THE OBESITY CRISIS

- Boost adherence
- Improve outcomes
- Hit quality scores

MONEY
Overlooked codes that could boost revenue

CAREERS
7 medical trends to watch in 2020

LEGAL
Provide patient record access—or else

TECHNOLOGY
The promise of next generation EHRs

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Taking on the obesity challenge

The arrival of 2020 means New Year’s resolutions. A common resolve of many people is, of course, to lose weight and get in better shape. Many patients will be turning to their physicians for help on this journey. You’ve probably met with some of these patients already.

Helping patients deal with chronic conditions—with obesity being one of the most consequential and challenging—is one of the most challenging jobs a primary care physician has. Physicians can try to prescribe, motivate, cajole, or scare patients into making life changes, but when a patient is not sitting in front of you in an exam room, there’s not much a physician can do to ensure their patient stays on track with their health goals.

But physicians have a hugely important role in assisting patients to improve their health and deal with obesity, and that’s the topic of this issue’s cover story. How can doctors motivate patients? Which strategies work, and which don’t? Our editors talked with physicians and other experts to share with you the best practices for helping your patients boost treatment adherence and improve their outcomes.

Also, in this issue, to help our audience members get your practice started off on the right foot financially, we have a feature on overlooked codes that many physicians neglect, and how using these codes—some of which are for procedures many physicians are already doing—can boost revenue.

In addition, we have articles on:

- Some of the major trends that will shape healthcare in 2020, and what physicians need to know;
- Why physicians should take patient requests for record access seriously, because ignoring them can result in fines and penalties; and
- How physicians can handle collections from patients in a compassionate manner.

2020 will be a year with tremendous opportunities for physicians, both when it comes to both the clinical and business side. Here at Medical Economics we will strive to provide the solutions you need to the challenges you experience each and every day while serving your patients.
COVER STORY

The obesity crisis

Tips to boost patient adherence and outcomes

PAGE 4

ALSO INSIDE

MONEY
10 Overlooked codes
What you need to know about longitudinal comprehensive care coding

LEGAL
15 Record access risks
How to avoid fines for not providing patient record access

PRACTICE MANAGEMENT
18 Compassionate collections
Get paid without ruining patient relationships

PHYSICIAN CAREERS
23 What’s coming in 2020
Seven trends for physicians to keep their eyes on

TECH
28 Next generation EHRs
Realizing the promise of improved systems

IN EVERY ISSUE

Tips to boost patient adherence and outcomes

PAGE 26

The obesity crisis

Alzheimer’s

Tips to boost patient adherence and outcomes

PAGE 4

WITNESS CONTEST

Back to basics

What a resident physicians learned about being the best physician from an intimidating mentor.

PAGE 26

MONEY

10 Overlooked codes
What you need to know about longitudinal comprehensive care coding

LEGAL

15 Record access risks
How to avoid fines for not providing patient record access

PRACTICE MANAGEMENT

18 Compassionate collections
Get paid without ruining patient relationships

PHYSICIAN CAREERS

23 What’s coming in 2020
Seven trends for physicians to keep their eyes on

TECH

28 Next generation EHRs
Realizing the promise of improved systems

IN EVERY ISSUE

Tips to boost patient adherence and outcomes

PAGE 26

The obesity crisis

Alzheimer’s

Tips to boost patient adherence and outcomes

PAGE 4

WITNESS CONTEST

Back to basics

What a resident physicians learned about being the best physician from an intimidating mentor.

PAGE 26

MONEY

10 Overlooked codes
What you need to know about longitudinal comprehensive care coding

LEGAL

15 Record access risks
How to avoid fines for not providing patient record access

PRACTICE MANAGEMENT

18 Compassionate collections
Get paid without ruining patient relationships
key provision of the Affordable Care Act (ACA), requiring all Americans to buy health insurance or face a tax penalty, was ruled unconstitutional December 18 by a panel of appellate judges, but the fight over the controversial healthcare law is likely to drag on for at least another year.

While the decision will have no immediate effects on the healthcare insurance coverage since the tax penalties associated with the mandate were reduced to $0 in the 2017, the fate of the rest of the law is in doubt. Groups such as the American Medical Association (AMA), American College of Physicians (ACP), and the American Academy of Family Physicians (AAFP) reacted far less positively to the ruling. In a trio of news releases Dec. 19, each group, who had led a joint brief with the district and appeals courts in support of the ACA, expressed their concern that the ruling would lead to further uncertainty amongst patients.

“Today’s decision leaves important health insurance protections shrouded in uncertainty despite overwhelming public support for these policies,” says AMA President Patrice A. Harris, MD, in a news release. Gary LeRoy, MD, president of AAFP, says in a statement that the appeals court’s decision to return the case to the district court, “prolongs the uncertainty that millions of Americans face about whether they will have access to health care.”

In his statement, ACP President Robert McLean, MD, says his organization will continue the fight to ensure Americans don’t lose their healthcare coverage.

“We remain hopeful that the courts will agree that these provisions are constitutional,” he says. “The Supreme Court will ultimately decide whether the ACA’s coverage requirements ... will be upheld.”

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**THE TOP TEN CHALLENGES FACING DOCTORS IN 2020**

**Medical Economics.com**
Amanda Stewart, MD, has a lot of experience dealing with obesity and its effects on patients. About 75 percent of the patients she treats at the Columbia, South Carolina, Federally Qualified Health Center where she works are overweight or obese. Most also have at least one comorbidity, such as diabetes or hypertension.

Moreover, as president-elect of the American Academy of Family Physicians, Stewart knows that many other family practitioners face similar situations in their practices. "It [patient weight loss] is a struggle doctors deal with every day, especially in family medicine, because we are on the front lines of helping our patients live healthy lives," she says.

For the last 40 years or so, obesity has been one of the nation’s most pervasive, and costly, public health challenges. And despite ongoing efforts to combat it, such as...
the AMA’s 2013 official recognition of obesity as a disease, the problem continues to worsen. A 2018 study published in *JAMA* found that the percentage of obese adults age 20 and over (defined as those with a BMI of 30 or more) increased from 33.7 percent in 2007-2008 to 39.6 percent in 2015-2016.

**OBESITY’S COST: HUMAN AND FINANCIAL**

During the same period, the percentage of adults with severe obesity (a BMI of 40 or more) increased from 5.7 percent to 7.7 percent. Even more worrisome, between 1986 and 2006, nearly one in five deaths among adults age 40 to 85 were tied to overweight and obesity, according to a 2013 study in the *American Journal of Public Health*.

In addition to its human toll, obesity imposes a substantial and growing cost on the nation’s healthcare system. A 2018 study in *Clinical Chemistry* found that the share of healthcare expenditures devoted to treating obesity-related illness in adults rose from 6.1 percent in 2001 to 7.9 percent in 2015.

The study also found that from 2010 to 2015, obesity accounted for 13 percent of all spending on prescription medications, compared with 6.9 percent on ambulatory care and 7.4 percent on inhospital care.

**OBSTACLES TO TREATMENT**

That obesity remains a major health problem is a testament to the obstacles both physicians and patients face in treating it. Many primary care doctors find it difficult simply to carve out the extended time needed for obesity counseling from schedules that are often built around 20-minute appointments. In addition, some PCPs are reluctant to discuss weight issues with patients or diagnose obesity. (See sidebar).

For patients, losing weight entails changes in lifestyle and attitude that many find challenging even to begin, much less sustain.

“To lose weight, and more importantly keep it off, requires a combination of changing the types of food you eat and increasing your level of physical activity,” says Douglas DeLong, MD, an internist in Cooperstown, N.Y. and chair of the American College of Physicians Board of Regents. “Those two things go hand in hand, and doing them together is really hard.”

For many, it also means overcoming feelings of guilt and shame, says Lydia Alexander, MD, an obesity specialist with the Kaiser Permanente Weight Management Group in San Francisco and a board member of the Obesity Management Association.

“A big problem I see is patients feeling depressed because they think they have caused their condition because they have no willpower,” she says. “I remind them that 70 percent of the country is either overweight or obese and if this were an easy problem to fix, we would have taken care of it by now.

“We wouldn’t tell a patient who’s clinically depressed they should get out in the sun more and try to be happier,” she adds. “There’s more to it than that.”

