEMENT

16  Benefits of the annual wellness visit  How to leverage it to improve your practice

19  Common patient complaints  Three common gripes and how to address them

TECHNOLOGY

20  Switching EHRs  How do you know the right time to switch?

24  Remote monitoring  What’s new that can help your patients?

LEGAL

30  Beware contractors  Why a new rules means practices must be careful who they work with

ALSO INSIDE

Reimbursement trends for 2020  PAGE 4

Chairman letter

Interactive

Our Advisers

Funny Bone

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Study: Gender discrimination still prevalent in medicine

Most female physicians have experienced gender discrimination in the form of lower pay or inappropriate words or actions from fellow physicians, according to a new survey by physician search firm Merritt Hawkins.

Of these female physicians, 75 percent experienced inappropriate words or actions from fellow physicians, 57 percent experienced them from managers or employers, and 56 percent have received lower compensation than their male colleagues, the survey says.

"Women are entering medicine in record numbers and are having a profound impact on the medical profession," Travis Singleton, executive vice president of Merritt Hawkins, says in a news release distributed with the survey results. "However, despite these achievements, female physicians continue to be paid less than their male counterparts and face other forms of workplace discrimination."

The survey results show that about 40 percent of female doctors are currently earning less than male physicians within their specialty. Of those, 73 percent said they had received a smaller base salary or production bonus than their male counterparts suggesting that the disparity in pay starts early in the female physician’s career.

About 74 percent of respondents believed that male physicians earn more even when choice of specialty and hours worked are accounted for, and 76 percent identified unconscious employer discrimination as the cause, the survey said.

"While employers may judge two candidates for the same job to be equally qualified, they may unconsciously imbue the male candidate with more financial value," Singleton says. "Even though female physicians are just as highly sought after as males, many female physicians believe their equal value is not reflected in their employment contracts."

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Getting paid in 2020 and beyond

Reimbursement trends every doctor needs to know

by TODD SHRYOCK Managing editor

Reimbursement for independent physicians is getting more challenging each year. Between the ever-changing reporting requirements from CMS and contractual differences among commercial payers, just keeping up can be a full-time job.

Insurers are asking for more and more data to document patient outcomes and Medicare has its own reporting requirements through the Merit-based Incentive Payment System (MIPS). New payment models that emphasize primary care are in the works, so decisions doctors make today can affect their future income.

So what reimbursement trends should physicians expect in the near future?
CMS ADDS MORE EMPHASIS TO PRIMARY CARE

The biggest changes announced by CMS won’t take effect until 2021. The agency announced it has aligned its E/M coding requirements for office and outpatient E/M visits with those adopted by the American Medical Association CPT Editorial Panel. It is also retaining four levels of E/M codes for new patients and 5 levels for established patients. Earlier, CMS had proposed paying a single flat fee for E/M levels 2-4 and retaining a separate payment for level 5 visits.

For 2020, the Medicare Physician Fee Schedule conversion factor includes a small increase from $36.04 to $36.09. The last of the increases for inflation that were part of MACRA occurred last year, and physicians are now facing a six-year period with no inflation update, meaning the conversion factor is not expected to grow in any meaningful way.

“The reason for this is CMS envisioned there would be more movement to more Alternative Payment Models (APMs) and value-based care arrangements, but we haven’t seen that transition to the degree Congress wanted when it passed MACRA,” says Anders Gilberg, senior vice president, government affairs, for the Medical Group Management Association.

For those in MIPS, 2020 is an important year because of escalating penalties, says Gilberg. “Those who don’t report any quality measures at all in 2020, they’ll see a 9 percent reduction in their payments,” he says. “The potential bonus has yet to be determined (it was 1.65 percent last year) because it’s budget neutral, but it’s really important to focus on quality reporting in 2020 to avoid the negative payment adjustment in 2022.”

CMS always intended MIPS to be a feeder system into APMs that would have less reporting burdens and better-aligned financial incentives for each specialty, says Gilberg, but the number of APMs is limited.

“There’s always been a notion that CMS would go back to fee-for-service, reset the payment model (away from MACRA), or allow them to coexist,” says Ash Shehata, MHA, MBA, national sector leader for healthcare and life sciences for consulting firm KPMG. “2019 was the year of reality setting in.” MIPS isn’t going away, but the number and types of APMs isn’t sufficient to move physicians out of it, he adds.

As a result, CMS is pushing for better quality measures and more APMs and continues to move away from fee-for-service with payment models such as Comprehensive Primary Care Plus and the new Primary Care First program.

“The idea here is to move all physicians to more value-based payments,” says Cheryl Damberg, Ph.D., distinguished chair of healthcare payment policy at The Rand Corp. “There are still large numbers of physician practices that are not becoming part of groups and remaining independent. CMS is trying to experiment and figure out how to get them into the game.”

Primary Care Plus establishes patient-centered medical home-like payments and cost efficiency measures, while Primary Care First, which launches in 2021, builds on that idea and adds monthly capitated payments for patients.

“The idea here is to move all physicians to more value-based payments. There are still large numbers of physician practices that are not becoming part of groups and remaining independent. CMS is trying to experiment and figure out how to get them into the game.”

—CHERYL DAMBERG, PH.D., DISTINGUISHED CHAIR OF HEALTHCARE PAYMENT POLICY, THE RAND CORP.

While these new models may seem enticing, a practice needs to carefully consider why it would change its practice model. “For practices that are efficient and running a clean operation, they can make additional money,” says...
How to get ready for Primary Care First in 2021

by Jeanette Ball, RN, PCMH CCE, Contributing author

Primary care has always been central to a high-functioning healthcare system. But as the industry moves from fee for service (FFS) to value-based care, the role of primary care has become even more important.

CMS has recognized this through the introduction of its Primary Care First program, which officially launches in January 2021. Primary Care First is a set of voluntary five-year payment options that support and promote advanced primary care by rewarding value and quality in the delivery of care to Medicare beneficiaries in 26 regions across the U.S.

Under the Primary Care First models, primary care physicians (PCPs) receive an up-front per member per month (PM/PM) payment for each patient and a flat fee visit rate together with performance-based adjustments, rather than being paid for services rendered.

Practices can then use that money to support services for patients by adding care managers, telehealth or other options CMS hasn’t traditionally paid for directly in the past.

Practices that enroll in the program will have their outcomes payments based on three different benchmarks. They can earn bonuses of up to 50 percent; if they are above the thresholds, however, they can also be penalized up to 10 percent of what they received. The quality measures themselves should sound familiar to most PCPs, as they include the patient experience, controlling high blood pressure, controlling HbA1c levels in people with diabetes, advanced care planning and colorectal cancer screening.

Obviously, Primary Care First is not a program to be entered into lightly, especially given that the benchmarks practices will be measured against include data from the top-performing health systems in the country. So how does a practice decide whether it’s ready?

One easy marker: If your practice has already qualified as a Patient-centered Medical Home (PCMH) you are moving in the right direction towards being an advanced primary care practice. If you’re not a PCMH, the following are best areas to address first:

**Provide 24/7 access to care with real-time access to EHR**

When patients can’t see their physicians when they want, they opt for more expensive choices such as the emergency department (ED). After a couple of those instances, the ED becomes their primary care provider.

To succeed in Primary Care First, physicians must make their care teams easily accessible. That doesn’t mean physicians must be open all the time. But they must have mechanisms in place for same-day appointments or appointments within a couple of days (depending on severity) and to respond to patient concerns when they occur. They must also be able to manage care transitions such as hospital or ED discharges. Telehealth (including video appointments) offers a great way to address this need.

**Develop high-quality understanding/documentation of Hierarchical Condition Codes (HCCs)**

The PM/PM for each patient is calculated based on risk. There is no going back after the fact because the patient required more care than anticipated. Therefore, it is critical that all of a practice’s physicians be well-versed in the nuances of HCC documentation accuracy. If not, they should seek help with gaining that understanding quickly.

**Establish good team-based care**

Physicians can no longer be eagles soaring alone. Improving outcome quality requires a team effort. Physicians, nurses, care coordinators/managers, dieticians, behavioral health specialists, pharmacists and more must all work together to drive population outcomes.
PRIVATE PAYERS CONTINUE TO PUSH FOR VALUE

Private payers have been increasingly paying for outcomes, and experts say this will not change in 2020 or beyond. “Value-based care is where the excitement is,” says Shehata, who adds that private payers have been watching CMS experiment with more risk sharing and what results it has achieved. “If anything, what the CMS payment models have done is driven the industry to step up its capability to accelerate risk-sharing.”

