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How we can stop America’s silent killer

If four jumbo jets filled with passengers crashed every day for a year, killing everyone on board, wouldn’t we mobilize as a community and do something about it? That’s the same amount of people who die annually from heart disease. Over 80 percent of these deaths can be prevented, but despite having the tools to avert this hypothetical crash, our patients continue to board the plane.

Heart disease is the underlying cause of one in three U.S. deaths and kills more Americans a year than all forms of cancer combined—and yet people still fear cancer more. The healthcare community has made significant strides in raising awareness of heart disease and cholesterol, but a recent survey conducted by MDVIP and Ipsos found that Americans still need help digesting the information and understanding their personal risk.

So how can we, as medical professionals, support our patients?

**DISPEL HEART DISEASE MYTHS**

One reason we continue to see cardiovascular events is that we focus on improving our patients’ low-density lipoprotein (LDL) levels, often skimming over other important factors such as saturated fats and inflammation.

According to the survey, more than half of Americans believe that people with heart disease should eat as little fat as possible—they don’t understand that unsaturated fats can actually help reduce their risk. In addition, three-quarters of Americans don’t know that most heart attacks occur in people with normal cholesterol levels, and only 35 percent are aware that inflammation is the trigger for most heart attacks. So not only do we need to dispel the misconception that cholesterol is the best indicator for heart disease risk, we also need more education about inflammation.

**KEEP PATIENTS UP-TO-DATE ON SCREENINGS**

Offering more comprehensive heart screenings and speaking with patients about their personal risk is the first step in heart attack prevention. According to the survey, only 14 percent of Americans had their inflammatory markers checked within the last year, while 54 percent have had their cholesterol levels checked. In addition, doctors should consider ordering a patient’s bloodwork in advance of his or her appointment, so they can review the results face-to-face with the patient and answer any questions the patient may have.

**CREATE PLANS FOR A HEALTHIER LIFESTYLE**

More research has found that heart disease can affect anyone at any age. Lifestyle changes, including diet, exercise, sleep, and stress management can make a significant difference in preventing and even reversing heart disease. Therefore, we need to help our patients create a lifestyle plan for optimizing their heart health—and this includes our younger patients, since the decisions they make in their 20s and 30s will affect them decades later.

Andrea Klemes, DO, FACE, is chief medical officer for MDVIP.
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Answers to physician’s coding questions

Importing drugs
Can physicians import prescription drugs for patients?

A staffing crisis
How to keep your practice functioning when short staffed

Reducing readmissions
How some hospitals are turning to analytics to help patients

Telemedicine opportunity
New rule opens reimbursement door for Medicare Advantage

Reduce no-shows
Three tips fill your schedule even when patients don’t show up

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SMARTER BUSINESS. BETTER PATIENT CARE.

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MedicalEconomics.com
Physician-run podcasts: Behind the scenes

Several physicians are hosting podcasts, a relatively new type of media program that is growing in popularity. Podcasts are radio shows, usually accessed by subscription or through media applications, which feature programs on a number of topics. Interviews, instructional segments, and in-depth documentaries are among the varied types of programs available on podcast channels.

Ni-Daako Darko, DO, a trauma surgeon in Altoona, Pa., runs the popular Docs Outside the Box podcast. He features interviews with physicians who have explored their talents in unexpected ways, such as writing for television. He was inspired to start the podcast because he felt that, as a doctor, he was not in complete control over his life and he had not explored other talents he knew he had. “I was in a box, so, I got a microphone, connected it to my laptop and created Docs Outside the Box,” Darko says. He explains that he went through a good deal of trial and error when he started. “There were great podcasts and some pretty bad podcasts out there. With that in mind, I figured there was room for me to make a bunch of mistakes,” he says.

Carrie Reynolds, MD, a pediatric gastroenterologist in Denver, Colo., runs the Hippocratic Hustle, a well-known podcast. Originally, she started the Hippocratic Hustle podcast to share the stories of women physicians who were practicing their careers creatively. She noticed that these stories had an overarching theme. “My guests had found freedom, and were practicing their pursuits creatively,” Reynolds says. And this inspired her to use the podcast as mission to help women physicians achieve financial independence (FI). “The FI message is important, because it gives us freedom to choose our lifestyle and work environment,” she says. Reynolds learned how to build her podcast by listening to podcasts about podcasting, and she noted that one of them in particular, Audacity to Podcast, was the most helpful. She now participates in a mastermind group run by Elsie Escobar, one of the founders of ShePodcasts, a Facebook group for women podcasters.

“Primary care physicians are trapped in a non-sustainable business model forcing them to see too many patients per day—all while reeling under the constraints of government and insurer rules, regulations, and responsibilities that take time away from patients. There is no time for developing a close trusting relationship so critical to effective care.”

—Stephen C. Schimpff, MD, on why primary care physicians should consider direct primary care

“There’s no need to ever feel stuck in a suboptimal situation. Every healthcare facility has pros and cons—but doctors who choose to spread their wings can make sure to get the best possible deal.”

—Suneel Dhand, MD, on how doctors can get off the corporate treadmill

INFLUENZA

- Flu season less severe than last
- Early oseltamivir treatment associated with 30 percent decrease in mortality for some flu strains
- Could a probiotic help prevent the flu?

For more, visit bit.ly/ME-influenza

MORE ONLINE To read more, visit bit.ly/physician-run-podcasts

Ten wearable devices physicians should watch for

As more apps come to market, wearable users look for more sophisticated devices. Here are 10 of them.

To view, visit bit.ly/10-wearable-devices

Slideshow spotlight

MedicalEconomics.com
Primary end point: A1C change from baseline at week 26

<table>
<thead>
<tr>
<th></th>
<th>Placebo</th>
<th>STEGLATRO 5 mg</th>
<th>STEGLATRO 15 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>N mean change</td>
<td>–0.2</td>
<td>–0.7</td>
<td>–0.8</td>
</tr>
<tr>
<td>from baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N=152; BL=8.0%  N=155; BL=8.1%  N=152; BL=8.0%

DIFFERENCE FROM PLACEBO, %  –0.5 (P<0.001)  –0.6 (P<0.001)

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

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

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

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

SELECTED SAFETY INFORMATION

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

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

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

Additional Selected Safety Information on next page.
Choose STEGLATRO™ (ertugliflozin) for appropriate adults with type 2 diabetes

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

SELECTED SAFETY INFORMATION (continued)

Acute Kidney Injury and Impairment in Renal Function: STEGLATRO causes intravascular volume contraction and can cause renal impairment. There have been postmarketing reports of acute kidney injury, some requiring hospitalization and dialysis, in patients receiving SGLT2 inhibitors. Before initiating STEGLATRO, consider factors that may predispose patients to acute kidney injury. Consider temporarily discontinuing STEGLATRO in any setting of reduced oral intake or fluid losses; monitor patients for signs and symptoms of acute kidney injury. If acute kidney injury occurs, discontinue STEGLATRO promptly and institute treatment. STEGLATRO increases serum creatinine and decreases eGFR. Patients with moderate renal impairment (eGFR 30 to less than 60 mL/min/1.73 m²) may be more susceptible to these changes. Renal function abnormalities can occur after initiating STEGLATRO. Renal function should be evaluated prior to initiating STEGLATRO and periodically thereafter. Use of STEGLATRO is not recommended when eGFR is persistently between 30 and less than 60 mL/min/1.73 m² and is contraindicated in patients with an eGFR less than 30 mL/min/1.73 m².