**GETTING STARTED**

Faced with these challenges, how can doctors help patients achieve a healthy weight level? A good place to start, experts say, is with a physical examination to determine the patient’s BMI, followed by a discussion of other issues that might be affecting their weight, says Tiffany Lowe-Payne, DO, a family practitioner and board-certified obesity specialist in Raleigh, N.C.

“I talk with them about things like the medications they’re taking, whatever chronic conditions they may have, and family history,” she says. “We know, for example, that if both parents are overweight, it increases the chances of overweight in their children by 80 percent. So it does no good just to look at their weight or BMI, give them a diet plan and send them on their way.”

DeLong says that when a patient’s BMI meets the definition of obesity, “I ask them whether they want to talk about it. Some may not want to, but they have other health issues like diabetes or osteoarthritis that make it critical that we discuss their obesity. So it comes up pretty frequently.”

**MOTIVATIONAL INTERVIEWING**

When counseling for weight loss, doctors who’ve done it advise using motivational interviewing: asking the patient to artic-
Battling obesity

Chronic Conditions

Patients need to understand that making a major lifestyle change like weight loss requires a shift in their mindset, says Lowe-Payne. “So using motivational interviewing, I will ask them to assess their level of readiness and their commitment to doing whatever it takes to create the change that they are seeking.”

DeLong will often start conversations by asking patients how they define weight loss. “Are they talking about losing 10 percent of their body weight, does it mean trying to get to a specific BMI, or something else entirely? I need to explore those questions with the patient before we can decide how best to proceed.”

Following that, DeLong asks patients about their dietary habits and daily routines, such as what they typically eat for their daily meals, the types of activities they engage in and how often, and how much sleep they get. Based on that information, he and the patient jointly decide on goals for reducing caloric intake and increasing activity. “I might start by suggesting they shoot for cutting out 500 calories a day, which is a couple of cookies. For most people that’s pretty doable,” he says. “Then I’ll say, I’m going to see you back in two months and I’d like you to lose four pounds in that time. Most people can wrap their heads around that.”

DeLong emphasizes the importance of setting goals that are realistic, modest, and based on each patient’s individual circumstances. “I don’t want them getting discouraged if they haven’t lost 20 pounds,” he says. “But I also don’t want them coming back having lost 20 pounds because I know they won’t be able to keep that up and the next time I see them they’ll be 30 pounds heavier.”

THE TIME CHALLENGE

DeLong acknowledges that finding time for weight management counseling in a schedule built around 20-minute appointments is a challenge, one that requires setting priorities. For example, he says, if a patient who’s come in for a routine physical expresses concern about their weight, he may make that the entire focus of the appointment and leave only a few minutes at the end for discussing any other issues.

The time challenge is made somewhat easier by knowing that he’ll probably see the patient frequently for at least several months. “You need to see these patients repeatedly because they usually require a lot of support to prevent backsliding,” he says.

Alexander uses a similar approach to time management. “I think it’s important to take the long view, and kind of sub-divide weight management plans into smaller periods of time,” she says. “So maybe the first appointment would be just broaching the topic and letting the patient know you’re available to help.”

Subsequent visits, she adds, might consist of showing the patient how to keep a food journal or explaining the link between obesity and other common chronic conditions. “Taking this bite-size approach works to the patient’s advantage by making it easier to absorb the information over time.”

DESCRIPTION:
Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter

INSTRUCTIONS:
There is no diagnosis associated with this measure. This measure is to be submitted a minimum of once per performance period for patients seen during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI.
“MEETING PATIENTS WHERE THEY ARE”

Alexander and others who’ve counseled patients for obesity emphasize the importance of “meeting patients where they are,” i.e. understanding and working within the constraints of each patient’s circumstances. For example, she’ll help patients who travel frequently for business to develop strategies for limiting their calorie consumption when eating in restaurants and/or in social situations.

Can medication or surgery cure obesity?

While calorie control and increased exercise are the basic elements of a weight loss plan, prescription medications are also a useful—if frequently overlooked—tool for combating obesity.

FDA-approved weight loss drugs first became available in 1959, and today the government has approved nine medications for long-term use in weight loss (see accompanying box). However, a 2019 GAO report found that fewer than 1 percent of Americans with obesity use them, which the agency attributes to their high cost, along with lack of physician knowledge about them, among other reasons.

Nevertheless, doctors who prescribe them say medications can be effective in helping some patients lose weight, at least over the short term. “Medications can be a potent adjunct to a weight loss regimen,” says Tiffany Lowe-Payne, DO, a family practitioner and obesity specialist in Raleigh, N.C. “They help to address issues like cravings, and some even help reduce emotional eating.”

She adds, however, that many of the drugs require prior authorizations for insurance coverage, which often requires a lot of time and documentation.

Douglas DeLong, MD, an internist in Cooperstown, N.Y., says that while none of the patients he’s counseled for weight loss have required medications, he knows they can be effective. “They definitely can help with modest amounts of weight loss, in the range of 10-15 pounds, and that can be very motivating,” he says. “The problem is that once patients stop taking them, they usually gain the weight back. So they [medications] probably work best as part of a very structured program.”

Bariatric surgery is another possible remedy for obesity. The National Institutes of Health recommends it for people with a BMI of 40 or more, or a BMI of 35 along with at least one obesity-related disease. For this subset of patients, “surgery is the only approach that has been proven to keep weight off for long periods of time and decrease mortality,” DeLong says.

Even so, bariatric surgery is performed infrequently, relative to the need for it. According to a study from the American Society for Metabolic and Bariatric Surgery, in 2016 only about 1 percent of adults who met the medical criteria for surgery received it. Experts attribute this to a lack of insurance coverage for the procedure, along with the fact that it’s generally viewed as a last resort, after behavior modification counseling and medications have proven ineffective.

DeLong refers a handful of patients each year to a bariatric surgery program in Albany, N.Y. “It’s rather selective, and they go through a lengthy process of behavioral health counseling and evaluating which patients are motivated enough to likely benefit from having surgery,” he says.

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<th>Brand name(s)</th>
<th>Year approved</th>
<th>Approved use</th>
<th>Approved for adults/children</th>
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<td>Adipex-P and Lomaira</td>
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<td>Short-term</td>
<td>Age 16 and older</td>
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<td>Bontril PDM</td>
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<td>1999</td>
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<td>Adults (18 and older)</td>
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<td>Liraglutide</td>
<td>Saxenda</td>
<td>2014</td>
<td>Long-term</td>
<td>Adults (18 and older)</td>
</tr>
</tbody>
</table>

Source: GAO Report to Congressional Committees, August 2019
Why aren’t weight issues discussed more often?

Despite the growing prevalence of obesity, and awareness of the need to address it, discussions about weight loss are surprisingly rare during patient visits. An April 2019 article in JAMA highlights the paradox. It notes that nearly 90 percent of patients with a body mass index (BMI) between 30 and 35 don’t receive a formal diagnosis of obesity, but also cites a study in which 97 percent of physicians agreed that doctors should counsel patients about obesity. Similarly, a 2012 study in the International Journal of Obesity found that 58 percent of primary care doctors performed no weight loss counseling, with about half of all counseling sessions provided by just 9 percent of physicians.

Given its importance as a health issue, why doesn’t obesity counseling occur more often? Experts in obesity treatment, along with physicians who have counseled patients, offer a variety of explanations, starting with lack of physician training. A 2015 survey of medical schools published in the Journal of Biomedical Education found that 71 percent weren’t providing the recommended minimum 25 hours of nutrition education, and most instruction was taking place in preclinical courses.

The result is that many primary care doctors “don’t have the comfort level where they feel they can walk patients through the process” of weight loss, says Tiffany Lowe-Payne, DO, a family practitioner in Raleigh, N.C., adding that she recalls “no more than two or three lectures” on nutrition training during medical school and residency.

Lacking what they feel is sufficient training during their education, more doctors are becoming certified in obesity medicine. In 2019 a record 726 doctors in the U.S. and Canada passed the certification exam, about two-thirds of whom were primary care providers, according to the American Board of Obesity Medicine.

That brought the number of board-certified specialists to 3,377, compared to 589 in 2013—the year the AMA officially recognized obesity as a disease, and a year after the U.S. Preventive Services Task Force issued a recommendation that adults with a BMI of 30 or more be referred to obesity specialists for “intensive, multicomponent behavior interventions.”