In addition, provider networks are widening. “It’s no longer just the inpatient, outpatient, and primary care...

Fortunately, the up-front payments in Primary Care First can help PCPs shore up areas where they’re currently need improvements.

Obtain powerful analytic data

Analytics are essential for succeeding in Primary Care First. Physicians must be able to risk-stratify their patient populations (low-medium-high) with a high degree of accuracy, using all the data (including those HCCs mentioned earlier). Physicians must know who their patients are, what their barriers to better health are, and have staff aligned to that population. This includes capturing data on social determinants of health (SDH), which must be a top priority.

Consider that PCPs see most patients for maybe two hours a year. The rest of the time, their health is being influenced by the safety of their neighborhood, the availability of fresh produce versus fast food, the quality of the air and water, housing stability and dozens of other social factors. Understanding those factors, and ensuring they are included in the EHR, can give physicians and care teams insights into the unseen drivers behind patient health so they can make better, more effective care decisions.

Making community-based organizations that assist patients with SDH issues part of the extended care team can help overcome barriers (including a lack of trust of physicians and medical professionals generally) as well.

Establish measures for evaluating performance measure success

Yet analytics aren’t only valuable in understanding patients. They can also help practices understand how well their physicians and care teams are performing.

To do so, they may have to take the uncomfortable step of unblinding their performance measurements to understand exactly where improvements need to be made. The outcome measures are not only related to provider effort but to the overall team caring for the population of that provider. The success of the practice in Primary Care First depends on all of their provider teams performing at a high level. If four are meeting the quality measures and one is not, what could be a bonus can quickly turn into a penalty. Analytics will help uncover any opportunities, so they can be strengthened.

Finally, there are the quality measurements themselves. While part of the attraction of Primary Care First is the reduction of administrative burden (versus other programs), physicians must still out-perform the national benchmarks. Real-time analytics will help show what’s needed now so practices can make adjustments where needed—rather than finding out after the fact that they missed out on bonuses they could have secured.

Practices that don’t have strong management to measure success at the beginning of the year, or at the midpoint of the year, will have a tough time following their lead and implementing the improvements needed to keep up. A common mistake is to think that just because a practice is up and running, it will continue to outperform.

Additionally, Primary Care First is not a “set-it-and-forget-it” type of program. Primary care physicians will be expected to make continuous improvement in their performance measurements in order to accre bonuses in subsequent years, which is even more incentive to develop an ongoing relationship with an organization that has expertise in performance improvement.

Provide process for patients/caregivers to give feedback

One easy way to accomplish this is to include one or more patients/ caregivers on the Board. They can then offer the patient perspective on practice improvements that will help elevate the patient experience—a critical, ongoing measure.

With the introduction of Primary Care First, it’s clear that CMS is now going all-in on transitioning to value-based care. The good news is a lot of the heavy lifting on WHAT to do has already been done by a few innovative health systems, so there are lessons learned available, and people who can help get new health systems started on the right foot.

Others have pioneered the process and made the missteps.

Primary care physicians today can follow their lead and implement the program improvements and technologies that have demonstrated their effectiveness, and set themselves up for success in the years to come.

Jeanette Ball RN, PCMH CCE, is a client solution executive at IT consultancy CTG.
Does telehealth pay?

Doctors looking to increase reimbursement might want to consider telehealth. CMS has been slowly pushing telehealth, making it an option for Medicare Advantage plans and ACOs, as long as they are part of risk-sharing contracts. It’s also allowed under Medicare Part B for treating substance abuse disorders.

States have also done more to promote telehealth through parity laws. “This requires private payers to pay telehealth equal to an in-office visit,” says Cindy Gaines, MSN, RN, chief nursing officer, Philips Healthcare. “Forty states have passed laws to make it more equitable to providers and patients.”

Telehealth reimbursement is currently a disjointed system where doctors often struggle to understand who is covered. “CMS is covering pockets of patients, some states are covering private payers, Medicaid isn’t covered yet—it’s hard to jump into telehealth, because it’s hard to know which patients are included,” says Gaines, adding that she expects these issues to be solved in the coming years. In addition, patients will start to expect it as an option, something small practices need to pay attention to.

“Small practices have to look for ways to extend their sightlines to manage a population with limited resources,” says Gaines. “They may be able to partner with another small group to do the services together. They don’t have to be part of a bigger system, but may need to develop relationships to facilitate telehealth.”

Most importantly, Gaines says, practices need to think about how telehealth can help them improve care for their patients. “It’s more than just managing the care for those who come through your doors anymore,” she adds. “You have to support patients living well with chronic diseases when they are not in the office. This isn’t about technology taking over care, but how it can augment care.”

providers,” he adds. “Now, they are bringing in pharmacy, home care, and the entire continuity of care.”

Zetter says physicians need to pay attention to payment trends among private payers to make sure they are maximizing their reimbursement potential.

“Private payers are looking for the same things as Medicare: patient access, engagement, low costs, and quality outcomes,” says Zetter. “They are looking for providers who participate in programs that meet all of those requirements.”

If doctors aren’t paying attention to costs—by, say, sending patients to a nearby imaging center instead of one that’s farther away but in the patient’s plan—the plan’s administrators will take a dim view of the physician and possibly terminate the contract.

“Several years ago, United Health dumped thousands of providers with no notice,” says Zetter. “They are allowed to do that if they don’t think you are participating and meeting the plan requirements the right way.”

Conversely, doctors who do exceptionally well with cost containment and patient satisfaction scores can be invited to join an exclusive provider organization and possibly earn bonuses.

“These are invite-only networks,” says Zetter. Invitees are high-quality, low-cost providers with good patient access, perhaps with evening or early morning hours.

“Even in today’s age with retail clinics as competition, there are still primary care physicians that have banker’s hours and they wonder why they are not successful,” he says. “You have to look at what’s happening around you.”

He says that to maximize reimbursement, doctors have to pay attention to data in their EHRs and from payers so they understand costs and can help patients not only stay healthy, but help them manage costs. The better physicians are at reducing costs, the more attractive they are to payers.

“If a payer wants a provider that is exceptional, then they are going to do whatever they can to get that doctor into their network, including increasing reimbursement,” says Zetter.

Private payers are sharing data with primary care physicians faster and better than CMS, because they see the value primary care provides Gilberg says. “They understand where the savings take place,” he says. “They are focusing more on value-based programs in primary care and trying to provide information to extend a practice’s ability to enter into risk-based contracts.”
However, this shift toward value-based care has also increased prior authorizations and prepayment reviews. “It’s ironic, because value-based care was supposed to work because it holds the physician accountable for cost and quality,” says Gilberg. “There shouldn’t be a layer on top of that in order to send a patient for a test. The physician is already being held accountable.”

PAYMENT CHALLENGES FOR SMALLER PRACTICES

Experts say mergers in the healthcare industry are likely to continue as payers try to find economies of scale and the right combinations to deliver on value-based care. “Larger organizations are better positioned to provide the infrastructure needed for value-based care that smaller ones may not have access to,” says Damberg. “But as more physicians have moved into bigger systems, they are having a hard time onboarding new physicians and getting them to sing out of the same hymnal and provide care in a coordinated way.

“It’s not a done deal that by merging into a larger system that physician performance is going to jump 20 points overnight and they’ll win the value-based care game,” she adds.

In fact, private payers don’t necessarily favor larger practices, because they have more negotiating leverage than smaller ones. Moreover, it’s still possible to make money in value-based care without being part of a larger group.

“A smaller practice, if they have a dedicated set of providers who are interested in providing value-based care, can be more nimble and do things more quickly if given the tools and resources to be more effective,” says Gilberg. “We see success on both sides, but a small practice is still typically disadvantaged.”

One way to minimize that disadvantage is to focus on either fee-for-service or value-based care, but not both, Gilberg adds. “If you are doing a little of both, the incentives don’t align with one another,” he says.

Another threat to small practice reimbursement is the rise of retail clinics. “The expectation is that these will be more efficient,” says Shehata. “Before we see any effect on pricing, we’ll probably see a more meaningful effect on the customer experience. The expectation is that patients will be able to shop across the market, and I think that will drive pricing and create transparency.”