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

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

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

Necrotizing Fasciitis of the Perineum (Fournier’s Gangrene): A rare but serious and lifethreatening necrotizing infection requiring urgent surgical intervention has been reported in postmarketing surveillance in females and males with diabetes mellitus receiving SGLT2 inhibitors. Serious outcomes have included hospitalization, multiple surgeries, and death. Patients treated with STEGLATRO presenting with pain or tenderness, erythema, or swelling in the genital or perineal area, along with fever or malaise, should be assessed for necrotizing fasciitis. If suspected, start treatment immediately with broad-spectrum antibiotics and, if necessary, surgical debridement. Discontinue STEGLATRO, closely monitor blood glucose levels, and provide appropriate alternative therapy for glycemic control.

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

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

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

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

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

STEGLATRO™ (ertugliflozin) 5 mg, 15 mg tablets

INDICATIONS AND USAGE

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

Limitations of Use

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

DOSEAGE AND ADMINISTRATION

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

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

CONTRAINdications

• Severe renal impairment, end-stage renal disease (ESRD), or dialysis (see Warnings and Precautions and Use in Specific Populations).

• History of a serious hypersensitivity reaction to STEGLATRO.

WARNINGS AND PRECAUTIONS

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

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

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

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

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

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

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

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

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

Lower Limb Amputation. An increased risk for lower limb amputation (primarily of the toe) has been observed in clinical studies with another SGLT2 inhibitor. Across seven Phase 3 clinical trials in the STEGLATRO development program, non-traumatic lower limb amputations were reported in 1.0% patient in the comparator group, 3.0% patients in the STEGLATRO 5 mg group, and 8.0% patients in the STEGLATRO 15 mg group. A causal association between STEGLATRO and lower limb amputation has not been definitively established.

Before initiating STEGLATRO, consider factors in the patient history that may predispose them to the need for amputations, such as a history of prior amputation, peripheral vascular disease, neuropathy and diabetic foot ulcers. Counsel patients about the importance of routine preventative foot care.

Monitor patients receiving STEGLATRO for signs and symptoms of infection (including osteomyelitis), new pain or tenderness, sores or ulcers involving the lower limbs, and discontinue STEGLATRO if these complications occur.

Hypoglycemia with Concomitant Use with Insulin and Insulin Secretagogues.

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

Necrotizing Fasciitis of the Perineum (Fournier’s Gangrene).

Reports of necrotizing fasciitis of the perineum (Fournier’s gangrene), a rare but serious and life-threatening necrotizing infection requiring urgent surgical intervention, have been identified in postmarketing surveillance in patients with diabetes mellitus receiving SGLT2 inhibitors. Cases have been reported in females and males. Serious outcomes have included hospitalization, multiple surgeries, and death.

Patients treated with STEGLATRO presenting with pain or tenderness, erythema, or swelling in the genital or perineal area, along with fever or malaise, should be assessed for necrotizing fasciitis. If suspected, urgent treatment immediately with broad-spectrum antibiotics and, if necessary, surgical debridement. Discontinue STEGLATRO, closely monitor blood glucose levels, and provide appropriate alternative therapy for glycemic control.

Genital Mycotic Infections.

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

Increases in Low-Density Lipoprotein Cholesterol (LDL-C).

Dose-related increases in LDL-C can occur with STEGLATRO (see Adverse Reactions). Therefore, consider alternative therapy for glycemic control.

Macrovascular Outcomes.

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

ADVERSE REACTIONS

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

Pool of Placebo-Controlled Trials Evaluating STEGLATRO 5 and 15 mg. The data in Table 1 are derived from a pool of three 26-week, placebo-controlled trials. STEGLATRO was used as monotherapy in one trial and as add-on therapy in two trials. These data reflect exposure of 1,029 patients to STEGLATRO with a mean exposure duration of approximately 25 weeks. Patients received STEGLATRO 5 mg (N=519), STEGLATRO 15 mg (N=510), or placebo (N=515) once daily. The mean age of the population was 57 years and 2% were older than 75 years of age. Fifty-three percent (53%) of the population was male and 73% were Caucasian, 15% were Asian, and 7% were Black or African American. At baseline the population had diabetes for an average of 7.5 years, had a mean HbA1c of 8.1%, and 19.4% had established microvascular complications of diabetes. Baseline renal function (mean eGFR 88.9 mL/min/1.73 m²) was normal or mildly impaired in 97% of patients and moderately impaired in 3% of patients.
Table 1 shows common adverse reactions associated with the use of STEGLATRO™ (ertugliflozin). These adverse reactions were not present at baseline, occurred more commonly on STEGLATRO than on placebo, and occurred in at least 2% of patients treated with either STEGLATRO 5 mg or STEGLATRO 15 mg.

### Table 1: Adverse Reactions Reported in ≥2% of Patients with Type 2 Diabetes Mellitus Treated with STEGLATRO® and Greater than Placebo in Pooled Placebo-Controlled Clinical Studies of STEGLATRO Monotherapy or Combination Therapy

<table>
<thead>
<tr>
<th>Number (%) of Patients</th>
<th>Placebo N = 515</th>
<th>STEGLATRO 5 mg N = 519</th>
<th>STEGLATRO 15 mg N = 510</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female genital mycotic infections†</td>
<td>3.0%</td>
<td>9.1%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Male genital mycotic infections†</td>
<td>0.4%</td>
<td>3.7%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Urinary tract infections‡</td>
<td>3.9%</td>
<td>4.0%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Headache</td>
<td>2.3%</td>
<td>3.5%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Vaginal pruritus*</td>
<td>0.4%</td>
<td>2.8%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Increased urination*</td>
<td>1.0%</td>
<td>2.7%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Nephropathy</td>
<td>2.3%</td>
<td>2.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Back pain</td>
<td>2.3%</td>
<td>1.7%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Weight decreased</td>
<td>1.0%</td>
<td>1.2%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Thirst¶</td>
<td>0.6%</td>
<td>2.7%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

† Includes: genital candidiasis, genital infection fungal, vaginal infection, vulvitis, vulvovaginal candidiasis, vulvovaginal mycotic infection, and vulvovaginitis. Percentages calculated with the number of female patients in each group as denominator: placebo (N = 252), STEGLATRO 5 mg (N = 252), STEGLATRO 15 mg (N = 245).