Another significant barrier to weight loss counseling has been lack of reimbursement, says Ada Stewart, MD, a Columbia, S.C., a family practitioner and president-elect of the American Academy of Family Medicine.

“There was some understandable reluctance among providers to add that to their workload and not get paid for it,” she says.

In recent years that has begun to change, Stewart adds. In 2012 Medicare started reimbursing for BMI screening and behavioral therapy, and some state Medicaid programs and commercial insurance plans have begun doing so as well.

A third challenge is the time required for obesity counseling, especially given that obesity is often accompanied by acute comorbidities that require immediate attention. In a January, 2018 survey of healthcare providers published in the journal Obesity, 52 percent cited “lack of time” as the reason why they don’t initiate discussions about weight loss, while 45 percent cited “more important issues/concerns to discuss.”

Along with these tangible causes are others that are harder to quantify but no less real. One is the social stigma attached to obesity, which can make any weight-related discussion difficult for doctors and patients alike. “It’s a very personal issue, and that makes it hard to find the right words to broach the topic,” notes Lydia Alexander, MD, an obesity specialist with the Kaiser Permanente Weight Management Group in San Francisco and a board member of the Obesity Management Association.

That stigma, she adds, contributes to higher rates of depression among people with obesity compared to the rest of the population, which in turn makes them more reluctant to seek treatment for it.

Added to that is the sheer difficulty of losing weight and keeping it off, which can discourage doctors nearly as much as it does their patients. “It takes time, and the long-term results can be very frustrating,” says Douglas DeLong, MD, an internist in Cooperstown, N.Y. and chair of the American College of Physicians Board of Regents. “It’s been just a handful of patients over my career that have been successful in losing a significant amount of weight. It’s a very hard thing to do.”
"I try to teach them how to plan ahead so they’re in control of the situation, rather than the situation being in control of them,” she explains.

For Stewart, the challenge is working with low-income patients living in areas with limited access to healthy foods. "I'm not going to tell a patient who gets their food at a Dollar General store to make sure they have fresh fruits and vegetables," she says. Instead, she advises those patients to buy foods with the lowest fat and sodium content they can find.

"You have to make things simple, and make sure patients really understand the goal and why it's important that they try to reach it," she adds. "If I tell a patient, 'losing 10 percent of your weight makes your risk of diabetes or hypertension much lower," that's something everyone understands."

DON'T FORGET ABOUT EXERCISE

The same principle of "meeting patients where they are" applies to the other side of the weight-loss equation: increasing physical activity. For example, for patients who find walking difficult, Alexander may recommend aquatic exercise.

"Most people aren't going to take up jogging, but maybe they can be encouraged to try something else," says DeLong. "It can even be something as simple as walking the dog twice a day instead of once. Anything helps."

On the other hand, patients should be cautioned not to view exercise by itself as the solution to weight loss, since "we can always out-eat our exercise," says Lowe-Payne. Its value lies instead in helping to remain at a healthy weight once it's been attained. "The individuals who've maintained weight loss over a long period of time are making exercise or physical activity a part of their daily routine," she says.

As for doctors, Lowe-Payne adds, they need to remember that overcoming obesity is a long and difficult process, and patients need their advice and support to accomplish it. "Most individuals don’t choose to live at an unhealthy weight and would lose weight if they could, but they need the skills and they need support from the medical community."

Alexander agrees, noting that shedding weight and keeping it off requires “a collaborative process” between the patient and their physician. "The ball’s in their court to take charge of their lifestyle," she says. "Our job is to treat their medical conditions and be there as their coach, to listen and to get them through it."
It’s a common complaint heard among primary care physicians: Evaluation and management (E/M) codes don’t adequately capture the time, skill, and resources necessary to plan and coordinate care for patients with complex medical needs. Although new, streamlined E/M guidelines for 2021 may help, several existing remedies can enable physicians to capture additional revenue for the services they provide.

More specifically, the U.S. Government Accountability Office (GAO) recently published a list of 58 CPT codes that fall under the category of “longitudinal comprehensive care planning” (LCCP) for Medicare beneficiaries diagnosed with a serious or life-threatening illness. These codes include elements of shared decision-making through interdisciplinary care as well as development of a care plan to address the following:

- Progression of the disease and treatment options
- Beneficiary’s goals, values, and preferences
- Resources and social supports that can mitigate the beneficiary’s health risks

Revenue from these LCCP codes can help physicians implement workflows and hire additional staff to support value-based care, says Abigail Burns, senior analyst at Advisory Board, a healthcare consulting company in Washington, D.C. “These codes are CMS’s way of providing a fee-for-service revenue source to enable providers to invest in the resources they need to help them succeed under value,” she says.

LCCP codes are becoming more common because commercial payers are increasingly paying for them, says Toni Elhoms, CCS, CPC, CEO of Alpha Coding Experts LLC, a coding consulting company in Orlando, Fla. Another reason is the trend toward capitated contracts under which physicians receive per-member per-month payments. “It’s a lot more cost effective to be proactive rather than reactive,” she says, adding that many LCCP services focus on disease management and prevention as well as care coordination with the goal of keeping people healthy. If you’re
reactive—and the patient requires more intensive services during a particular month—you’re on the hook and don’t receive additional compensation.”

Here are the most significant revenue opportunities for primary care and tips for how physicians can overcome the barriers that may prevent them from performing (and correctly billing) these LCCP services.

1 **Chronic care management (CCM)**
   **CPT CODES:** 99490 ($42.17), 99491 ($83.97), 99487 ($92.98), 99489 ($46.49)
   **TYPE OF PATIENT:** Patients with two or more chronic conditions expected to last at least 12 months or until the patient’s death
   **BILLING FREQUENCY:** Per month
   **WHO CAN PROVIDE/BILL:** Any physician or other qualified healthcare provider

2 **Transitional care management (TCM)**
   **CPT CODES:** 99495 ($166.50) and 99496 ($234.97)
   **TYPE OF PATIENT:** Patients with medical and/or psychosocial problems that require moderate or high complexity medical decision-making during the transition to a community setting following discharge from certain inpatient hospital settings
   **BILLING FREQUENCY:** 30-day period beginning on the date of discharge from an inpatient setting
   **WHO CAN PROVIDE/BILL:** Any physician or other qualified healthcare provider

**Barrier:** NEED TO RETHINK STAFF RESPONSIBILITIES. Although some practices may need to hire an additional staff member or work with a third-party vendor, leveraging the existing care team is ideal, says Burns. For example, an RN can provide these services for complex patients while an LPN can provide them for less complex patients, though the physician still needs to be involved in developing the care plan. Using a medical assistant to perform some of the administrative tasks associated with TCM and CCM is also helpful, she adds. For example, they can obtain discharge information, provide patient education, or connect patients with community resources.

**Barrier:** PERCEIVED LACK OF RETURN ON INVESTMENT FOR CCM. Although CCM itself doesn’t pay a large sum, the financial gains occur as practices identify, perform, and bill other necessary services (e.g., wellness visits, vaccines, and office visits), says Vanessa Bisceglie, MBA, BS, OHCC, PMP, NCP, CEO of Care Vitality in Skokie, Illinois, a third-party care management vendor that provides CCM, TCM and BHI services as an extension to a provider’s practice. CCM also helps physicians boost their MIPS scores and achieve bonuses if they’re part of an Accountable Care Organization. “They need to look at the big picture,” she says. “It’s about catching things earlier and keeping patients out of the hospital. By doing that, revenue comes back to the office instead of going to the ER and the hospital.”

In addition, HCPCS code G0506 (comprehensive assessment and care planning) is a one-time Medicare-specific CCM code that many providers overlook, says Elhoms. This code, which pays $63.43, is for the initiation of CCM for new patients or patients not seen within one year prior to the commencement of CCM. When the provider who gains consent and initiates the comprehensive care plan as part of the office visit personally performs the extensive assessment and care plan beyond the usual effort associated with the E/M service, annual wellness visit, initial preventive physical exam, that same provider can also bill G0506, she adds.

**Barrier:** TRACKING TIME FOR CCM. CCM is only billable once per month, and each code has associated time requirements. If the EHR doesn’t automatically track time spent, then practices need to create their own solutions, says Kathy Pride, RHIT, CPC, CCS-P, CPMA, senior vice president of coding and documentation services at Panacea Healthcare Solutions Inc., a healthcare IT consulting company in St. Paul, Minn. Even something as simple as an encrypted Excel spreadsheet with a
CPT codes for this encounter:

- **99496** (transitional care management services) = $234.97*
- **99497** (advance care planning) = $86.49

*Note: This code is billable only once every 30 days following discharge from an inpatient facility.