Damberg says it’s probably too early to know how retail clinics will affect reimbursement rates, but it’s something the industry is closely watching. “Will they find less expensive ways to offer comparable services and maybe more conveniently?” says Damberg. “They may be more in line with what the next generation’s tastes are and how they consume products versus the traditional old-school model for practices. If they can walk into a doctor’s office in a mall and immediately get primary care services, that’s a potential game changer.”

“One factor working in favor of physicians is their scarcity. “People underestimate the limited supply of physicians, and health systems have to compete pretty aggressively to keep these people,” says Damberg. “They have to stay competitive in how they negotiate with them, because they can’t afford to lose them.”

The number of smaller practices is also proving to be a reimbursement challenge for a market that wants to push more risk to physicians as part of their contracts. “There is still a lot of care provided by independent and small practices,” says Damberg. “That’s a big question mark for CMS and the commercial market in how to bring them along and control spending while still providing quality care.”

“Those who don’t report any quality measures at all in 2020, they’ll see a 9 percent reduction in their payments. It’s really important to focus on quality reporting in 2020 to avoid the negative payment adjustment in 2022.”

— ANDERS GILBERG, SENIOR VICE PRESIDENT, GOVERNMENT AFFAIRS, MGMA

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MEDICAL ECONOMICS | JANUARY 10, 2020
CODING INSIGHTS

Tips for handling combination visits

Some of our Medicare patient’s complain about their $20 or so co-pay when we bill ‘Combination visits’, a G0439 Annual Wellness visit (AWV) and another Current Procedural Terminology (CPT) code for managing their problems during the same visit. Is there a good solution to this issue or any advice to maybe remedy this?

A. This is not an uncommon scenario and has been going on since the AWV codes came out in 2011. And no matter how well your front-desk, MA’s or nursing staff or the provider themselves explain to the patient how this type of coding and billing works – it seems there are always some that will be unhappy about it – even if they agree at the time of service to go ahead and perform both types of services.

But when they get that bill a couple of weeks later, all recollection of that flies and they often seem to feel somehow taken advantage of. This usually only occurs when they need to dip into their pocket and pay for something.

But there is a way to reduce the complaints significantly that works rather well, at least for the chronic disease follow version of these combination visits.

The problem typically arises when a patient is scheduled for their AWV, either at the end of the prior visit, or in the interim, and all perceive this as the purpose of the visit. And we know there is no cost or co-pay for these.

But sometimes the patient brings a list of problems, or has an acute problem, or this is a standard interval (say, 90-day visit) for chronic disease follow up.

When telling the patient that if these ‘additional’ problems are addressed in the course of this otherwise preventive or screening encounter, that there will be a co-pay (or in the case of high-deductible plans an ‘all-pay), the problem visit is the ‘add-on’ service that is costing them. It might even be seen as a version of bait and switch, or somehow ‘padding’ your bill.

But for chronic follow ups, if you simply schedule the next visit as a problem-oriented visit, and at that visit introduce the AWV as the add-on service – patients don’t complain because the ‘add-on’ service is the free one. They were expecting their normal co-pay for the chronic problem follow up – and so there is nothing to complain about.

Say to tell ‘while you are here for your problem management visit, lets save you a trip and go through these Medicare screening items to make sure we’re on top of any issues that may have developed’. And have them fill out their HRA (Health Risk Assessment) form, do your Mini-cog and other screens.

No one complains when you add-on a free one.

This also quiets those that seem stuck on the idea that an AWV somehow ‘includes’ management of stable problems. By having the evaluation and management of problems the focus of the visit – it more clearly delineates the ‘separateness’ of the AWV screening and preventive services.

Money

Bill Dacey, MHA, MBA, CPC-I is principal in The Dacey Group, Inc., a consulting firm dedicated to coding, documentation and compliance concerns for physicians. Bill is an evaluation and management (E/M) coding expert and has been active in physician training for more than 25 years. Send your coding questions to medec@mmhgroup.com.
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FINANCIAL STRATEGIES

Financial safeguards for busy doctors

Doctors are unique. You’ve spent years in undergrad school, medical school, and residency. Now, you are responsible for managing the health of your patients. Between clinical and administrative duties, coordinating with other physicians, and keeping up with medical research and advances, you’re wearing a lot of hats. So many, that it may become easy to overlook your own financial health.

Like caring for your patients’ physical health, the first step in managing your own financial health is gathering data and creating your roadmap for success, and then make sure you are hitting your goals.

It’s important to review your financial plan regularly—or immediately in the wake of a significant life event such as marriage, birth of a child, a health event, death of a family member, divorce, or changes in your practice.

Once each year, review your roadmap, including:

- **Investment Planning**: Make sure your asset allocation is still appropriate given your risk tolerance and goals and rebalance or change your portfolio if necessary.
- **Retirement Planning**: The retirement landscape is changing. Americans are living longer, which means they will require a larger pool of assets to support themselves during the 20 or 30 years of retirement. Use a retirement planning tool or meet with your advisor to be sure you are on track.
- **Insurance Planning**: Review existing coverages and identify any uncovered risks, including health, disability, life, personal liability, business insurance, and long term care insurance.
- **Estate Planning**: It is critical to have a plan in place so that you have control over how your assets are distributed at your death and who is given authority to make medical and financial decisions on your behalf in the event of your incapacity. By planning ahead, you can also reduce taxes on what you leave behind and minimize the chances of unpleasant and costly family legal battles. Once your plan is developed, it is important to regularly review beneficiaries, trustees, health care representatives, and guardians.
- **Tax Planning**: It is important to ensure your tax plan is coordinated with your investment and estate plans.
- **Lifestyle Planning**: Revisit your goals for your housing, activities, and business including succession planning and multi-generational planning.

As your life and practice evolve, you will encounter issues that call for specific financial actions. Some of the most common topics include planning for long-term care, housing needs, and multi-generational financial planning.

Paving a path to financial security requires time and effort—two commodities in short supply for busy physicians. But making smart decisions can add up to 3 percent to a portfolio’s return. This could add many to the longevity of your portfolio and set you up for long-term success. Starting early is ideal, but it is never too late to begin.

Four important steps for financial health

- Begin planning or, at a minimum, saving early. Understand the retirement options that are available to you.
- Cover your risks: business, life, and disability.
- Review your roadmap periodically and after all major life events.
- Coordinate your investment, retirement, tax and estate plans to ensure desired results.

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Primary care physicians sometimes struggle to effectively treat patients with diabetes. Almost half of patients with diabetes don’t meet their related goals, including A1C blood glucose levels, blood pressure, and LDL cholesterol levels, according to a study in the *New England Journal of Medicine*. That’s a problem in the U.S., where more than 30 million people are diagnosed with diabetes, accounting for $237 billion a year in medical costs.

The healthcare system is shifting to value-based medicine, notably through Medicare’s Merit-based Incentive Payment System (MIPS). That program rewards or punishes physicians financially, depending in part on their ability to meet quality metrics, including for patients with diabetes. Physicians are being measured on how they manage their patients’ A1C, blood pressure, LDL cholesterol, and smoking cessation, among others.

How can doctors motivate patients to adhere to treatment plans while meeting national quality metrics and maximizing reimbursement for diabetes care?

**GIVING PATIENTS RESPONSIBILITY**

Given all the metrics to track, such as A1C levels, the healthcare system has made diabetes mostly about the numbers, says Randall Stafford, MD, Ph.D., an internist and director of the Program on Prevention Outcomes and Practices at Stanford Preventive Research Center, Palo Alto, Calif. But doing that diminishes patients’ ability to feel they’re contributing to their disease management. “If we continue to push for more attention on the numbers, it could backfire,” he says.

One way Stafford motivates his patients is by asking them to correlate how they’re feeling with what they’re doing for their own care, including diet, exercise, and blood sugar management.

“It seems like common sense, but we’ve lost track of that to some degree,” he says. “We drastically undersell behavior as a strategy in diabetes.” Behaviors are important links to what people can do to better manage their diabetes, he says.
Diabetes affects 30.2 million U.S. adults with prevalence expected to reach 54 million by 2030. It is a leading cause of cardiovascular disease and mortality as well as of significant disability related to micro- and macrovascular complications.

Cascade of care, disparities
Study authors analyzed serial cross-sectional studies included in the 2005-2016 National Health and Nutrition Examination Survey (n = 1742 diagnosed and 746 undiagnosed) to evaluate the cascade of diabetes care in the United States, defined as diabetes diagnosis, linkage to care and achievement of treatment targets.