‡ Includes: balanitis candida, balanoposthitis, genital infection, and genital infection fungal. Percentages calculated with the number of male patients in each group as denominator: placebo (N = 260), STEGLATRO 5 mg (N = 267), STEGLATRO 15 mg (N = 260).

* Includes: thirst, dry mouth, polydipsia, and dry throat.

### Renal Failure

Hypertension and volume depletion may also increase the risk of hypotension in other patients at risk for volume contraction and adverse reactions related to volume depletion, particularly in patients with impaired renal function (eGFR less than 60 mL/min/1.73 m²). In patients with moderate renal impairment, increases in serum creatinine and decreases in eGFR were observed to reverse after treatment discontinuation. In a study in patients with moderate renal impairment, these abnormal laboratory findings were observed to reverse after treatment discontinuation.

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

<table>
<thead>
<tr>
<th>Study</th>
<th>Creatinine (mg/dL)</th>
<th>eGFR (mL/min/1.73 m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>0.83</td>
<td>89.5</td>
</tr>
<tr>
<td>Week 6 Change</td>
<td>0.00</td>
<td>0.03</td>
</tr>
<tr>
<td>Week 26 Change</td>
<td>0.07</td>
<td>0.5</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Monotherapy (26 weeks)</th>
<th>Placebo (N = 153)</th>
<th>STEGLATRO 5 mg (N = 156)</th>
<th>STEGLATRO 15 mg (N = 152)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall (N %)</td>
<td>1 (0.7)</td>
<td>4 (2.6)</td>
<td>4 (2.6)</td>
</tr>
<tr>
<td>Severe (N %)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>2 (1.3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Add-on Combination Therapy with Metformin (26 weeks)</th>
<th>Placebo (N = 209)</th>
<th>STEGLATRO 5 mg (N = 207)</th>
<th>STEGLATRO 15 mg (N = 205)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall (N %)</td>
<td>9 (4.3)</td>
<td>15 (7.2)</td>
<td>16 (7.8)</td>
</tr>
<tr>
<td>Severe (N %)</td>
<td>1 (0.5)</td>
<td>1 (0.5)</td>
<td>0 (0.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Add-on Combination Therapy with Metformin and Sitagliptin (26 weeks)</th>
<th>Placebo (N = 153)</th>
<th>STEGLATRO 5 mg (N = 156)</th>
<th>STEGLATRO 15 mg (N = 152)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall (N %)</td>
<td>5 (3.3)</td>
<td>7 (4.5)</td>
<td>5 (2.6)</td>
</tr>
<tr>
<td>Severe (N %)</td>
<td>1 (0.7)</td>
<td>1 (0.4)</td>
<td>0 (0.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In Combination with Insulin and/or an Insulin Secretagogue in Patients with Moderate Renal Impairment</th>
<th>Placebo (N = 133)</th>
<th>STEGLATRO 5 mg (N = 148)</th>
<th>STEGLATRO 15 mg (N = 143)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall (N %)</td>
<td>48 (36.1)</td>
<td>53 (38.5)</td>
<td>39 (27.3)</td>
</tr>
<tr>
<td>Severe (N %)</td>
<td>3 (2.3)</td>
<td>5 (3.4)</td>
<td>3 (2.1)</td>
</tr>
</tbody>
</table>

* Overall hypoglycemic events: plasma or capillary glucose of less than or equal to 70 mg/dL.
† Severe hypoglycemic events: required assistance, lost consciousness, or experienced a seizure regardless of blood glucose.
Genital Mycotic Infections. In the pool of three placebo-controlled clinical trials, the incidence of female genital mycotic infections (e.g., genital candidiasis, genital infection fungal, vaginal infection, vulvovaginitis, genitale mycotic infections, vulvovaginal mycotic infections, vulvovaginitis) occurred in 3%, 9.1%, and 12.2% of females treated with placebo, STEGLATRO™ (ertugliflozin) 5 mg, and STEGLATRO 15 mg, respectively (see Table 1). In females, discontinuation due to genital mycotic infections occurred in 0% and 0.6% of patients treated with placebo and STEGLATRO, respectively. The range of mean baseline LDL-C values was 96.6 to 97.7 mg/dL across treatment groups (see Warnings and Precautions).

In the same pool, male genital mycotic infections (e.g., balanitis candida, balanoposthitis, genital infection, genital infection fungal) occurred in 0.4%, 3.7%, and 4.2% of males treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively (see Table 1). Male genital mycotic infections occurred more commonly in uncircumcised males. In males, discontinuations due to genital mycotic infections occurred in 0% and 0.2% of patients treated with placebo and STEGLATRO, respectively. Phimosis was reported in 8 of 1729 (0.5%) male ertugliflozin-treated patients, of which four required circumcision.

Laboratory Tests. In the pool of three placebo-controlled trials, dose-related increases in LDL-C were observed in patients treated with STEGLATRO. Mean percent changes from baseline to Week 26 in LDL-C relative to placebo were 2.6% and 5.4% with STEGLATRO 5 mg and STEGLATRO 15 mg, respectively. The range of mean baseline LDL-C values was 96.6 to 97.7 mg/dL across treatment groups (see Warnings and Precautions).

In the pool of three placebo-controlled trials, mean changes (percent changes) from baseline to Week 26 in hemoglobin were -0.21 g/dL (1.4%) with placebo, 0.46 g/dL (3.5%) with STEGLATRO 5 mg, and 0.48 g/dL (3.5%) with STEGLATRO 15 mg. The range of mean baseline hemoglobin was 13.90 to 14.00 mg/dL across treatment groups. At the end of treatment, 0.1%, 0.2%, and 0.4% of patients treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively, had a hemoglobin increase greater than 2 g/dL and above the upper limit of normal.

In the pool of three placebo-controlled trials, mean changes (percent changes) from baseline in serum phosphate were 0.04 mg/dL (1.9%) with placebo, 0.21 mg/dL (6.8%) with STEGLATRO 5 mg, and 0.26 mg/dL (8.5%) with STEGLATRO 15 mg. The range of mean baseline serum phosphate was 3.53 to 3.54 mg/dL across treatment groups. In a clinical trial of patients with moderate renal impairment, mean changes (percent changes) from baseline at Week 26 in serum phosphate were 0.01 mg/dL (0.8%) with placebo, 0.29 mg/dL (9.7%) with STEGLATRO 5 mg, and 0.24 mg/dL (7.8%) with STEGLATRO 15 mg.

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

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

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

USE IN SPECIFIC POPULATIONS

Pregnancy. Risk Summary. Based on animal data showing adverse renal effects, STEGLATRO is not recommended during the second and third trimesters of pregnancy. The limited available data with STEGLATRO in pregnant women are not sufficient to determine a drug-associated risk of adverse developmental outcomes. There is no information regarding the presence of STEGLATRO in fetal tissue, and the risk to the mother and fetus associated with poorly controlled diabetes in pregnancy (see Clinical Considerations).