One month post-discharge, the patient is seen for a follow-up visit during which the physician performs a comprehensive exam and high-complexity medical-decision making. The physician also determines the patient would benefit from ongoing chronic care management (CCM) given his chronic conditions and obtains the patient’s consent to receive this service.

CPT code for this encounter:

- **99215** (Level 5 office visit for an established patient) = $147.76

One week later, the patient returns to the office for his first CCM visit during which a qualified healthcare professional spends 95 minutes discussing how to manage his chronic conditions, creating a comprehensive care plan, and connecting him with support services. During this visit, the provider also identifies that the patient has severe depression. They spend 20 minutes using a validated rating scale to perform an assessment and then coordinate care with a psychologist.

CPT codes for this encounter:

- **99487** (CCM, 60 to 89 minutes) = $92.98*
- **99489** (CCM, each additional 30 minutes) = $46.49*
- **99484** (BHI) = $48.65*

*Note: This code is billable only once per month.

After receiving CCM for three months, the patient’s pancreatic cancer worsens, and he is put on hospice for palliative care. His primary care physician supervises the hospice care.

CPT code for this encounter:

- **G0182** (hospice care supervision) = $109.56*

*Note: This code is billable only once per calendar month.

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**Barrier: TOO MANY DOCUMENTATION REQUIREMENTS FOR CCM AND TCM.** The good news is that EHR vendors are increasingly building templates to help physicians satisfy all documentation requirements for CCM and TCM, says Bisceglie. Physicians can also work with third-party vendors to develop these templates. However, CCM and TCM are about more than simply checking off a box in a template. These services require providers to find and address all of a patient’s care gaps, which is why it’s important to learn the components of each code and doing what’s best for each patient.

“Providers need to make sure they’re providing the full scope of the service that’s required to bill for the code and providing value to the patient,” says Bisceglie. This means tackling everything from coordinating care with specialists, helping patients take their medications correctly, identifying and reconciling duplicate prescriptions, and addressing social determinants of health, she adds.

**Barrier: OBTAINING PATIENT CONSENT FOR CCM.** Obtaining consent (and thus getting patients to agree to a coinsurance or deductible) is a relatively easy process if physicians focus on providing value to the patient, says Bisceglie. She suggests using the following language: “This is a service you’re not receiving but something that Medicare covers to help us coordinate your care. I think you can benefit from this service, and it can help us make sure we provide you with the best possible care.”

**Advance care planning (ACP)**

- **CPT CODES:** **99497** ($86.49) and **99498** ($76.04)
- **TYPE OF PATIENT:** No restrictions
- **BILLING FREQUENCY:** No limits
- **WHO CAN PROVIDE/BILL:** Any physician or other qualified healthcare provider

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**Editor’s note:** Toni Elhoms, CCS, CPC, CRC, CEO of Alpha Coding Experts in Orlando, Fla. provided this scenario.
Barrier: PHYSICIANS DON’T KNOW THESE CODES EXIST. Medicare pays for ACP when physicians perform it as part of the AWV or as a separate Medicare Part B medically necessary service, says Elhoms. The only difference is whether the patient’s deductible and coinsurance apply. When the same provider performs the AWV and ACP on the same day—and bills it with modifier -33 for preventive service—Medicare waives the deductible and Part B coinsurance. To avoid denials, physicians must document the total time spent discussing ACP, what the discussion entailed, and the outcome (i.e. whether the patient signed any documents).

Barrier: NO RETURN ON INVESTMENT.
One potential reason for this is physicians not billing BHI when they perform CCM. Although BHI may not apply in some cases, these two services tend to go hand-in-hand because mental health conditions sometimes drive exacerbation of chronic conditions (e.g., depression that causes worsening diabetes). Often physicians only bill for CCM even though they spend time assessing the patient’s behavioral health condition and coordinating care with a specialist, says Bisceglie. The only caveat is that services they perform to meet criteria for BHI cannot count toward meeting the criteria for CCM, she adds.

Consultants can help physicians identify the personnel necessary to provide BHI (and what licenses and other qualifications may be necessary depending on state requirements), create a payer matrix to determine coverage for the service, and even examine the physical office space to determine whether additional offices are needed or whether the practice needs to shift walls, add doors, etc. to promote efficient workflows, says Sonal Patel CPMA, CPC, CMC, a healthcare coder and compliance consultant with Nexsen Pruet LLC, a business law firm in Charleston, SC. “Physicians will definitely see a return on investment if everything is done compliantly the first time,” she adds.

Barrier: PHYSICIANS DON’T KNOW THIS CODE EXISTS. Physicians may be performing elements of this code during an AWV or IPPE without realizing they can perform a more in-depth assessment using standardized instruments and then bill CPT code 99483, says Elhoms. From a workflow standpoint, physicians typically see signs of impairment (e.g., poor historian, confusion, or forgetfulness) during the AWV or IPPE and tell the patient they must come back for an assessment. Although physicians can technically report the AWV or IPPE with CPT code 99483, it makes more sense to schedule a separate visit so the physician can block off more time (usually an hour) to perform all of the components of the code, she adds.

**Behavioral health integration (BHI)**
CPT CODE: 99484 ($48.65)
TYPE OF PATIENT: Patients with any mental, behavioral health, or psychiatric condition who may warrant this service
BILLING FREQUENCY: Per month
WHO CAN PROVIDE/BILL: Any physician or other qualified healthcare provider

**5 Cognitive impairment assessment**
CPT CODE: 99483 ($263.81)
TYPE OF PATIENT: Patients with cognitive impairment
BILLING FREQUENCY: Once every 180 days
WHO CAN PROVIDE/BILL: Any physician or other qualified healthcare provider

“It’s a lot more cost effective to be proactive rather than reactive. If you’re reactive—and the patient requires more intensive services during a particular month—you’re on the hook and don’t receive additional compensation.”

—TONI ELHOMS, CCS, CPC, CEO OF ALPHA CODING EXPERTS LLC, ORLANDO, FLA.
CODING INSIGHTS

Talk to your patients about screening v. monitoring diagnostic tests

Q Do you have any suggestions to minimize our biggest patient complaint: getting an unexpected charge when they think all tests performed that day are part of their physical?

A You are certainly not alone. An unexpected charge for a patient is the top complaint we hear from physician networks, groups and individual offices. Patients who come in for an annual physical exam often expect that all the labs ordered for the visit, or at the visit, will be considered preventive and paid in full by their insurer. Some patients are surprised to later receive a bill for a diagnostic service.

Some tests are considered preventive services, such as a screening colonoscopy or mammogram. However, lab tests ordered to monitor a patient’s existing condition are not considered screenings and instead are billed with the diagnosis code for the condition being monitored, for example hypertension or diabetes.

ICD-10-CM defines a screening as “the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram).”

Some screenings, such as screening for lipid disorders, have a specific ICD-10 code. Many of these are found in category Z13, “Encounter for screening for lipoid disorders.”

Let’s use hyperlipidemia as an example. For a patient with no known history of hyperlipidemia who is being screened for the disease, you would use diagnosis code Z13.220, “Encounter for screening for lipoid disorders.” For a patient already diagnosed with hyperlipidemia who is undergoing a lab test and being monitored or treated, you would use a code from category E78, “Disorders of lipoprotein metabolism and other lipidemias.”

The best way to counter—or at least minimize—a patient complaint in situations such as these is to talk clearly with your patients. A physician recently explained the difference between these types of services with the following analogy:

“When you take your car in for a tune-up (or patient physical), there are certain services that are included each time (the physical itself, anticipatory guidance and orders for screening tests). However, if you also need a nail removed from a tire (or a diagnostic test for known condition), this would be an additional charge.”

Consider this analogy next time you need to speak with your patients about what’s included with an annual exam, and what’s not.

Renee Dowling, CPC, is a billing and coding consultant with VEI Consulting in Indianapolis, Ind. Send your billing and coding questions to medec@mmhgroup.com.
Providing record access
Practices must adhere to all record requests—or face legal consequences

by KEITH LORIA Contributing author

Last year, St. Petersburg, Fla.-based Bayfront Health paid an $85,000 fine to the U.S. Department of Health and Human Services Office of Civil Rights for failing to provide a pregnant woman with a complete copy of her medical record—which included the fetal heart monitor records of her unborn child—within the 30 days required by HIPAA.