They were also interested in potential disparities in diabetes care related to age, gender, and race. Primary outcome measures were proportion of participants overall and stratified by age, sex, and race/ethnicity who were linked to diabetes care and met glycemic, blood pressure, cholesterol level, and smoking abstinence targets and a composite of all targets.

Leading indicators
Odds of achieving the composite target of blood sugar, blood pressure, cholesterol, and non-smoking were lower among younger participants (aged 18-44 years), women, and non-white adults with diabetes.

Insurance coverage was the strongest indicator of diagnosis, linkage and achievement of the composite treatment targets. The authors note that while elevated lipids may be relatively easier to treat than hypertension and hyperglycemia, the LDL-C target was the least likely of the 3 to be met.

Only 6 in 10 adults with diagnosed diabetes were prescribed a statin in the 2013-2016 study period, even though there was modest growth in the use of statins over the 3-study time frame.

Implications
Interventions to help promote early control of risk factors in younger patients, the authors suggest, would help slow or curtail the progression of complications that lead to diabetes morbidity and mortality. Sex disparities in cardiovascular care, they point out, as well as access to care, may have contributed to sex disparities in diabetes care.

The authors state: “While there may be some underlying physiologic differences in the prevalence of hypertension and insulin deficiency that correlate with race/ethnicity…access to and effectiveness of healthcare remain major factors that have not been adequately addressed despite numerous innovative interventions targeting these populations.”
He also explains to patients why they should be taking certain actions, even when they feel well. He may tell them to take their statin even if their cholesterol is normal, as diabetes causes life-long changes.

Lifestyle changes are the hardest for patients to make, so he encourages small ones. “We ask patients to lose 1 pound, not 50, and then we give a lot of feedback,” he says. He tells patients that even a small weight change will help their blood pressure glycemic control, and he tells them that weight change is mostly a result of dietary adjustment.

TIME IS ESSENTIAL

It takes time to find out what challenges patients experience while managing their diabetes, a problem further complicated by how brief the typical office visit is.

“Time is the biggest factor in gaining patient trust so they’ll share this information,” says Ashok Balasubramanyam, MD, an endocrinologist and professor of medicine at Baylor College of Medicine in Houston.

During visits with his patients who have diabetes, he asks numerous questions about neuropathic complications, sexual dysfunction, depression, mood issues, and adherence. “I can’t think of any way other than making time and asking the questions,” he says.

Even though it takes time away from the patient/physician discussion during the visit, the easy part of improving care is measuring and recording the needed metrics. This is something a physician should be doing at every visit, and can be easily incorporated in the EHR, Balasubramanyam says.

“Diabetes isn’t one thing,” he says, and selecting treatments to recommend for each patient is something many endocrinologists strive for but aren’t always accomplishing. “If you treat everybody the same, you get a mixed bag of results that won’t make a difference,” he says.

Instead, he recommends risk stratification measures, using clinical analytical tools. For each measure, like controlling sugar or blood pressure, there are subgroups with evidence. To get to that level of sophisticated treatment, he recommends education. The American Diabetes Association sponsors good research, publications, and CME, he says.

In Price’s practice, staff members ensure that the patient is set up to receive annual eye exams, and the medical assistant periodically checks the charts to make sure the patients kept the appointment. If not, the chart is annotated and Price follows up with them at the next primary care visit. Patients with diabetes get their urine and thyroid checked yearly, and Price looks for the results when they come in.

Price recommends that his patients with well-controlled diabetes come for office visits at least twice a year, once for a full physical and once for a six-month check. If their diabetes is not well-controlled, he’ll ask them to come every three months, and if poorly controlled, every two to four weeks to check their sugars and adjust their medication.

USING A TEAM-BASED APPROACH

Using a team approach to diabetes care allows staff to spread the tasks around, Stafford says. “The physician may be in position of authority and seen as the captain of the team, but I don’t think the physician needs to do all the tasks.”

With limited time for visits, a team-based approach enables additional patient education and care, boosting reimbursement as well. “If the goal is an A1C below a certain threshold, it doesn’t matter if the physician, dietician, or community health worker is part of that process,” Stafford says. A team-based approach also allows the patient to get more attention to the social and psychological dimensions of the disease.

Endocrinology centers may be better equipped with healthcare extenders, but small offices can bring in specialists as well. Price has a diabetes educator come to the office once a month. Insurance is billed for these visits, as many of the patients have benefits that cover it. For those without insurance, Price’s office covers the cost.

The Oak Forest Health Center in Oak Forest, Ill. uses a team-based approach to diabetes care. Almost 25 percent of their patients are diagnosed with type 2 diabetes. The team schedules lab tests before visits, calls patients with pending lab orders, preps upcoming patient charts with A1C values, and conducts a daily huddle to share information before the day’s visits begin.

Patients complete self-directed goal sheets at each visit, discussing them with the physician, who logs and monitors goals. Newly diagnosed patients and those with A1C levels at nine or above, are referred for diabetes education and care management. The program has been successful in better controlling patients’ diabetes.
Counseling for obesity: What you need to know

According to CMS’s National Coverage Determination (NCD) for Intensive Behavioral Therapy, the therapy for obesity consists of the following:

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 this framework:

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), help 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.

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 the six month visit. 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, a minimum amount of time is 15 minutes, and the time must be documented in the medical record. The physician cannot bill for more than a 15-minute interval, but, if more time is spent with the patient, the total time should be noted in the medical record.

CMS started reimbursing 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. Currently, this code reimburses at about $25, and is for patients with a Body Mass Index (BMI) of 30 kg/m2 or greater.

While many may argue that this reimbursement amount isn’t worth the physician’s time, I would suggest that the need for this type of discussion between a physician and patient is priceless when it comes to a patient’s overall health.

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Medicare Annual Wellness Visits (AWVs) offer practices a way to improve the health of their patients, increase revenues, and improve quality scores in value-based reimbursement programs. Yet, according to a 2017 SmartLink survey, only 10 percent of clinicians have done AWVs with more than 80 percent of their eligible Medicare patients. Half of the surveyed providers brought in less than 40 percent of eligible patients for AWVs.

This data is consistent with a recent analysis of Medicare claims data showing that nearly half of AWVs were performed by just 10 percent of the doctors.
who provide them. A national study by the American Medical Group Association found that under 20 percent of eligible Medicare patients received AWVs in 2016.

What accounts for this shortfall? Wide geographical variations in the prevalence of AWVs suggest that physicians are much more likely to promote them to patients in some areas than in others. Accountable care organizations (ACOs) are also more likely than practices outside of ACOs to offer AWVs because they benefit financially from assessing health risks and filling care gaps, according to a 2017 report in JAMA.

Another reason is a lack of understanding among patients and providers as to what services the AWV includes. On the clinician side, this confusion results in operational challenges. Clinics often lack the appropriate process, staffing, and technology necessary to provide all the required services to a large percentage of patients.

While orchestrating an AWV program requires time and money, the practices able to deliver AWVs effectively to most of their eligible patients could see a substantial return on investment. Moreover, these visits would generate follow-up visits for preventive services that patients might not otherwise seek from their physicians.

AWVs offer additional benefits. The screening tests and other preventive services arising from those visits can help physicians raise their quality scores in the Merit-based Incentive Payment System (MIPS), CMS’s pay-for-performance program. If they belong to an ACO that participates in the Medicare Shared Savings Program (MSSP), AWVs can help ACOs improve their scores on 13 MSSP quality metrics. AWVs also can support the attribution of patients to ACO providers.

**PROCESS IS PARAMOUNT**

In order to provide AWVs at scale, it’s important to think through all the steps that it entails: who does what, how, and when. Patient identification, eligibility checking, education and outreach, office workflow, data capture, ability to retrieve the data for future quality metrics reporting, and completion of the scope of service all have to be taken into consideration.

One of the most important aspects of the AWV process is patient education and scheduling. Patients need to have a clear understanding of what to expect, as an AWV visit will be different from that of a “sick” E/M visit.

AWV is not an office visit that requires a physical exam by the provider. The patient is screened with multiple questions related to their wellness, usually by a nurse. If the patient has questions related to an acute or chronic illness, or medication refills, they will be asked to schedule a future E/M visit.