In animal studies, adverse renal changes were observed in rats when ertugliflozin was administered during a period of renal development corresponding to the late second and third trimesters of human pregnancy. Doses approximately 13 times the maximum clinical dose caused renal pelvic and tubular dilatations and renal mineralization that were not fully reversible. There was no evidence of fetal harm in rats or rabbits at exposures of ertugliflozin approximately 300 times higher than the maximal clinical dose of 15 mg/day when administered during organogenesis (see Data).

The estimated background risk of major birth defects is 6.0% in women with pre-gestational diabetes with a HbA1c ≥7 and has been reported to be as high as 20-25% in women with HbA1c <10. The estimated background risk of miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2.4% and 15-20%, respectively.

Clinical Considerations. Disease-Associated Maternal and/or Embryo/Fetal Risk. Poorly-controlled diabetes in pregnancy increases the maternal risk for diabetic ketoacidosis, pre-eclampsia, spontaneous abortions, preterm delivery, stillbirth, and delivery complications. Poorly controlled diabetes increases the fetal risk for major birth defects, stillbirth, and macrosomia related morbidity.

Data. Animal Data. When ertugliflozin was orally administered to juvenile rats from PND 21 to PND 90, increased kidney weight, renal tubule and renal pelvis dilatation, and renal mineralization occurred at doses greater than or equal to 5 mg/kg (13-fold human exposures, based on AUC). These effects occurred with drug exposure during periods of renal development in rats that correspond to the late second and third trimester of human renal development, and did not fully reverse within a 1-month recovery period.

In embryo-fetal development studies, ertugliflozin (50, 100 and 250 mg/kg/day) was administered orally to rats on gestation days 6 to 17 and to rabbits on gestation days 7 to 19. ertugliflozin did not adversely affect developmental outcomes in rats and rabbits at maternal exposures that were approximately 300 times the human exposure at the maximum clinical dose of 15 mg/day, based on AUC. A maternally toxic dose (250 mg/kg/day) in rats (707 times the clinical dose), was associated with reduced fetal viability, and a higher incidence of a visceral malformation (membranous ventricular septal defect). In the pre- and post-natal development study in pregnant rats, ertugliflozin was administered to the dams from gestation day 6 through lactation day 21 (weaning). Decreased post-natal growth (weight gain) was observed at maternal doses ≥100 mg/kg/day (greater than or equal to 331 times the human exposure at the maximum clinical dose of 15 mg/day, based on AUC).

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

Data. Animal Data. The lactal excration of radioabeled ertugliflozin in lactating rats was evaluated 10 to 12 days after parturition. ertugliflozin derived radioactivity exposure in milk and plasma were similar, with a milk/plasma ratio of 1.07, based on AUC. Juvenile rats directly exposed to STEGLATRO during a developmental period corresponding to human kidney maturation were associated with a risk to the developing kidney (persistent increased organ weight, renal mineralization, and renal pelvic and tubular dilatations).

Pediatric Use. Safety and effectiveness of STEGLATRO in pediatric patients under 18 years of age have not been established.

Geriactic Use. No dosage adjustment of STEGLATRO is recommended based on age. Across the clinical program, a total of 876 (25.7%) patients treated with STEGLATRO were 65 years and older, and 152 (4.5%) patients treated with STEGLATRO were 75 years and older. Patients 65 years and older had a higher incidence of adverse reactions related to volume depletion compared to younger patients; events were reported in 1.1%, 2.2%, and 2.6% of patients treated with comparator, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively (see Warnings and Precautions and Adverse Reactions). Therefore, STEGLATRO is expected to have diminished efficacy in elderly patients with renal impairment (see Use in Specific Populations).

Renal Impairment. The safety and efficacy of STEGLATRO have not been established in patients with type 2 diabetes mellitus and moderate renal impairment. Compared to placebo-treated patients, patients with moderate renal impairment treated with STEGLATRO did not have improvement in glycemic control, and had increased risks for renal impairment, renal-related adverse reactions and volume depletion of adverse reactions (see Dosage and Administration, Warnings and Precautions and Adverse Reactions). Therefore, STEGLATRO is contraindicated in patients with severe renal impairment, ESRD, or receiving dialysis. STEGLATRO is not expected to be effective in these patient populations (see Contraindications). No dosage adjustment or increased monitoring is needed in patients with mild renal impairment.

Hepatic Impairment. No dosage adjustment of STEGLATRO is necessary in patients with mild or moderate hepatic impairment. ertugliflozin has not been studied in patients with severe hepatic impairment and is not recommended for use in this patient population.

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

For more detailed information, please read the Prescribing Information. usp-mk8835-1810r001 Revised 10/2018

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Stop selling primary care physicians short

I would like to respond to the comments by Edward Volpintesta, MD, in the March 25, 2019, issue. As a primary care physician myself, I would first say that based on his response to Dr. Dinklage and his prior article in the American Journal of Medicine “Primary Care Training Must Change,” Dr. Volpintesta himself appears to have sold out his own profession. He seems to believe that his colleagues in primary care are all practicing as first-aid stations, appeasing our patients until they can see a real physician with adequate training to handle the “life-threatening” problems.

I myself see patients in the clinic, hospital, nursing home, and emergency room. I practice obstetrics, including operative vaginal deliveries, cesarean deliveries, postpartum tubal ligations, versions, etc. I also do EGDs and colonoscopies.

Physician training gives us a strong foundation of medical knowledge so that we know our limits, thus allowing us to seek specialty consultation when appropriate, avoiding extraneous, unnecessary and costly labs, imaging, and referrals. Ideally, in the outpatient setting, primary care physicians are preventing the patient from ever getting to the “life-threatening” stage of their disease process.

While there are obvious concerns over primary care shortages, nurse practitioners practicing unsupervised is NOT a safe or wise answer.

“While there are obvious concerns over primary care shortages, nurse practitioners practicing unsupervised is NOT a safe or wise answer.”

Alisha Scott, MD
BLAIR, NEB.
Under value-based pay, practices may find they need ancillary services just to maintain their current revenue. Once the decision is made to add a service, the next step is to find out whether, and how much, payers will reimburse for it.
does the practice have to decide if it can provide the service for less than a pulmonologist, it has to weigh whether in-house testing will reduce the number of its patients requiring trips to the emergency department or hospitalization, which would drive up the overall cost of caring for that patient.

"In a value-based world, it becomes a more nebulous calculation than it cost me ‘X’ dollars to do a pulmonary function test and I get paid ‘Y’ dollars for it," he says.

ANCILLARIES REMAIN COMMON

Whatever their reasons for doing so, many primary care practices continue to offer some form of ancillary service. In the 2018 Medical Economics Physician Report, 91 percent of family, and 89 percent of internal medicine practices said they offer at least one of 16 types of ancillary services, with lab services and electrocardiogram being the most common. Among all non-surgical primary care survey respondents, 84 percent said they provide ancillary services.

Moreover, experts say, the growing role of alternative and value-based payment models doesn’t alter the fundamental questions of whether patients will benefit from an ancillary service and whether the practice can make money providing it.