This is significant because it shined a light on an issue that many physicians aren’t aware: with limited exceptions, HIPAA gives patients the right to get copies of all of their medical records and allows them to see all original medical records, usually at a medical provider’s office.

Shuhan He, MD, an emergency medicine physician at Massachusetts General Hospital, says one of the most common misconceptions is that patients somehow are limited in obtaining their own medical records because of HIPAA.

“Many smaller practices actually use it as a way to prevent patients from accessing their own records for fear of mishandling data in some capacity,” he says. “What I always emphasize is that the legislation itself was called the Health Insurance Portability and Accountability Act. The rule actually encourages patients to access their own information and move it between practices, even if providers and healthcare entities are required to protect that information at a higher burden.”

Thus, patients are treated as the ultimate decision-makers regarding their data. That’s important, he notes, because data is often used for ad targeting, resold to other companies for email spam, and basically used as a treasure trove for companies to monetize.

As an example, Shuhan He says, if he were to see a patient with heart pain at 2 a.m. in the emergency department, and it was someone who was on vacation or whose doctor wasn’t immediately avail-
able, he would have to make assumptions about the person’s medical history based on just the acuity, because of his inability to obtain records quickly.

“If the patient had clearly documented medications and imaging history, and perhaps previous diagnoses, I’d love this information,” he says. “It helps me put the patient’s symptoms in context. But I don’t have time to request medical records in this situation, so I will be ordering much more diagnostic imaging and lab results to ensure I don’t miss any critical diagnosis.”

PROVIDING THE RECORDS

Anwar A. Jebran, MD, a third-year internal medicine resident at Weiss Memorial Hospital in Chicago, says providing access to records is necessary as it enables patients to make informed decisions, and every patient has a right to obtain their records in a timely manner.

“That’s why practices need to have a process in place,” he says. “There should be an efficient and simple process to provide records in a timely fashion, and quality improvement projects should be performed consistently to improve this process.”

Alam Hallan, RPh, CDE, director of pharmacy at Guelph General Hospital in Ontario, says access to records empowers patients and gets them more engaged in their health, improving patient satisfaction and reducing cost.

He suggests practices use systems that are compatible with interoperability standards such as HL7 FHIR, an interface for exchanging electronic health records, which would eliminate much of the manual workload associated with accessing records.

“For practices without that, having a system to handle these requests with posted timelines works well,” he says. “Corroborating information with the patient before adding it to their health records is also a good practice of verbally sharing the patient’s health records and then giving them the option of either giving them a copy or letting them manage their own documents.”

Dusty Hall, owner of Nab Life Health, an internal medicine clinic in Niceville, Fla., says patients at his clinic can fulfill medical record requests either by the patient completing a medical information form or providers sending a request to the office, typically via fax.

MGH’s Shuhan He says all patients should own their records and understand how to document and protect them as they would their critical legal documents.

“I encourage patients to take photos of their X-rays and take photos of printed versions of medical records at discharge,” he says. “If a patient requests it, I will print their medical record from the visit as well.”

MONEY MATTERS

The HIPAA Privacy Rule permits a covered entity to charge a reasonable, cost-based fee that covers certain limited labor, supply, and postage costs that may apply in providing an individual with a copy of medical records in the form and format requested or agreed to by the individual.

However, the laws for copying medical records vary from state to state in terms of fees. For instance, in Florida, searches for medical records are $1 per search per year, and $1 per printed page and $2 for microfilm.

“It gets more complicated when you cross state lines so our fail-proof policy is simply not to charge at all,” Hall says.

Healthcare systems often charge a fee for handling and time of administrators to prepare documents, which many doctors feel is totally reasonable because it does take time as a medical record can often be hundreds of pages long between physician notes, notes from nursing, pharmacy, radiology, lab values, EKG’s, and more.

Jebran says insurance should cover these fees as delaying or not accessing the records for financial reasons might harm the health and safety of the patient in the long run and might delay patient care.

The law is very clear. People have a right to their data. While it’s an important part of those in healthcare to make records easily accessible, this acknowledgement has taken time and new talent to come into the industry to see this viewpoint, Jebran says.
LEGALLY SPEAKING

Did I wrongfully terminate my employee?

In the wake of several years of highly publicized domestic abuse scandals, many employers are asking the same question: Can we fire an employee who has committed a crime, such as domestic violence?

Here’s a scenario: A physician has a 50-year-old staff person who has worked with him for 20 years. He knows her family and has spent time socially with both her and her family. She is under contract and can be terminated within 90 days for almost any non-discriminatory reason and immediately for “cause.”

Reasons for termination for cause include conviction of a crime, which is a common termination clause in almost all employment agreements.

Three months ago, the employee was arrested for brutally beating up her husband after finding out about his adulterous relationship with another woman. She threw a wine glass at him and shards of glass cut his neck in numerous places, resulting in extensive bleeding.

The employee was immediately arrested, despite arguing that her behavior was justified. The story ran in the local newspapers, and social media lit up with the employee’s actions. In every mention of the story, the physician was noted as being her employer.

Consequently, he was very concerned about the negative impact on his practice as he received word that patients were frightened and multiple appointments were canceled. The physician immediately terminated the employee, feeling justified by the impact her actions had on his reputation. The employee is now awaiting trial and has filed a lawsuit against the physician for wrongful termination.

There is no clear, correct response to such a complicated situation. However, there are several factors physicians should consider before taking any adverse employment actions against employees involved in domestic violence disputes.

The first is: Has the employee been convicted?

There’s a big difference between being arrested/charged and being convicted. Without a conviction, a physician could open himself to a wrongful termination suit if he or his employee were simply accused of or charged with domestic violence. The tricky part here, of course, is that most employers don’t undertake background checks on existing employees. Our physician only knew about his current employee because of the local press coverage.

The next question is whether employing the individual carries a current workplace risk — regardless of the publicity. The physician could open himself to a wrongful termination suit if he can’t tie the domestic violence incident directly to a specific workplace risk.

Termination of the employee becomes more difficult if the offender is a good performer, co-workers don’t feel at risk, and the employee’s spouse does not work in the office. Patients appointments is not enough to terminate the employee.

The situation might be different if the abuser is in the public spotlight, for example, as a face of the practice. That were the case, it becomes safer to let the employee go, particularly if the person is working under an agreement that includes strict prohibitions on offensive behavior. At that point, since the person’s actions are likely eroding your brand, it becomes easier to apply the “workplace risk test.” That is questionable with our physician’s scenario where an unknown employee has been accused of the crime.

This situation also would be different if a person convicted of domestic violence is in a position as a role model for other employees. Keeping this person could erode the reputation of the practice. That could be grounds for making the argument that the person poses a threat to your business.

In the end, despite the poor publicity this incident has brought to the practice and the potential for some financial loss if she stays employed, he would have been wise not to terminate her until — and if — she is convicted of domestic abuse.
Many patients find themselves with high deductible insurance plans leaving them on the hook for a larger percentage of the cost for their care.

These costs often create financial hardships for patients. Nearly 25 percent of Americans had trouble paying a recent medical bill, according to a 2016 survey by the Kaiser Family Foundation and the New York Times.

It doesn’t take a large medical bill to push a patient into debt, as the average unpaid medical debt recorded on credit reports is $579, according to a 2014 report from the Consumer Financial Protection Bureau. The same report found that 54 percent of patients with medical debt have no other debts listed on their credit reports.

This can create difficult problems for physicians, who try to ensure their patients are receiving the care they need while also trying to fund their practices.

Sterling Ransone, MD, a family physician in Sterling, Virginia, says that these high-deductible insurance plans are saving people money in the short-term, but are leading to unexpected consequences.

“We are seeing a lot of people not coming in, and we’re seeing people delay care because their deductibles are so high, they feel like they can’t afford to come,” he says. “I’ve had a couple of folks where basically their families drag them down here because they were looking ill, and they really didn’t want to come in because they were worried about their copay.”