According to CMS, an AWV (G0438/G0439) and an E/M service (99212-99215) can all be billed on the same date, as long as separate documentation supports each of these services. However, frequent billing of both AWV and E/M services on the same day may have higher risk of triggering an audit, according to coding experts.

**THE RIGHT TOOL FOR THE RIGHT JOB**

As a preventative care visit, the AWV does not usually require a provider to spend face-to-face time with the patient (except in an FQHC/RHC setting). However, in order to conduct the AWV visit using clinical support staff such as an MA or LPN and without provider involvement, the visit needs to be highly structured.

Clinical pathways and algorithm logic are necessary to ensure interventions for health risk factors and that the appropriate preventative screening schedule is created for the patient. It’s possible to capture the required patient information either on paper or via an EHR template; in general, however, both paper and EHRs fall short when it comes to the beneficiary counseling component and creating a personalized prevention schedule.

For example, establishing a list of risk factors and conditions for which interventions are recommended along with treatment options, as well as furnishing personalized health advice and referrals as appropriate, cannot be provided by the EHR or determined by an MA without appropriate guidance.

EHRs also can’t provide eligibility checking for any recommended preventative services, causing the AWV to take longer than it should. As a result, both...
paper and EHR templates for AWV information gathering would require manual eligibility checking for preventative services and the development of clinical pathways and protocols. Otherwise, the AWV should be conducted by more highly skilled staff, such as an RN, non-physician provider, or physician.

The other option is to use interoperable software on the EHR that is specifically designed to process the AWV smoothly and ensure compliance with all of the CMS requirements, including the automatic creation of an eligibility-based personal prevention plan. Then support staff can be used to quickly complete the AWV.

**BUILDING A STAFFING PLAN**
Once the process and technology are defined, a staffing plan can be created. The decision to use either contract or permanent employees, and the number of employees to hire, will be influenced by patient volume and seasonality factors.

For example, the winter season is usually accompanied by more acute sick visits, so the practice might decide to focus on performing more AWVs during the summer months. Depending on the volume of AWVs to be done per day, the practice may need additional staff.

Practices also need to make sure they have the appropriate staffing level for patient outreach, education, and scheduling. This assumes, of course, exam room availability to see the desired volume of patients within a defined timeframe.

**INSOURCING VS. OUTSOURCING**
Clinics that approach launching an AWV program with the right people, process, and technology can be successful, regardless of whether they outsource all or part of the program.

However, many that insource their AWV program struggle to scale the program effectively. While on the surface it may seem more cost effective to insource, clinics tend to underestimate the full cost of doing AWVs on their own, especially during the ramp-up phase when processes are inefficient and/or insufficient.

One Federally Qualified Health Center, for example, was able to garner only 112 AWVs in the first six months using four staff members across six locations. They decided to test outsourcing at one location with one contracted medical assistant onsite. Over the next three months, their own staff of four completed 172 AWVs across six locations.

In contrast, the outsourced location completed more than 200 with only one MA. From both a revenue and profitability perspective, the outsourcing approach proved to be more productive as well as more lucrative.

When you do the math, it’s easy to see why an outsourced program, when deployed efficiently and at greater scale, will be more economically viable than an insourced program. According to the latest Physician Fee Schedule, Medicare pays $161-$227 for initial AWVs and $108-$152 for subsequent AWVs, depending on practice location.

For practices that lack the know-how and staff, but prefer an insourcing model, a hybrid approach may make sense. An outside vendor can supply just the technology, patient outreach, and scheduling, while the clinic provides the staff to conduct the AWV. Another possibility would be to initially outsource the program entirely so as to leverage an outsourcing firm’s expertise in AWV processes and best practices.

After the program is up and running and there is time for knowledge transfer to take place, the clinic can transition to a partially or fully insourced model.

**THE BOTTOM LINE**
In the Medicare patient population, prevention is often overshadowed by chronic and acute issues. The AWV is an opportunity for both physicians and patients to make preventive care a priority. But it is significantly underutilized.

Practices that wish to increase the percentage of Medicare patients receiving AWVs will need to overcome some operational challenges. However, a combination of the right staffing, technology, and process, whether insourced or outsourced, can help them provide this important service to the majority of eligible patients, while earning additional income.

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PRACTICAL MATTERS

Three common patient complaints — and how to address them

Rudeness
Complaints in this category range from being verbally attacked by a receptionist to feeling insulted by a physician. One writer, the relative of a patient, spent countless hours in the waiting room during her loved one’s multiple treatments and claimed the entire office, including the specialist, was in on a network of gossip behind the couple’s back.

Other circumstances deemed rude by patients include having to wait for every appointment, feeling that they weren’t being listened to by a distracted doctor, and not being introduced to others in the room (interns, residents, other staff, etc.).

One patient wrote to tell me about the time a billing clerk suddenly entered the examination room mid-procedure to discuss another patient’s insurance claim with the doctor.

It’s understandable that patients can misinterpret visual and verbal cues, especially when they’re concerned about their health. While a physician’s attention is on their tablet, the patient might be longing for eye contact. And patients can easily take the slightest hint of brusqueness in a doctor’s voice as exasperation.

Shifting these perceptions can be as simple as taking a moment for an attitude adjustment between patients. On a more general scale, practices may want to develop a set of guiding principles with all employees, making sure those standards include injecting an element of kindness and compassion into every patient interaction. This applies to all departments, from reception to billing.

Rushing
Patients are frustrated and confused when they’re not allowed what they feel is adequate time to have a complete conversation with a medical professional about their symptoms, results, treatments, medications, diagnoses, and plans. They clearly don’t like being rushed. When the physician is behind, they’re affronted.

While most people understand that doctors need to deal with urgent situations and unexpected booking changes, they appreciate being notified if there’s going to be a delay. This courtesy allows them to change their plans accordingly, because their time is valuable, too.

A big part of this problem lies in unrealistic scheduling. Depending on the practice, there may be little or no say about how much time is allotted for each appointment or how many patients are seen in a day. If a physician is in the enviable position of controlling her calendar, she should do what she can to make the day flow more smoothly.

Brainstorm with staff about ways to educate patients as to what they can expect during their appointments. Instruct receptionists or booking clerks to explain to patients how long they’ll have for their visit. If, for example, the practice’s policy is to deal with only one concern per visit, make that clear.

Reproach
Some patients say they’ve been made to feel that they’re to blame for their medical conditions. And let’s face it, that’s often the case. But they don’t appreciate being scolded or talked down to. What they’d rather have is understanding, support, and advice, which can be challenging when the practice is seeing the same people with the same problem repeatedly.

A lot of people are scared and intimidated when they visit a doctor. The last thing they need is to feel belittled, too. I’ve received lamentations about everything from a loss of character and morality in the medical profession to a lack of transparency in healthcare in general. And while it’s not possible to validate these one-sided complaints without a full investigation, it is wise to consider them as examples of potential problems in a practice.

The bottom line is this: Patients want patience as much as physicians do. Beyond rudeness, rushing, and reproach lies respect.

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Stanley Anderson, MD, founder of an independent three-physician family practice in Canton, Ohio, says he “loved” the first electronic health record (EHR) system his practice implemented in 2012.

“It had such a great primary care focus, which so many of the EHRs at the time didn’t have,” he says. “And it was very easy for us to use, too.”

But the combination of regulatory changes, as well as his practice’s participation in an accountable care organization (ACO), made the system unsustainable from both a clinical and business perspective.

“All of a sudden, we needed to have direct messaging. Then a patient portal. And we needed to be able to e-prescribe narcotics and be able to connect to a national database,” he says. “Once we joined the ACO, we found our EHR could not interface with their system—we had to manually extract information to get it over to them.”

Anderson’s EHR vendor said that it could add functionality to the system to meet these new requirements, but at a significant cost—nearly three times the monthly fee that the practice was already paying.

“It was a lot more money than an independent family physician group should be paying,” Anderson says. “So we decided that it was time to start looking for a more cost-effective alternative that could get us all the functionality we needed.”

As the healthcare industry continues to evolve, driven by a variety of clinical and regulatory forces, many provider organizations are wondering if it’s time to move to a new EHR. In a recent survey, Reaction Data reported that 39 percent of their provider respondents said their organizations were considering making a switch.

And research conducted by Black Book Research in 2018 suggests that larger health systems and hospitals are not the only ones thinking about ditching their current EHRs. Black Book found that 30 percent of physician practices intended to invest in new systems within the next three years.
There are many reasons why individual practices and hospital systems may be considering a new EHR—ranging from physician dissatisfaction with the current system, to outdated software that is no longer adequately supported by vendors, to a need for platforms that better facilitate data analytics and value-based care models of reimbursement.