Nick Fabrizio, Ph.D., FACMPE, now a principal with the Medical Group Management Association, previously spent 10 years as practice administrator for a large primary care group. “We had a lot of long, hard discussions around questions like, ‘is this service one that we feel comfortable in providing, can we provide a high level of quality in doing it, and is it more convenient for our patients to have it done by us rather than someone else?’”

The easiest way to determine if patients will use an ancillary service, Fabrizio says, is to ask them—either through a mail or online survey, or face-to-face at the end of an appointment. Another useful technique is to look at the services and procedures for which patients are most frequently referred out. Among the practices he consults with, the most common ancillary procedures include stress tests, ultrasounds, and blood labs.

A factor practices sometimes overlook when considering ancillary services is any laws and regulations governing who can provide the service and under what circumstances, says Owen Dahl, MBA, FACHE, principal of Owen Dahl Consulting in The Woodlands, Texas. For example, laboratory services have to meet the requirements of the federal Clinical Laboratory Improvement Amendments. “The encouragement there would be to check your state laws and federal regulations to make sure your staff and providers meet the necessary criteria for that service,” he says.

IMPACT OF ALTERNATIVE PAYMENT MODELS

While in the past ancillary services often were seen as a source of additional revenue, under value-based payment models, practices may find they need them just to maintain their current revenue, says Dahl.

“In a world of fee-for-value, the key is not necessarily to generate revenue, it’s to protect against loss of revenue,” Dahl explains. “That’s
because you might wind up getting dinged financially for referring to a very expensive outside provider. So then you'd want to be able to control your expenses by offering that service at a lower cost than referring it out.

For Lovelace Family Medicine of Prosperity, S.C., being part of an alternative payment model—specifically, an ACO—has provided a bonus to its decision some years ago to acquire a dual-energy X-ray absorptiometry (Dexa) scanner—a device used to measure bone density—a somewhat unusual and costly purchase for a practice in a rural area.

"By virtue of having the Dexa, we're detecting osteoporosis and preventing women from having hip and spinal compression fractures," says family physician Oscar Lovelace, MD, the practice's founder. "That's allowed us to keep patients out of the hospital for hip fractures and skilled nursing facilities for rehab, which is saving thousands of dollars for our ACO."

The same dynamic applies to the practice's hospital-grade chemistry analysis machine that it uses to perform blood counts and metabolic panels. He cites the example of a diabetic patient who comes in with a dangerously high blood sugar level. "If we catch that patient early and can give them intravenous fluid hydration and insulin in our office, we can save a trip to the hospital that would cost Medicare $10,000 easily," Lovelace says.

WILL PAYERS COVER IT?
Once the decision is made to add a service, the next step is to find out whether, and how much, payers will reimburse for it. The challenge, says Kohl, is that insurance plans differ in their coverage policies and amounts. For practices that contract with a large number of payers, determining how many patients will be covered for the service is often a difficult and time-consuming exercise.

If an insurer doesn't cover a service, practices can sometimes persuade them to do so by showing it will reduce costs of care, says Fabrizio. That's particularly true when it comes to counseling for lifestyle and chronic disease issues, such as smoking cessation, weight management and diabetes education. "Can you keep my patients healthier and prevent their needing more costly services by providing that counseling? If I'm a payer that's something I'm certainly looking at," he says.

PATIENT DEMAND REMAINS A DRIVING FORCE
But even with the complexities of value-based care and differing payer requirements, ancillary services at many practices are still determined by such basic factors as the practice's location and the needs of its patient population. Lovelace Family Medicine's decision to acquire sophisticated blood lab technology was driven in part by high rates of diabetes and blood-related diseases among its patients.

"We're able to manage a lot of things in the office right then during the patient's visit, rather than having to send them to the hospital, because we have that lab capability," Lovelace says.

Other services the practice offers have been added largely because of patient demand, says Lovelace. And even though the demand for some, such as laser hair removal, is less than in urban areas, "one of the good things about being a part of the community and providing continuous care is it allows you to consider the long haul when you're making decisions about whether to invest in the technology you need for an ancillary service."

While financial return is always an im-

“The most important thing is to think about what's comfortable, what's truest to who you are as a person and a medical professional.”

— NARESH RAO, DO, FAMILY PHYSICIAN, SPORTS MEDICINE AT CHELSEA
Money

Ancillary services

“In a world of fee-for-value, the key is not necessarily to generate revenue, it’s to protect against loss of revenue.”

—OWEN DAHL, MBA, FACHE, PRINCIPAL, OWEN DAHL CONSULTING, THE WOODLANDS, TEXAS

Important consideration when considering an ancillary service, Lovelace says, “if it allows us to at least break even, if it improves our quality of care and it doesn’t come with too much regulatory hassle, as a rule, we’ll probably do it.”

Fabrizio says that settling for break even on an ancillary service is generally a reasonable approach, given that the service will benefit patients. At the same time, he notes, practices need to consider what other opportunities it may be foregoing by adding the service.

“Adding a service takes “X” number of hours in staff time and physician time. If they didn’t provide that service, how many more of their ‘regular’ patients could they see?, he says. “And it’s not just the physician time, but also the staff time and the room utilization resource that you also have to figure.”

Patient demand has also guided the practice Sports Medicine at Chelsea which, despite its name, provides both family and sports-related procedures and services. The New York City-based practice has a patient panel numbering some 40,000 and has undergone several physical expansions since its founding in 2006, according to Naresh Rao, DO, FAOASM, one of its three physicians.

The practice’s family medicine services are popular among patients of all ages, while sports medicine attracts younger, physically active patients, of which there are many in Manhattan’s Chelsea neighborhood where the practice is located. “Being an osteopathic family practitioner and fellowship-trained in sports medicine opens up a whole bunch of ancillary services we can deliver to our patients,” Rao says.

Family medicine services the practice offers range from sleep studies to tropical medicine to cryotherapy and wart removal. On the sports medicine side, services include joint and soft tissue injections, musculoskeletal ultrasounds, integrative sports medicine and physical therapy, among others.

The latter has been responsible for most of the practice’s growth in recent years, says Rao, such that the practice how employs four full-time and one half-time therapist.

“Half the patients that come to our office see a physical therapist, because there’s such a recurrent nature to physical therapy,” he says.

By and large, Sports Medicine’s commercial payers are “pretty accepting” of its ancillary services, Rao says, in part because the practice belongs to an Independent Practice Association, which negotiates payer contracts on its behalf. If a service is not covered, or requires a prior authorization, the practice makes sure to inform the patient. “We find that when the patient is told upfront what they’ll have to pay for, it tends to produce higher levels of satisfaction,” he says.

For practices considering ancillary services, Rao says: “The most important thing is to think about what’s comfortable, what’s truest to who you are as a person and a medical professional. I love family medicine, it’s the base of everything we do here, and there’s a lot we can do to build on that base. So if you’re comfortable in a particular realm, then by all means go for it.”
We are getting denials when we are billing a simple skin repair code with a lesion excision. Can you help us figure out why the repair code is being denied in these situations? It’s happening with all insurance carriers, so it’s difficult to know what’s going on without calling each of them.