Waiting to receive care can lead to greater health issues which can increase the cost for patients further, Ransone says.
According to the Kaiser and New York Times survey, 32 percent of adults between the ages of 18 and 64 have postponed getting needed care due to the cost and 40 percent said they have relied on home remedies and over-the-counter drugs.

**BEFORE THE PATIENT GETS IN THE OFFICE**

Windel Stracener, MD, runs a family practice in Richmond, Indiana, at the Wayne County Community Health Center. He said a large barrier to care in his practice is just tracking what is covered for each patient in the ever-changing insurance marketplace.

“So, we have to change what we do from day to day, just based on whether people have the same coverage they had when you saw them four days ago,” he says.

There are staff members at the center who focus on tracking these changes and ensuring that the physicians don’t make financially devastating healthcare decisions for their patients, according to Stracener.

This strategy can avoid some medical bills that can lead to debt.

Andrew Hajde, a healthcare industry adviser and assistant director of association content for the Medical Group Management Association, recommends using technology before the patient arrives for their appointment to see what they will have to pay.

“Engage with that patient, either with your front office staff or with some sort of a financial counselor in the office, so they understand that they’re going to be paying a portion of their bills and what that means to them,” he says.

**COMMUNICATION IS KEY**

Hajde says that making patients aware of their payment obligations is an important component in receiving compensation for care before a practice has to send it to a collections agency.

“I think some practices get themselves in trouble because they don’t do that up front, customer service and communication,” he says. “And they let patients continue to be seen indefinitely without paying and then they rack up large balances. It’s more about prevention instead of trying to fix it after the fact.”

He says customer service can give a patient a feeling that the practice cares about them.

“I think it’s critical that throughout the process all the way from when the patient walks through the door the first time, through when their claim’s paid, that whoever is in charge of the billing department for that practice is in constant communication with the patient to about their balances and continuing that relationship with a positive interaction with that patient,” Hajde says.

“We are seeing a lot of people not coming in, and we’re seeing people delay care because their deductibles are so high, they feel like they can’t afford to come.”

—STERLING RANSONE, MD, A FAMILY PHYSICIAN IN STERLING, VIRGINIA

**COST TRANSPARENCY**

Patients are hungry to know what their care will cost them so they can make informed decisions about care providers, according to a September 2019 survey from United Health Group.

Ransone says that when a patient comes in, he discusses the cost of various services with them. “I’ll say, ‘Well, this is what I think you need,’ and I’ll tell them what the cost is at the point of care,” he says. “And we try to update that fairly frequently. So, we try to be pretty upfront about that.”

Hajde says this transparency is very important in practices that offer more expensive services.

“So that’s where really having that transparency and upfront kind of conversation about fees and patient balances is critical,” Hajde says. “Nobody likes any surprises as it relates to out of network or anything else. So, they want to have con-
stracener says patients with high-deductible insurance policies tend to be the ones asking in advance how much a healthcare procedure will cost, and his practice will work with those who can find their care in another location for less. his practice will help the patient shop around for better prices on care, and will help make arrangements for that care with another physician if necessary.

another option available to patients is the "hospital compare" section of the medicare.gov website which offers patients a comparison of hospitals in their area. it also includes information about how prices compare with national averages.

payment plans
another useful strategy is to set up a payment plan with the patient that would allow them to pay their balance over time rather than all at once.

hajde recommends setting up a plan within the practice if possible, but a practice should be willing to work with a third-party company if the cost is high.

"if we’re just talking about a smaller balance, … offering a payment plan through the practice where they pay on that to the practice over a period of six to 12 months, i would say is a lot more appealing to patients versus them trying to get approval for credit and other things," he says.

to set up a payment plan, hajde recommends:

• setting up a notification in the ehr reminding the practice when payments are due
• generating electronic or print statements for the patient
• having a staff member call those who fall behind on payments in order to find a way to get payments flowing once again

third party companies should be used for procedures that likely won’t be covered by insurance, like cosmetic surgery, according to hajde.

"so, let’s say somebody is going to pursue having bariatric surgery or something like that, it’s going to be several thousand dollars or more for them to pay," he says.

"i think that’s an example where something like credit company that works with healthcare would be super beneficial for patients because they can pay on something like that over time."

even with these plans in place, though, there’s still the chance the practice won’t get paid. stracener says, "and there are times where you just have to look at things and realize that your patient can’t pay, and you have to let it go," he says. "what we try to do is work things out and make decisions based so that everybody feels good about what happened."

when to send bills to collections and what to expect if you do

before sending a medical bill to collections, it’s best to exhaust all other options. but sometimes that just isn’t going to happen and a collections agency may be
the spark which can get a patient paying again, Stracener says.

He says his practice sends the patient three or four statements and will make an equal number of phone calls, and if they are not answered and payment doesn’t resume the bill is then sent to collections.

Stracener says this is often enough to get the patient paying again.

Sending a bill to collections, though, is not a panacea. Hajde says that when a bill is sent to collections the amount that can be recovered has already been reduced.

"By that point, the practice has already lost a lot of money if they didn’t engage the patient early and make sure that they work with them on paying their bills up front or as early as possible," he says.

He says that the cost of sending a bill to a collections agency is already cutting into the amount that can be collected, while Crowe LLP, a public accounting and technology accounting firm, found in 2017 that the average collections on hospital inpatient accounts is 10.9 percent, while outpatient accounts average 18.2 percent.

Sending a bill to collections, or filing a civil lawsuit can also backfire on the practice by leading to negative publicity. For example, the University of Virginia came under fire in September 2019 for suing 36,000 patients over a six-year period in an effort to collect on more than $106 million in unpaid bills.

Ransone said this has tarnished the hospital’s image. “It’s really tough because it’s horrible optics there,” he says. “So, they’ve got a lot of issues that they’re going to have to work through to try to figure out how to go about doing it.”

Stracener says his philosophy is that by the time a bill must be sent to collections he assumes he’s not going to receive any of it. “So, anything that we get is a bonus,” he says.

“There are times where you just have to look at things and realize that your patient can’t pay, and you have to let it go. What we try to do is work things out and make decisions based so that everybody feels good about what happened.”

— WINDEL STRACENER, MD, RUNS A FAMILY PRACTICE IN RICHMOND, INDIANA

"When you are a physician you sometimes feel, when it comes to money, you're in a no-win position," Stracener continues. "And I think that you try very hard to balance that with the financial needs of the practice with the social needs of the community and the medical needs of the community, and just try to do what’s right for the right reason.

— WINDEL STRACENER, MD, RUNS A FAMILY PRACTICE IN RICHMOND, INDIANA

Using up most of or all of their savings...
When the patient wants to be the doctor

When’s the last time a patient told you how to practice medicine? Odds are it has happened in the past week. With increasing frequency, patients arrive at their physicians’ office demanding a specific test or treatment.

You shouldn’t always honor your patients’ wishes, but you do need to know how to respond to common situations in a respectful but firm way that emphasizes what’s best for patients. Here are four principal drivers of patient-driven healthcare:

1. The Internet – There seem to be no limitations to the medical advice patients digest on the internet.
2. The Media – Reports of a medical study or a celebrity’s novel cure will generate a sudden spike in patient interest.
3. Direct-to-consumer advertising – Big pharma hopes to have patients tell you what medication to prescribe.
4. Alternative Healthcare – In many markets, providers of alternative healthcare are referring patients to primary care physicians for specific tests or therapies.

When in these situations, you must determine whether the requested test or therapy is indicated by the standard of care for a reasonable physician. In other words, would a reasonable physician prescribe the course of care sought by the patient? If the answer is no, then you should not acquiesce to the patient’s demands.

When a patient requests a specific test or treatment, such as a particular name brand medication, you are obligated to inform the patient of your best medical judgment. If you routinely prescribe the drug and it is the best clinical choice, then there should be no problem. If you do not routinely prescribe the drug or it is not the appropriate clinical choice, then you should advise the patient.

Again, the determination for how to proceed hinges on what a reasonable physician would prescribe under the circumstances.

Rodney K. Adams, JD, has a joint appointment at the University of Richmond Law School and Virginia Commonwealth University, Dept. of Health Administration.

How healthcare will change in 2020

A look at seven things that will impact physicians this year

by KEITH LORIA  Contributing author

With an election year just about upon us, there are a number of changes coming from the current administration that are going to impact healthcare in 2020. Changes in allowable benefits, home health, hospice carve-ins, and new CPT codes for remote home monitoring are just a sample of these.