But Leela Vaughn, vice president at Epic, a leading EHR vendor, says that many healthcare organizations are eyeing a switch so they can fulfill their most basic mission: to provide the highest quality care for their patients.

“These organizations are considering factors like interoperability, efficiency, and data analytics in their decisions,” she says.

And for good reason: having such functionalities on hand can vastly improve care coordination, provide workflow efficiencies, and help providers better understand and meet the needs of the patients they serve.

But with so much in flux, how can provider organizations know when it’s the right time to make their move?

MAKING A DECISION

In recent years, large healthcare systems like the Mayo Clinic, Houston Methodist, and the U.S. Department of Veterans Affairs have rolled out new EHR platforms.

Vince Vickers, a partner at the consulting firm KPMG who specializes in the healthcare industry, says it’s not surprising. The continued consolidation of provider organizations, as well as the release of more innovative and more secure technologies like the cloud, have provided new incentives for provider organizations to make a switch. And, he notes, EHR vendors are now dealing with a very different type of customer than before.

“The doctors who are coming into the field today are much more tech-savvy than their predecessors. They have expectations for the kind of systems they want to use,” he says. “Patients have changed, too. They want to be able to interact with providers in new ways. The older your system is, the less likely it’s going to be able to meet those new needs.”

Nicholas Desai, MBA, chief medical innovation officer at Houston Methodist who oversaw the system’s move to the Epic platform in 2016, says that the right time to change EHRs will vary from organization to organization. With so many new systems now on the market—not to mention many older, smaller EHR vendors going out of business for failing to meet regulatory and technology demands—he says it would be all too easy to put off making a decision about investing in a new platform. But, he cautions, taking a wait-and-see approach could backfire.

“Many organizations think they can put off getting a new EHR for a couple of years and just make do with what they have,” he says. “But when you are working that hard to just make do, you lose your competitive edge. You lose out on ways to improve care and patient satisfaction. You may lose providers who don’t want to keep dealing with workarounds or putting in extra time to get the data they need. You put yourself in a really bad spot.”

Vickers adds that it’s not easy, especially for smaller physician groups, to make the decision to switch, since doing so is expensive and time-consuming.

“It’s going to cost you to make the jump,” he says. “So, if you are only mildly dissatisfied but your current EHR isn’t impacting your business that much, stay where you are. Instead of getting something new, find ways to stay in tune with the market, getting better educated on what’s out there and what’s coming, watch what your peers are doing, and learn more about what opportunities might work once things change.”
The promise of next-generation EHRs

All across the United States, the delivery of care is stressful for both patients and doctors. Patients want better access to their information and to be actively engaged in their own care. Doctors want to spend more time with patients but face intense time pressures.

According to a 2018 survey, 60 percent of doctors report they spend between 13 to 24 minutes on average with each patient. During some of these precious minutes, they are struggling to follow electronic health record (EHR) requirements and processes. Current EHRs are not work-flow confluent as the patient is asked the same questions multiple times. Providers struggle with fragmented systems that require separate log-ins, and many of the processes are simply not clinically useful.

Click fatigue and multitasking can lead to mistakes. It’s estimated that multitasking immediately decreases productivity and accuracy by 40 percent. Additionally:

- 70 percent of doctors using EHRs attribute the bulk of their administrative burden to the software, according to a 2017 study. However, doctors’ opinion of EHRs improved when their medical institutions made efforts to optimize the software is used.
- 92 percent of clinicians say lengthy prior authorization protocols have impeded timely patient access to care and impaired patient clinical outcomes, according to an American Medical Association survey.
- 89 percent of senior patients (age 55 and older) surveyed said they want to manage their own healthcare—and will require better health technology access to do so.

A more thoughtful EHR can deliver a better experience for both sides. What’s needed is a tool that leverages cutting-edge technology to deliver better usability, flexibility, and value, designed by clinicians who truly understand the healthcare workflow. For patients, an EHR should provide a patient portal that integrates data into a clinical registry, allowing access to all of their data in a single location. Electronic enterprise-wide data is essential to manage the patients doctors care for every day. Unfortunately, current EHRs typically do not deliver the insights or tools providers need to manage their high-risk patients when they are not in the hospital.

Even if a specific EHR does offer such population health management capabilities, it requires excessive amounts of manual data access and manipulation, leading to time wasted and higher costs.

With the introduction of the Medicare Access and CHIP Reauthorization Act (MACRA) and the 2015 Merit-based Incentive Payment System (MIPS), along with APMs, providers are being reimbursed for performance rather than fee-for-service. One of the performance measurements is Promoting Interoperability (formerly Advancing Care Information), and new CEHRT-qualified EHR systems are ready to meet this new requirement.

To improve outcomes via improved data sharing and automation, the next generation of EHRs offer these four improvements:

**Usability:** Make key clinical data easily available by streamlining workflows and navigation with fewer clicks and a common patient banner, which puts certain patient information in the same location regardless of application. This enables providers to focus on the work that matters most. The EHR should integrate and aggregate data into a clinical registry, allowing patients to access all of their data from a single portal.

**Flexibility:** Care organizations have numerous regulatory requirements and certification standards. A better EHR allows organizations to create additional fields to meet the unique needs of their workflow. Organizations can define and link fields to medical code sets to stay current with ever-changing regulatory requirements and advances in healthcare information technology.

**Technology:** Leverage the latest technology for a scalable and portable solution that meets doctor and patient needs, while avoiding vendor lock and enabling constant improvements. Systems that use cloud-based infrastructure can do this while keeping patient data secure and up-to-date.

**Value:** Next generation EHR solutions do not need to be costly. They can provide greater value—including all implementation and support costs—without sacrificing functionality. Cloud-based infrastructure eliminates the demand for large in-house IT staffs and data storage, allowing outsourced IT to handle the heavy lifting.

Both sides of the healthcare equation are under strain, but it doesn’t have to be that way. Technology has created the challenge, and better technology can provide the solution. It’s past time to fulfill the original promise of EHRs—reducing risk, improving efficiencies, and supporting high quality patient outcomes.

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By developing specific evaluation criteria, based on their organization’s needs and core values, providers can better gauge when that clinical or business impact may become too much to bear. But, Desai adds, as healthcare continues to evolve, providers also need to keep one eye to the future as they deliberate on the matter.

“Simply put, if your current solution can’t evolve with your organization and doesn’t integrate well with the systems your doctors need in order to provide the right care to patients, it’s time to find a new EHR,” Desai says.

DEVELOPING A PLAN

Mark Hess, senior vice president at Stoltenberg Consulting who has advised several provider organizations on EHR selection, says deciding to replace your current EHR platform may be the easiest part of the process. Once that decision is made, the real work begins. It’s important that organizations take the time to develop a detailed plan to help guide them from vendor selection to implementation.

“Ultimately, an EHR is just a tool. It’s an important tool but in and of itself, it can’t meet your core values or your goals,” he says. “So in order to invest in the right one once you’ve decided to switch, you need the input of your providers. Take the time to speak to them about what they really need so you can look at potential replacements through that lens.”

Anderson strongly recommends asking other providers about their EHR experiences to help make a suitable replacement selection.

“Talk to the people who are using a particular system. Talk to them about the mistakes they made, what they wish they had known, and what they would do differently if they had to make a switch again,” he says. “No EHR is perfect. But by talking to the people who use it every day, you can gain better perspective on what will work for you and what won’t.”

Desai says such conversations are important, and providers should be having frank conversations with EHR vendors as well. He adds that choosing a new EHR cannot be an IT-driven initiative—patient care needs to be at the center of any plan. He recommends that providers be given the opportunity to test new technologies early on in the process so they can determine whether it will work for them, with a specific focus on how well a new system will integrate with existing systems, and whether it can be customized for specific specialties or programs.

“This is your chance to ask questions and see how a system actually fits into how your people actually do their work,” he says.

“Our EHR was a lot more money than an independent family physician group should be paying. So, we decided that it was time to start looking for a more cost-effective alternative that could get us all the functionality we needed.”

— STANLEY ANDERSON, MD, FAMILY PHYSICIAN, CANTON, OHIO

Perhaps most importantly, Desai says healthcare organizations, regardless of size, need to develop strategies for successfully managing change during design, build, implementation, and data migration. By putting together a strategy that includes change management every step of the way, provider organizations are more likely to maintain clinical efficiency as they transition between EHRs.