A: This is a common coding mistake, and there are a couple of things that you can do to remedy it prior to billing.

First, make sure that you check the National Correct Coding Initiative (NCCI) edits when reporting multiple codes. The Centers for Medicare & Medicaid Services (CMS) developed the NCCI to help ensure correct coding methods were followed and to avoid inappropriate payments for Medicare Part B claims. These are automated pre-payment edits where the code pairs are compared when billed on the same date of service for the same patient. The American Medical Association notes, “If there is an NCCI edit, one of the codes is denied.”

Second, confirm that you aren’t unbundling codes. Unbundling refers to using multiple CPT codes for parts of a procedure when a single code is available, either due to misunderstanding or in an effort to increase payment. Reviewing the section guidelines for the codes involved is key to determining this. When there is a single code that captures payment for the component parts of a procedure, this is the code that should be billed.

For your example:
You billed for a lesion excision and a simple skin repair on the same service date. However, the Current Procedural Terminology (CPT) section coding guidelines for excisions read, “Excision is defined as full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (non-layered) closure when performed.” So separately coding the repair would be wrong and generate an NCCI edit because you are unbundling the codes. In rare instances, the repair could have been performed on a different site from where the lesion was removed, and, in these situations, it is acceptable to bill for both and append a modifier (likely modifier 59) to let the payer know the procedure was indeed separate from the excision. In these situations, make sure that you have reviewed the documentation to ensure the repair was for a different location.

Q: We often hear that the flu vaccines only help protect patients against a percentage of the flu strains that are out there, so I understand why there are new vaccines coming out all the time. Are there any new codes for 2019?

A: Yes, a new influenza vaccine code has been introduced for dates of service in 2019, as follows:

90689 Influenza virus vaccine, quadrivalent (IIV4), inactivated, adjuvanted, preservative-free, 0.25 ml dosage, for intramuscular use

This code can be utilized for all vaccines that fit this description. The Centers for Medicare and Medicaid Services’ physician fee schedule reimbursement amount for this code has not yet been published.
Legally Speaking

Can I import medication for poor patients?

Let’s say there’s a physician who is aware that some states, including his, have taken initiatives to import medications from Canada. But he can get the identical brand name drugs even cheaper from India. He intends to provide the drugs to his poorer patients at no charge, and his patients are eternally grateful.

One of these patients is so happy that he sends a letter to the local newspaper applauding the efforts of his physician. The article, written by a local reporter, is picked up by the national press and covered in the national news.

Three days later FDA agents show up at the doctor’s door threatening him with both civil and criminal penalties. What is the basis? He was only trying to save his patients money.

Did he do anything wrong?

Drug costs rise

What is clear is that prescription drug expenditures are one of the fastest growing segments of the United States healthcare system. Over the last several decades, prescription drug spending has increased dramatically, whereas other components of the healthcare system, such as hospital care and physician services, have risen less.

Several factors have led to this tremendous increase in expenditures.

First, prescription drug utilization per capita has grown dramatically because of the aging population. In addition, older, less-expensive drugs are being replaced by new, high-priced drugs. Finally, many manufacturers have increased the prices of drugs already on the market. With this increase in the cost of prescription prices, many consumers may be forced to choose between purchasing basic necessities and filling their required treatment prescriptions.

The reason prescription prices in the United States are, at times, more expensive than the prices for identical medications from other countries is clear. Costs in the United States costs remain high because of current patent protection coupled with the unregulated free market system.

The cost for these medications is governed by the laws of supply and demand. Since there is no price ceiling for many of the currently required drugs in the United States, (such as is in place in Canada), prices remain quite high. Thus, there is the inevitable desire to import the drugs from abroad where the cost of such pharmaceuticals may be less.

In all fairness, the pharmaceutical industry maintains that the reasons behind the high prices of American drugs are the cost of the research and development needed for new break-through drugs. In 1993, the pharmaceutical industry spent $12.7 billion on research and development. A decade later this figure more than doubled to over $33.2 billion. It continues to increase.

What the law says

With all this said, there is still a natural desire to get the same medications available to our patients from a cheaper source. Our doctor turned to India. Other physicians have looked to Canada, Europe and South America. Whatever the source, and despite his admirable intent, Dr. Rash’s actions are illegal.

FDA regulations prohibit the re-importation of exported prescription drugs manufactured in the United States by anyone but the actual U.S. manufacturer. In part, the justification for such laws lies with Congress’ intent to ensure the safety and efficacy of the prescription drugs.

The FDA cannot vouch for the safety of a product once it is sent to another country; it becomes out of the FDA’s control.

There are both civil and criminal consequences for our example doctor if he continues this approach. He would be advised to discontinue his actions.

David J. Goldberg, MD, JD, is a dermatologist and healthcare attorney. Send your legal questions to: medec@ubm.com.
Melissa Lucarelli, MD, knows what it’s like to run a practice that’s short-staffed.

The family physician in Randolph, Wis., has 12 employees in her office. In the past year, four have gone on maternity leave, including the clinic manager and the claims manager.

“We had to be very creative in how we compensated in order to stay open and keep seeing patients,” says Lucarelli, a member of the Medical Economics editorial advisory board.

It’s a problem most small- to medium-sized practices face at some point: A staff member quits unexpectedly or goes on leave for a long period of time because of pregnancy, illness, accident, or emergency. How the practice compensates for that staffing shortage can affect its revenues, workloads, staff morale, and even the quality of care patients receive.

CROSS-TRAINING TO THE RESCUE
In many practices, existing staff must pick up the slack when there is a vacancy.

That requires cross-training in various jobs, says Melissa White, practice administrator at Newton Family Physicians in Newton, N.C. The practice has six physicians and four nurse practitioners supported by a non-clinical staff of 12. “Everyone is cross-trained in at least one job and many in two,” White says. “All of us can do something else or everything else. It’s a condition of being in private practice.”

For example, the practice typically has two people working the front desk, but three others can step in as needed. The single checkout employee has two backups, and so on.

All employees must embrace cross-training as a condition of employment, White says. “We make it very clear that it’s a team effort and if you aren’t willing to be part of the greater good, maybe it’s not a good fit for you,” she says, adding that she once fired a staffer who was good at her primary job, but who wouldn’t train up to the required level in a secondary role.

It’s a similar story at Associated Physicians, a 20-doctor independent practice in Madison, Wis. Job applicants are informed they’ll be cross-trained and the training begins immediately when the person is hired, says Executive Director Terri Carufel-Wert, RN, MHA.

The practice sends new employees to its EHR provider for training and pairs new workers with veteran employees. Staff members also have monthly online training in their own specialty and others, and employees are asked to share their knowledge with each other.

The practice also solicits employee input on such things as the best ways to learn and what skills are required, says Business Operations Manager Margaret Wilkinson, CMC.