There are an additional set of fundamental changes coming from the administration affecting clinicians related to payment models. For example, earlier this year, CMS announced five new primary care payment models designed to incentivize the entire healthcare system to transition to value-based care, especially for patients with complex, chronic, and high-need conditions.

Here are eight policy changes that could make a huge impact in 2020.

1 **Medicare for All is front and center**

Michael Abrams, managing partner of the global healthcare consulting firm Numerof & Associates, a global healthcare consulting firm based in St. Louis, says there will be no ignoring Medicare for All in 2020.

“It’s already a hot policy topic among presidential candidates, and I suspect the debate around its potential pros and cons will only continue to intensify; some arguing that the significant expansion of healthcare coverage is worth the incredibly expensive price tag, and others arguing there’s no way today’s providers will be able to respond to its ramifications,” he says.

2 **Stark Law changes are coming**

Emily Felder, senior policy advisor and counsel with D.C.-based Brownstein Hyatt Farber Schreck, a lobbying firm specializing in healthcare, notes HHS is
rewriting the rules for the Stark Law, or physician self-referral, and will issue a proposed rule later this year. That will set up 2020 as the year to debate the proposed changes and a broader discussion about the role of Stark.

CMS Administrator Seema Verma has called Stark “outdated” and said while it makes sense in a fee-for-service (FFS) system to prevent inappropriate financial incentives, it doesn’t apply the same way to value-based systems.

“Changes to Stark will be largely positive for two reasons,” Felder says. “One, the administration is aware that the 30-year-old law needs to be updated and adapted for today’s evolving system, and two, there is commitment and action to make it reflect the intent of the law. The administration sees these changes as part of the larger ‘Regulatory Sprint to Coordinated Care.’”

The demand for price transparency

John Nicolaou, healthcare expert at PA Consulting, a global healthcare consultancy with U.S. offices in New York, says the price transparency regulation proposal, started by executive order earlier in the year, and now part of a CMS proposed rulemaking, is currently in comment period.

“This would require hospitals to publish gross and negotiated rates for services in an accessible format, including commonly used ‘bundles’ of services,” he says.

Robbie Hughes, founder and CEO of Lumeon, a digital health company leveraging Care Pathway Management, based in Boston, expects that heading into 2020 there will be more movement around Trump’s order on price transparency, aimed at lowering rising costs of care by showing prices upfront to patients.

“The executive order describes the concept of price transparency as the means to creating a ‘shoppable’ experience—the idea that there could be packages of care at understandable, logical prices,” he says. “Not only will this force providers to package their care into ‘shoppable’ products for consumers, but it will also ultimately drive down prices through market forces.”

The ideas in this executive order will likely be reflected in a bigger policy package that will need bipartisan support and approval from both houses in Congress.

“Nobody will disagree on making it easier and more affordable for Americans to consume healthcare,” Hughes says. “The challenge I anticipate we’ll see is around industry agreement on an approach that ensures the consumer sees the benefit of reduced healthcare costs.”

International reference pricing for therapies paid for by Medicare

Both political parties have proposed plans that involve some form of reference pricing, and a recently released study by the Senate Ways and Means Committee found some therapies may cost fourfold more in the United States than other comparator countries.

Meg Alexander, managing director, reputation and risk management practice for Syneos Health, a healthcare research organization based in Morrisville, North Carolina, says some reference pricing proposals, such as the version posed by the administration, may enable payers to more closely “manage” certain drug categories. However, reference pricing could also deliver several un-intended consequences that may have the opposite effect of making drugs affordable and accessible for Americans.

“For example, some reference pricing proposals involve vendor ‘middle men’ for drug management, increased payer management strategies, and could involve a flat physician administration fee for therapies offered under Medicare Part B,” she says. “This may translate into fewer physicians offering such therapies due to administrative and

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— MICHAEL ABRAMS, MANAGING PARTNER, NUMEROF & ASSOCIATES

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— MICHAEL ABRAMS, MANAGING PARTNER, NUMEROF & ASSOCIATES
reimbursement hassles; thereby leading to American patients potentially struggling to find doctors to administer the medicines they need.”

5 The rising cost of insulin
Sami Inkinen, CEO and founder of Virta Health, a San Francisco-based health tech company specializing in type 2 diabetes reversal through nutritional intervention, believes in 2020, there will be policy changes roll out to help address the rising cost of insulin, which the FDA Commissioner Scott Gottlieb, MD, has called unacceptably high for a decades-old drug.

“Insulins are biologic drugs, and they will be regulated as such for the first time in 2020. The transition will spur generic competition in the insulin market and impact costs,” Inkinen says. “The shift has been long planned, but it comes amid growing public outrage and media stories focused on patients having to ration their insulin, travel abroad to buy cheaper insulin, and make choices between buying insulin or putting food on the table.”

6 Pushing for interoperability
HHS is aggressively pushing forward with new requirements to hasten the adoption of interoperable electronic health records and utilizing brand new legal authorities to do so. In its February 2019 Interoperability and Patient Access proposed rule, CMS requires all Medicare, Medicaid, and federal exchange plans to share claims data information electronically with enrollees.

“While this is an important policy objective to further the administration’s goal of giving patients access and control over their own data, it could create a burden for plans to operationalize this new rule and ensure it complies with data safety standards,” Felder says. “This rule is set to be finalized by the end of the year, and plans will be charged with implementing it in 2020.”

7 Lowering drug prices
Lee Barrett, executive director and CEO of Electronic Healthcare Network Accreditation Commission, the nonprofit standards development and healthcare accreditation company, says to the extent to which managed care companies manage drugs, as well as other healthcare service delivery, the current focus on bringing drug costs under control is relevant.

“Nobody will disagree on making it easier and more affordable for Americans to consume healthcare. The challenge I anticipate we’ll see is around industry agreement on an approach that ensures the consumer sees the benefit of reduced healthcare costs.”

— ROBBIE HUGHES, LUMEON

House Speaker Nancy Pelosi’s bill to lower prescription drug prices would save Medicare $345 billion over 10 years, according to a preliminary analysis from the nonpartisan Congressional Budget Office.

The main thrust of the plan would allow Medicare to negotiate lower prices on up to 250 of the most expensive drugs—including insulin—per year and apply those discounts to private health plans.

“If Medicare were to move in the direction of the Pelosi proposal, in which drug prices would be indexed against foreign prices and the government would negotiate prices downward, we would expect that drug prices in the commercial market would fall as well,” Barrett says. “While a political agreement on an approach to lowering drug prices will be difficult, we think there is a reasonable chance that drug manufacturers and PBMs [pharmacy benefit managers] will be squeezed considerably in 2020, and managed care organizations, like other payers/controllers of care, should benefit.”

This past summer, the Trump administration dropped the proposed drug rebate rule aimed at PBMs, then introduced a plan to import drugs from Canada. As the public is still searching for a solution, 2020 will undoubtedly see more discussions about how to reel in drug prices.
“Dr. M is terrifying.” I was less than two weeks into my intern year, clutching the lapels of my white coat like my program director might rip it from me at any moment and banish me back to medical school. I didn’t think I could get any more terrified, and yet, I did at the brief words of my seniors. Without ever having met her, I was terrified. I had managed to avoid her during my weeks on the inpatient gynecology service, but had no such luck on call. My chief that day saw the tightness of my morning smile, patted me comforting on the back, and then sent me upstairs with her to postpartum rounds.

Dr. M has closely cropped black hair, neatly kept dark nail polish, and a line of silver earrings up the shell of her ears. When she looks at you, you’re a butterfly pinned under bright lights, and she definitely knows that you spent your free hour yesterday evening watching Netflix instead of reading that week’s journal club article on the use of mifepristone for induction of labor. When we got to the door of our first patient, I started with, “So, um, this lady…” and then meandered, focusing all of my strength on simultaneously not stuttering and not forgetting who this patient was out of the fifteen I had seen this morning.

Dr. M quickly put me out of my misery. “Tracy, how are you structuring your presentations?” My terror rapidly peaked. She waved aside my jumbled answer. “Start with the subjective and the patient’s history. Then vitals, exam, labs, imaging. Your assessment and plan. When you do it the same way every time, you’re less likely to forget anything. Okay? Now start over.” That day, postpartum rounds must have taken three times as long as it usually did, but by the end, I was presenting the same way every time.