“Change is never easy, so you really need to be prepared,” he says. “You need something that can pull information in real time, aggregate it, and then source it in a way so that a provider, whether it’s a physician or nurse or therapist, can use it in a way that fits into the flow of what they do every day. That takes a lot of upfront planning. But if you do it, you have a much greater chance of selecting something that’s sustainable even as healthcare, as an industry, continues to evolve. That’s really what you need.”

— STANLEY ANDERSON, MD, FAMILY PHYSICIAN, CANTON, OHIO
TECH TALK

What’s new in remote patient monitoring?

For years, CMS balked at reimbursing physicians for remote patient monitoring (RPM) and other types of non-face-to-face care, but it seems those days are over. During the past two years, the agency has built on its existing coverage of chronic care management-related RPM services by adding new codes for RPM reimbursement.

Physicians who haven’t yet taken advantage of these new reimbursement codes because of concerns about staffing or implementation may want to consider leveraging mobile-enabled remote patient monitoring (mRPM). This technology is much more efficient and cost-effective than past approaches such as telephonic RPM. Easy to implement, it can provide nearly immediate clinical and financial value for large group practices or solo practices with minimal clinical support staff.

Adding mRPM
Physicians who aren’t yet participating in the chronic care management (CCM) program may have shied away because of the expansive requirements. In addition, reservations may surround a perceived need—and the related costs—to hire additional care team members or outside services to perform the care management interactions.

That’s where mRPM comes in. An automated schedule uses push notifications to prompt patients to enter requested biometric, objective and subjective data (including social determinants of health); patients can then respond at a time and place convenient for them.

Once the data has been received, a clinician assesses the information and can decide if there is any need for a face-to-face visit or phone conversation. With a dashboard for the physician practice and a patient-friendly mobile app for check-ins between appointments, mRPM can greatly enhance communication between providers and patients. In addition, patients become more aware and engaged in their own care without overburdening care teams.

Avoiding the data deluge
Because it can control the quantity and quality of patient-reported data captured at the practice, mRPM is cost-effective. With the right platform, a patient is enrolled in an mRPM “care journey” specific to their health needs. The patients’ questionnaire responses via the app are automatically forwarded to clinicians and reviewed by the practice, health system and/or health plan to assess risk and follow up with an intervention when needed.

Patient-reported data shared in this way is surrounded in context at a pre-determined frequency appropriate for each patient’s clinical condition/s and care plan. This process is much more efficient and relevant than receiving a flood of non-actionable biometric data multiple times a day, or whenever the patient decides to share it with the doctor—which could be not frequently enough, or too frequently.

Moreover, mRPM doesn’t require the patient to acquire or learn a new device or specialized equipment because smartphones and mobile devices are already so widely used.

Engaging the patient
The phenomenon of improving patient adherence to a care plan through gentle reminders is based on the Nudge Theory, a Nobel Prize-winning behavioral economics theory contending, in part, that indirect suggestions and positive reinforcement can influence people’s actions. That means physicians and organizations need to make it easy for patients to create and follow new healthy habits.

While relevant patient-reported data capture and revenue enhancement are the primary goals of an mRPM program, an ancillary benefit of an appropriately structured mRPM program is stronger patient engagement. That’s because the simple act of being reminded, or “nudged,” to capture and report outcomes on a consistent, unobtrusive basis can elicit positive health behaviors that providers did not anticipate, or even explicitly recommend.

In the coming years, nothing will be easier or more habitual for patients than to communicate and share data using their personal mobile device. Technology such as mRPM makes virtual care more efficient and beneficial.

Harry Soza is president and CEO of CAREMINDr, a Silicon Valley tech company involving in mobile-enabled remote patient monitoring. Send your tech questions to medec@mmhgroup.com.
Both the Stark Law and the Anti-Kickback Statute are well-intentioned regulations meant to prevent doctors from referring Medicare patients to facilities they would profit from or receiving anything of value for Medicare referrals.

But as healthcare has evolved from strictly fee-for-service toward more value-based care models, these laws can make it difficult for physicians to coordinate care for a patient across facilities. Recognizing that these laws could hinder moving Medicare providers toward the goals of value-based care, the federal government has proposed changes to both the Stark Law and the Anti-Kickback Statute.

Medical Economics spoke with William Maruca, JD, who has extensive healthcare law experience and is a partner in the Pittsburgh office of Fox Rothschild LLP, about the proposed changes to the laws. The transcript has been edited for brevity and clarity.

**Q:** Medical Economics: Why is the government looking at changing the Stark Law and the Anti-Kickback Statute to begin with?

**William Maruca:** I think what’s driving this is the evolution of payment models that has outpaced this regulatory scheme, which goes back a number of decades and really hasn’t kept pace. I

**Medical Economics:** Why is the Stark Law and the Anti-Kickback Statute well-intentioned regulations meant to prevent doctors from referring Medicare patients to facilities they would profit from or receiving anything of value for Medicare referrals.
think that a lot of this is driven by what the private insurance industry has done to try to move away from fee-for-service payments toward value-based payments of one kind or another, and the perception that the existing regulatory system is an obstacle to participating in those arrangements.

The goal is to clear a lot of the obstacles out of the way so that providers could participate in these value-based enterprises and value-based arrangements without fear of running afoul of either of these rules.

“I think what this is going to do is encourage the growth of networks that will reward physicians for certain decisions that they make. So if by coordinating all that care, from the beginning of care to the end, and all the different players can save some money, you can now get a piece of those savings.”

Q: ME: For a long time, doctors have been practicing under the rules that you can’t self-refer or financially gain from referrals. Is this enough to get them to change their behavior, or will that take time?

WM: I think what this is going to do is encourage the growth of networks that will reward physicians for certain decisions that they make. So if by coordinating all that care, from the beginning of care to the end, and all the different players can save some money, you can now get a piece of those savings.

There are other things that you might be able to do that will produce better results. For instance, some of these organizations might be able to provide you with some technology for patients that will improve outcomes, have patients be more compliant, or monitor their condition so that they there can be an earlier intervention. In the past, there may have been concerns about those types of freebies or discounted arrangements as potentially being a kickback or Stark violation.

Q: ME: Are there other new risks for doctors in these proposals that they need to worry about?

WM: Potentially, but maybe not so much for doctors as the organizations they might contract with. For instance, there was a new term bandied about here that I’d never heard before. They often talk about these cost savings or cost-shifting arrangements where there’s an overall population to manage and it can be dangerous for an organization to cherry pick the healthiest patients. They now use this wonderful term called “lemon dropping,” which is screening out all the sick patients, where the risk is likely to be too high. So if these organizations get caught doing either of those things—only accepting healthy patients or somehow finding a way to discourage or screen out the sickest patients—the
organizations will get in trouble and so will the physicians participating.

**Q:** ME: What else do doctors need to know about these changes?

**WM:** I don’t think anything that anybody’s currently doing that has been vetted by their counsel is going to become prohibited. I don’t think there’s any “gotchas” in here that if these rules are adopted, that you’d better undo or unwind any kind of a transaction. I think if anything, they may find that some arrangements that were previously unapproved or prohibited might now be possible. For instance, there’s a rule that allows subsidizing local transportation. And in the past, there was a concern that if you provided transport for your patients to your facility, then that’s a patient inducement and not legal. That’s an area where the old rules were a little more restrictive, and now they’re going to be a little more open.

There’s one area that’s been a headache for those of us in this field for a long time, which is that an arrangement cannot be “commercially unreasonable.” That was never very well defined.

So what a lot of people have worried about with that concept of commercial reasonableness—does that mean that a party cannot lose money in a transaction? And if they do, does that mean it’s automatically commercially unreasonable? Now, if you have a good business reason to enter into a transaction, even though it may ultimately lose you money, but you can justify it, then it’s OK.

Another area that probably isn’t getting as much attention is the so-called patient engagement safe harbor. That’s where you can provide in-kind remuneration to a patient. For instance, if you have a glucose monitor for somebody who’s diabetic and you think it will be better for the patient to monitor their diabetes in their home, a value-based enterprise such as an ACO could buy the machine on behalf of the physician practice, and the physician practice could provide that monitor to a patient.