HIGHLIGHTS

tip Practices should cross-train their employees to ensure critical functions are covered in the event of an emergency or an unexpected resignation.

Many practices turn to staffing agencies to fill vacancies. This can be a fast and easy way to find a credentialed temp, but drawbacks include expenses and work restrictions.
Operations

Staff shortages

Detailed written descriptions of office procedures and policies are invaluable for training new staff members and getting temps up to speed quickly, adds Lucarelli.

Hiring temps

Many practices turn to staffing agencies to fill vacancies. This can be a fast and easy way to find a credentialed temp, but has drawbacks, such as the expense and work restrictions.

Lucarelli has hired temporary workers from agencies to fill vacancies, but prefers not to. Her quarrel is not with the quality of their work, but the extra cost and the restrictions on their duties. Office temps cost 50 percent more than regular staff once the agency fee is included, which is more expensive than paying overtime to an existing employee, she says.

She also doesn’t like that temps work under a contract that can limit their hours and duties. While an employee might stay late to get a job done or help out, temps tend to stop working as soon as their shift ends, she says. And she once had a temp skip a day because her contract did not require her to come to work if it was snowing. “And this is in Wisconsin,” she says.

“They’re not beholden to your employee handbook; they’re beholden to their employer’s contract,” she says.

“If a practice has to repeatedly use an agency it should request the return of any previous temps who have performed well, proven a good fit with the practice culture and are already familiar with office operations, Fabrizio says. The less time spent bringing a temp up to speed with policies and procedures, the more time they can spend working and the more smoothly the office will run.

Temp agencies can be a good way to scout new employees, says Carufel-Wert, who has hired billers and coders from their ranks. “That’s been nice because you’ve been able to try them before you hire them,” she says.

Float pools

To avoid the extra expense and uncertainties of a temp agency, some practices rely on their own “float pools” of workers who can fill in for a single shift, a week, or even months. These people often have other jobs, but are looking to earn extra income.

Lucarelli says she is always on the lookout to add to her pool of former staff members, friends they’ve recommended and even patients who can fill in short-term. It helps to stay on good terms with former employees so they’re willing to return, she says.

Avoiding staffing shortages

While some staffing shortages are unavoidable, many practices do what they can to reduce turnover and shortages.

A leave doesn’t always mean the employee can’t work at all. While she was on maternity leave, Lucarelli’s clinic manager still managed payroll and other business office functions on a part-time basis.

If a staffer gives notice at Associated Physicians, Carufel-Wert and Wilkinson will talk to the person about their reason for leaving and sometimes make changes to persuade them to stay, such as more flex time or even a raise. That’s easier and less expensive than hiring a replacement, they say. Of course, any accommodation must be reasonable and can’t have a negative effect on the rest of the staff.

“I’m not going to be held hostage by an employee’s demands,” Carufel-Wertz says.

Associated Physicians surveys salaries in its market to make sure its pay is competitive. It also pays for employees’ continuing education programs and sometimes gives raises if an employee acquires an additional skill.

Of course, staffing shortages can happen to the best-prepared practice. In that case, Wilkinson says, “You put your survival mode hat on and do what you can do.”

“We had to be very creative in how we compensated in order to stay open and keep seeing patients.”

—MELISSA LUCARELLI, MD, FAMILY PHYSICIAN, RANDOLPH, WISC.
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SECOND OPINION

We must fight prior authorizations

When medical school applicants ask me for pre-interview advice, I tell them, “When they ask you why you want to go into medicine, don’t say ‘I want to help people.’ That’s what everyone says.” And everyone says it because we want to care for others.

But unless you really want to help people, there are less stressful and more lucrative career paths.

In today’s healthcare system, we cannot perform the most basic task of caring for our patients. When I started practice a little less than 20 years ago, I didn’t have to get prior authorizations (PAs) for drugs. At least, not very often.

Now, there are all these nonmedical people dictating what tests or drugs are and are not available. Now, I’m forced to deliver the bad news to my patients after mumbling to myself “I hate insurance companies” for the nth time that day that. Now, I must submit three or four PAs a day — and that doesn’t count the prescriptions I change because I am certain the PA will get denied.

I’ve reached a point where I feel like there’s no point in even trying. Once the insurance company says, “Brand X is not preferred. Formulary alternatives are Y and Z,” I know the PA questions will include “Has the patient tried and failed Y and Z?” and “Does the patient have a contraindication to Y and Z?”

If you answer no, Brand X is denied. It doesn’t matter that the patient has been on Brand X for a decade and Y and Z didn’t exist then. If he hasn’t previously tried them with no benefit, he has to switch.

I wouldn’t mind so much if the insurance company’s reason was based on clinical studies showing Brands Y and Z are superior, but it usually isn’t. Sometimes, data that suggests certain drugs are superior are the formulary exclusions. In some drug classes, the preferred drugs are changed annually, back and forth and back and forth, among the members of the class.

Physicians battle with insurance companies daily to get the medications their patients need. We also have to wrangle with insurance companies for tests to be performed. For example, I have a patient with an adrenal mass. The American Association of Clinical Endocrinologists (AACE) guidelines say to reimagine after three to six months. My patient was a little lax in scheduling, so it was eight months later when she called to say she needed a precertification. It was rejected.

Her insurance company’s policy is to reimagine after 12 months. I even did a peer-to-peer review. My “peer,” a non-endocrinologist, told me the insurance company would not cover the test any earlier because it follows different guidelines from the AACE.

My patient had to anxiously wait for the next four months before her insurance company would cover her test. Her anxiety translated into multiple phone calls to my office staff and me. I understand, of course, but I am also frustrated that I can’t care for her. My hands are tied.

There are many things that contribute to what is being called physician burnout: the increasing cost of doing business, decreases in reimbursement, increasing regulations, changes in patient expectations of physicians and physician practices, and online reviews.

The biggest obstacle we face every day, and the one most likely to result in burnout, is payers and pharmacies interfering with our medical expertise. Their desire to save a buck is antithetical to delivering what we believe is the best care for our patients. The healthcare system needs to put patients back at the forefront and let physicians practice medicine.

Melissa Young, MD, FACE, FACP, is sole owner and solo practitioner at Mid Atlantic Diabetes and Endocrinology Associates, LLC.

Addressing America’s silent killer

READ MORE
Providers at West Des Moines, Iowa-based UnityPoint Health, a network of hospitals, clinics, and home care services in Iowa, Illinois, and Wisconsin, wanted to know why patients were being readmitted within 30 days. So they asked patients, “Why do you think you’re back?”

This approach allowed patients to speak openly, which gave nursing leaders insight into patients’ greatest challenges. Patients can struggle with a lack of access to follow-up appointments, food insecurity, or an inability to pay for medications, says Rhiannon Harms, executive director of strategic analytics at the health system.

Open-ended questions are important. It’s difficult to ask a question such as “Can you pay for your medications?” says Harms.