Subjective. History. Vitals. Exam. Labs. Imaging. My assessment and plan. It became my mantra as I weaved around OR carts to present a new finding from a patient on the floor to my chief wedged next to the attending during a vaginal hysterec-
tomy, as I tapped my foot waiting for an elevator up from the emergency department, as I typed up my fifth history and physical from triage on labor and delivery. Do things the same way each time, and you’ll be less likely to forget anything.

As I’ve gotten farther along in residency, the pace has only picked up and the patients have only gotten more complex. The amount of detail I’m liable to forget has only accumulated. OB/GYN is unique in the vastness of our field; we are the van-
guard of women’s medicine and women’s surgery, despite receiving less surgical experience than any of our surgical counterparts and having to master the field of obstetrics in addition to women’s primary care.

Little wonder that talks about splitting the residency back into obstetrics and gynecology, extending the residency beyond four years, and general hand-wringing about the number of residents that graduate feeling that they are ill-equipped to prac-
tice, have become more than a rumble in the field.

As a new third-year resident, I’m no stranger to the feeling of opening up a patient’s chart after an extensive tumor debulking for ovarian cancer and being crushed by the anxiety of, “How am I possibly going to take care of her?”
Whenever I get overwhelmed, I go back to the basics. I talk to the patient. I review their history. I look at their vitals, their incisions, and touch their abdomen. I check that their labs are up to date, and that the final read from the radiologist is in for all their imaging.

I form my assessment and plan, and if I’m stumped, I ask my chief (right now I’m steadfastly ignoring the question of what I’m going to do when I’m the chief). This rigorous approach to organizing how I think about patients and how I present these patients to others has grounded me during times of panic. I know that as long as I do things the same way every time, I’m less likely to forget things and more likely to be a better doctor.

On one of my calls halfway through my second year as a resident, as my chief was joking that I might as well be a third-year resident now, I got a call from the ED that one of our GYN oncology patients had arrived for us to see. She was a lovely, sweet lady, who was a few months postoperative from a hysterectomy; she had called in earlier because when she went to the bathroom that morning, she felt like something had “fallen out of her vagina.”

Just yesterday, she had gone to a local tulip festival and had done a fair bit of walking. She wondered if that was what was causing her problem today.

Her problem was a vaginal cuff dehiscence. As I slowly withdrew my gloved hand after her pelvic exam, my stomach having plummeted off the cliff as soon as my index finger ran over the stitch at the edge of her cuff, I said weakly to the ED nurse next to me, “Can we get her in some Trendelenburg position please.”

Subjective. History. Vitals. Exam. Labs. Imaging. My assessment and plan. I repeated those words to myself through the panic ringing in my ears. That mantra steadied my voice as I systematically laid out her story to my attending over the phone, as I texted my chief to let her know about my add-on case, and as I communicated to the patient that she was not likely to be leaving the hospital that night. I was absolutely terrified, but because I stuck to the basics, because Dr. M made sure I knew them well, the patient got the care she needed in a timely fashion.

I’m terrified of fewer things now. Every summer that rolls by, I’m reminded of how much less as I look into my new intern’s eyes as they bravely fight against the urge to hyperventilate. After we settle them down with the note templates they need for labor and delivery and where all the bathrooms are located, talk turns to their new co-residents and attendings. We try not to sugarcoat it.

“Dr. M is terrifying,” I say. “But she’s the reason I’m a better doctor.”

Tracy Chen, MD, is currently a third-year OB/GYN resident at Thomas Jefferson University Hospital in Philadelphia, Pennsylvania. She graduated from medical school and undergraduate university at the University of Buffalo, and wants to thank everyone in the residency program for having hearts just as warm as Buffalo winters are cold.
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. Physicians struggle with fragmented systems that require separate log-ins, and many of the processes are simply not clinically useful.

by JAY HAUGHTON Contributing author
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 how the software is used.
- 92 percent of clinicians say lengthy prior authorization protocols have impeded timely patient access to care and harmed 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 the specific EHR does offer such population health management capabilities, it again requires excessive amounts of manual data access and manipulation, leading to time wasted and higher costs.

With the introduction of Medicare Access and CHIP Reauthorization Act (MACRA) and the 2015 Merit-based Incentive Payment System (MIPS), along with APMs, providers are being reimbursed by performance versus 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.

Jay Haughton, RN, BBA, is a Clinical Solutions Consultant for DSS Inc.

The four promises of next generation EHRs

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 empowers 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 advancements in healthcare information technology.

**Technology**
Leverage the latest technology for a scalable and portable solution that meets doctor and patient needs today, while avoiding vendor lock and enabling constant improvements. Solutions 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, and it doesn’t have to be this 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.
The EHR-friendly way to boost collection results

On average, multi-physician practices pay between $180,000 and $200,000 for their electronic health record system (EHR)—a significant and crucial investment.

An EHR is often the beating heart of a health-care organization, housing all operations, patient services, and information as well as powering the revenue cycle. Modern EHRs have propelled physician practices into the future and revolutionized the way providers manage their businesses. However, a gap exists within many EHR platforms that can seriously impact profitability.

Modern EHR platforms can handle all clinical aspects of the revenue cycle with ease, but they lack visibility into the back end of the revenue cycle. Agent performance problems that go undetected and untreated include everything from long hold times and too much time off the phones to procedural mistakes and missed opportunities to discuss high-priority claims.

Moments like these are costly for providers, and they add up to big losses over time.

New tools have been created to seamlessly integrate with existing EHRs and offer the missing capabilities providers need to optimize their revenue cycle.

Let’s take a look at these capabilities and how they enhance EHR value.

Increase efficiency through automation

Many collection agents spend their days manually searching for the status of claims and then making calls (typically, with long hold times). It’s an inefficient, tedious process that wastes time agents should be spending on higher-value accounts.

By automating routine tasks, navigating IVRs to minimize hold times, and helping agents prioritize account work, modern receivables systems put time back in agents’ hands. Claim statuses, for example, are automatically obtained through payer websites and updated in the EHR; from there, the system handles any follow-ups and routes denials and other specific statuses to actionable pools. All of this happens without any agent involvement.

Measure and manage agent performance

When it comes to lowering operating costs and increasing revenue recovery, the ability to measure, track, and manage agents’ performance is a considerable advantage for providers.

By filling the EHR gap, providers enjoy the benefits of a steady stream of real-time data from the front line. How much time are agents spending on low-value accounts? How productive are they working on site versus remotely? How many accounts are being checked with the payer during one phone conversation?

Valuable real-time insights like these can help bring focus to mismanaged workflows, and team leaders can use the data (which feed directly into an automated QA program) to help agents maximize their time and address larger performance trends—regardless of where agents are based.

By introducing a tool that’s designed to bring accountability to A/R and seamlessly integrates with an existing EHR, providers can simultaneously improve efficiency, boost revenue recovery, and increase overall employee engagement and retention. In an era of shrinking provider margins, these are the keys to a more efficient, profitable collections operation and a stronger, more competitive enterprise.

Shawn Yates is director of product management for healthcare at Ontario Systems. Send your technology questions to medec@mmhgroup.com.
4 WAYS TO START IMMEDIATELY INCREASING REVENUE

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- Medicare mandates yearly cognitive assessment
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- Reimburses using 6 CPT codes, National Average = $750 - $1000 per test
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- Easy to understand biomarkers facilitate more informed medical interventions, such as biofeedback.

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- Provides a 1 page summary report
- Assesses peripheral nerve health (c-fiber function) and asymmetry between each hand and foot
- Reimburses $130/test (national average)

ALLERGY TESTING
- Turn Key, comprehensive system
- 80-panel test, NO HIGH RISK (shellfish/peanuts/berries)
- 2 Minutes to apply, 15 minutes to show results
- Reimburses average $270 - $350/test, costs ~ $100/test (antigens/applications)
- Options for Immunotherapy Treatment

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— Mark J. Nelson, MD
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Physicians fighting burnout

Burnout has become as much a part of medicine as the stethoscope, with too many doctors feeling overworked, over-regulated, and underappreciated. The result is physicians retiring early, changing careers, or losing their love of medicine at a time when there is already a shortage of primary care physicians.

In the next issue, we share the stories of seven health professionals and what they are doing to battle burnout in their careers and the profession.

“A hacker logged into my fitness tracker and stole all my steps!”