In the past, that would have violated the rules because it would have been an incentive for the physician to refer to the network. And secondly, it would be a violation for the patient or for the physician to give something of value to the patient. Now, they’re saying this is for improvement in quality, it’s a reasonable thing to do and you can show that it’s going to improve outcomes, so they’ll let you do it.

“I think that a lot of this is driven by what the private insurance industry has done to try to move away from fee-for-service payments toward value-based payments of one kind or another, and the perception that the existing regulatory system is an obstacle to participating in those arrangements.”

**Q:** ME: Are there people that are against these changes? And if so, who are they?

**WM:** They’ve excluded some of the players that are deemed to be a higher risk for fraud, and those are the players that are going to be unhappy that they’ve been left out. But that list includes pharmaceutical companies, distributors, device manufacturers, and laboratories. They’re all going to be flooding the OIG with comments saying, “you can trust us, we’ve got a code of ethics, we’ve learned our lesson over the years, you shouldn’t single us out as being untrustworthy.”

But I think there has been enough trouble in those industries just by a few bad apples, that at this point, they’re hesitant to include them in these models. Other than that, I don’t think too many people are going to object to this because I think overall it’s a package of changes that is encouraging more innovation and more flexibility. There may be those that say it didn’t go far enough.”
My step-children roll their eyes and laugh at me when I say, "Life is a journey," because I say it so often. What I hope to convey to them is that life is long and complex, and that for all of us, experiences along the way continue to shape who we are, how we live, and how we view the world.

As a person, and as a physician, I am proof of that. I am older and wiser, and I am also a better physician than I was 30 years ago. And I know it is the totality of my life journey, and the interactions I have had with the patients I have been privileged to care for over many years, that have shaped me and made me a better doctor.

These days, as I proudly watch my daughter grind through medical school, all-consuming with studying and doing well on exams, I try to give her advice and perspective, but not surprisingly it often falls on deaf ears. What I know is that I was not a dissimilar student. Life balance is always hard as a medical student. I remember at that stage of my career, as a future internist, it was all about knowing everything. I wanted to be a great internist, and I believed "book smarts" was the answer. Only with time have I come to realize that being a great internist requires so much more.

One of my early growth moments came from my mother—as they often do. I was seven months pregnant with my second child when I diagnosed my mom with stage 4 adenocarcinoma of the lung. She had a large pericardial effusion at diagnosis and as an internist’s daughter, I knew the prognosis. I was devastated and I began to grieve immediately. She moved in with us to receive her care in Cincinnati.

The next day I accompanied her on her first cycle of chemotherapy. As her disease progressed, I felt it was important to talk to her directly about her prognosis, often saying that it was likely she had only weeks or months left, thinking that information would allow her to prepare and would allow us to have all the
conversations we needed to have. In hindsight, I was trying to prepare myself for her death in some way and to control the uncontrollable. But I now understand my approach was wrong.

What she said to me in the days before she died profoundly changed the way I practice medicine. She told me that as a cancer patient approaching death, the only thing one has left is hope. And although she knew my intentions were good, and I was trying to help her with factually correct information, it took away her hope.

Since her death, I have cared for my cancer patients in a completely different and, I believe, better way. Even at the end, when they are in hospice, I am cautious to allow them hope, and to follow their own journey to making peace.

Another patient, this one much younger, also changed my life. In his early twenties he had a seizure while playing tennis with his family and was diagnosed with a large brain tumor. Following surgery to remove it, he was hemiparetic, bedridden and completely unable to care for himself.

Visiting him in the hospital and then in the rehab facility was one of the most significant patient interactions of my career. Sitting with him ten days’ post-op, as he needed help to go to the bathroom, with a very uncertain future, he remained hopeful, positive, kind, and connected to his friends and family.

I treasure the handwritten note he sent me thanking me for my care and support. With hard work over time, and an unwavering positive attitude, he largely neurologically recovered. Within months he was walking and returned to his job in Chicago.

Three years later he fell in love with a woman who was also a cancer survivor and they married. Unfortunately, at the same time they learned they were expecting, his cancer returned. I saw him in the months prior to his death, and his grace and strength were incredible. He died just a few weeks before his son was born.

During his final months, he remained hopeful and joyful, and he never complained. The way he lived his life taught me how to live, a gift without a price tag.

What my patients, including my mother and the young man with cancer, have taught me over the years has impacted who I am as a person, and how I practice. That’s what makes caring for them such a gift.

Witnessing the devotion of children to aging ill parents, the love shared by elderly couples as they become frail and sick, the strength patients show with a terrible diagnosis, the generosity of people when others are in need, and the courage they show as they approach death—all of that has taught me an immense amount about life and love. It has also helped me share what I’ve learned with other patients. That’s why caring for them along their journey is a tremendous privilege.

Then there’s my own breast cancer diagnosis at age 49, which taught me more than I ever thought possible, and has further impacted the care I give my patients. As a women’s health internist, my focus has been on caring for women at midlife—through menopause, changes in sexual health and breast cancer survivorship. Now, when I lecture in the community, I can share that I am living with exactly what many of my patients experience—chemotherapy-induced menopause, sexual dysfunction, radiation fibrosis and more. In the exam room, I can be empathic in a way I could not have been without my experience.

But the most powerful gift of my cancer diagnosis was learning in the most profound way the value of close, connected relationships. My family, friends, patients, and community supported me in ways I did not know were possible. I never felt more loved than I did during my treatment. Experiencing that love, and the gratitude I now have for my life and my profession is impossible to put into words.

Simply put, it has made me a better person. And, yes, a better doctor, too.

Lisa Larkin, MD, a women’s health internist, is founder and CEO of Ms. Medicine, an organization committed to improving healthcare for women through its primary care concierge model provided by specialty trained women’s health providers. She is also founder and president of Lisa Larkin, MD, and Associates, a direct primary care, concierge medicine and women’s health internal medicine practice in Cincinnati, Ohio.
New rule on ‘bad actors’ means more work for practices

Although many medical practices run a standard background check on new employees, sometimes they do not look closely into vendors and contractors with whom they do business, and few run a check through the Office of Inspector General exclusion database. Having someone working for your organization, even in a management or administrative capacity, can put a practice at risk of losing its provider number.

Effective in November, the rules became complicated and extensive, as CMS now requires Medicare, Medicaid and Children’s Health Insurance Program (CHIP) providers and suppliers to disclose certain affiliations they may have with other providers and suppliers who are considered “bad actors.”

This new rule is an effort to cut down on fraud, abuse and waste and to save taxpayer money. Of course, the administrative burden to healthcare providers will be significant.

In the eyes of CMS, “bad actors” may include providers or entities who have had previous negative interactions with CMS, such as having been sanctioned, experienced a payment suspension, been excluded from federal programs, had billing privileges denied, revoked, or terminated or an outstanding debt owed to the government (including federal student loans).

It does not matter whether these particular issues were corrected by the affiliated person or entity, only that they occurred.

The process of identifying all possible affiliations will be introduced over time, but CMS will start by asking providers and suppliers to identify providers/suppliers with whom they are/have been affiliated in the prior five years that require further disclosure.

How will medical practices be affected by this new rule? First, each practice must try to determine which providers and entities might be considered an “affiliated relationship.” According to CMS, affiliation can mean relationships such as:

- a general or limited partnership interest in another organization;
- an interest where an individual or entity exercises operational or managerial control over the day-to-day operations of another organization;
- an interest where an individual is acting as an officer, director, manager of another entity; or
- any reassignment relationship under Medicare regulations.

To track down these types of relationships, every practice will need to look closely at its providers and vendors. It will then need to ask those with whom it has, or is looking to have, any affiliation to answer questions designed to determine whether the relationship is one that must be reported to CMS.

A provider or supplier who is identified as being a “bad actor” upfront will likely need to be avoided entirely to best protect the practice. I have recommended that my clients develop a questionnaire to be completed by all parties with whom they do business, and we will also start to introduce representations and warranties into all written contracts in order to address the rule. The consequences for non-compliance are significant. Enrollment in Medicare, Medicaid and CHIP might be put at risk, which can mean losing your provider number and no longer being able to bill federal payers.

To make sure your practice is in compliance with the new rule, be sure to work with health law counsel and your organization’s compliance officer to scrutinize all existing and future relationships.

Ericka L. Adler, JD, LLM, has practiced in the area of regulatory and transactional healthcare law for more than 20 years. Send your legal questions to medec@mmhgroup.com.
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