UnityPoint Health combines the patient narrative with retrospective data on readmissions to create a readmission risk score for the patient—and that information is communicated to the patient’s care team.

For example, Patricia Newland, MD, a family medicine physician, relied on the predictive analytics tool to prevent a readmission by one of her patients. During a follow-up appointment, Newland used the tool to determine that her patient was likely to experience an onset of symptoms within the next 13 to 18 days. She shared this information with the patient and told her to call the practice at the onset of symptoms, which could include shortness of breath, wheezing, and coughing.

The patient called the practice in that timeframe complaining of those symptoms. Newland got the patient in for a same-day appointment, consulted with her patient’s pulmonologist, and changed her patient’s medications—and thus prevented a hospital readmission.

Newland relies on her practice’s clinical care coordinator to highlight the patients who are at highest risk of being readmitted. It also helps that her practice keeps same-day appointment slots open.

Team huddles, which take place at her practice three or four times a week, allow the team to coordinate patient care. Newland, who also serves as a physician leader in the health system, is responsible for educating clinical care coordinators across the health system about the use of predictive analytics to prevent readmissions.

Once physicians realize that access to this information can help their patients, they embrace this tool, she says. In fact, Newland considers the readmission risk score as the “fifth vital sign” in her patients’ follow-up care.

Payers can support this work by paying for home-based health providers and devices to monitor a patient’s vital signs in the home, says Newland. “If we could do those things, it might keep a patient out of the hospital.”

UnityPoint Health has reduced all-cause readmissions by 40% within 18 months of using the predictive analytics tool. The health system’s home health team also used it to determine their most vulnerable patients.
patients when the community was hit by a blizzard. With this insight, home health providers could tailor their visit schedules to see patients who were in most need of care, says Harms.

FOCUSBING ON DIABETES
In his quest to reduce readmissions at Kansas City-based University of Kansas Health System, David Wild, MD, vice president of lean promotion, discovered that patients with diabetes were more likely than other patients to be readmitted three times within 90 days at the nonprofit, academic medical center.

Wild used predictive analytics to comb through variables such as total length of stay, number of chronic conditions, whether the hospital admission was planned or unplanned, smoking history, the age of the patient, and payer type (public or private).

Inability to access follow-up care, patient discharge disposition (the presence of a family member in the home or a stay at a skilled nursing or rehabilitation facility), and the total number of chronic conditions were the biggest drivers of readmissions for diabetes patients, he says.

With this insight, all patients who have been readmitted to the hospital three times in 90 days—not just those with diabetes—are connected with a case manager who helps them secure follow-up care. On an average day, five to nine inpatients meet that criteria, says Wild.

In May, when Wild started this project, the readmission rate for diabetes patients was 25%.

Currently, the readmission rate for diabetes patients is 13.9%. Wild attributes University of Kansas Health System’s success to improved engagement with nurses on inpatient units and incorporating diabetes educators for daily information sessions with patients on medications.

He welcomes support from payers. For example, coverage of diabetes education in the outpatient setting could help prevent readmissions.

PHYSICIAN ENGAGEMENT HELPS
Flagler Hospital, a nonprofit healthcare facility in St. Augustine, Florida, has 400 physicians, according to Michael Sanders, MD, its chief medical information officer. With that number of physicians, wide variation in clinical practice is likely. That’s a pet peeve for Sanders, who also laments the impact of waste on healthcare spending in the United States. (Wasteful spending in healthcare exceeds $1 trillion each year, an amount that two experts writing in Health Affairs say “could fund the entire Medicaid program twice over.”)

To address this, Sanders decided to reduce variation in care for patients with pneumonia. After looking at more than 16,000 patients over four years, he discovered that many patients with pneumonia were getting daily X-rays and blood tests, which increases the cost of care without improving outcomes.

He also learned that introducing nebulizer treatments for patients with pneumonia and chronic obstructive pulmonary disease early in their hospital stays improves clinical outcomes.

Sanders had the proof in hand, but changing how physicians practice medicine is tough. To tackle this, he taps his longstanding relationships with physicians involved in Flagler Hospital’s EHR deployment, which started in 2012. These physicians act as “ambassadors” for adhering to the care path designed for pneumonia patients, says Sanders.

Flagler Hospital has reduced pneumonia-related readmissions from 2.9% to .4% since March. In addition, the hospital has saved $1,350 per patient and reduced the length of stay for pneumonia patients by two days. Going forward, Sanders expects the hospital to save $726,300 annually because of this work.

Payers should care about this, he says. They’ll benefit from the elimination of unnecessary tests and the reduction in cost.

“They should be looking at ‘same cause’ readmissions and rewarding hospital systems that can not only reduce cost, but also readmission and mortality as well. They must recognize that this effort costs hospital systems in dollars and work effort, and reward them accordingly.”

Insurance companies could also pass on those savings to members who use hospital systems that reduce cost while improving outcomes, adds Sanders.

Editor’s note: This article was first published in Managed Healthcare Executive, our partner publication.
The federal government recently finalized a rule that will allow Medicare Advantage plans to offer telemedicine as a core benefit. As a result, practices of all sizes will have a greater incentive to adopt virtual visits, observers say.

Traditional fee-for-service Medicare provides very limited coverage of telemedicine. For the most part, virtual care is covered only in rural areas, and virtual consultations must be initiated in healthcare facilities.

Providers can’t bill for virtual visits with patients from their homes, with one exception: CMS last fall ruled that physicians can bill traditional Medicare for brief “virtual check-ins,” in which they determine whether a patient should come into the office. Remote evaluation of video recordings and images is also covered.

The new rule doesn’t expand telemedicine coverage under fee-for-service Medicare. However, it gives Medicare Advantage plans carte blanche to cover any form of telemedicine, wherever it is provided or initiated. Since more than a third of Medicare patients belong to these plans, this could mean a significant change for many physicians.

Some Medicare Advantage plans already cover virtual care as a supplemental benefit for which plan members must pay extra. Now that telemedicine is a core benefit, however, “providers would be more likely to invest in the infrastructure to make this available,” says Jerry Penso, MD, MBA, president and CEO of the American Medical Group Association (AMGA).

Steven Waldren, MD, vice president and chief medical informatics officer of the American Association of Family Physicians (AAFP), says that when Medicare Advantage plans begin to cover virtual visits with patients’ own physicians, “I think it would convince more doctors to add telemedicine to their practices.”

MODERN TELEmedicine

The telemedicine used today represents the confluence of two forms of the technology: secure online messaging, which has been around since the early 2000s, and virtual visits based on audio-video conferencing.

Until around 2015, video visits were usually conducted between patients and doctors who worked for outside services such as American Well, Doctors on Demand, and Teladoc. But there are inherent limits to this approach, because the outside doctors don’t know the patients who consult them, and they rarely coordinate care with the patients’ regular physicians.

“The critical piece is to make sure the care is coordinated,” Penso notes.

Today, however, the telemedicine medical practices use is likely to connect patients directly to their own physician or his or her colleagues, rather than an outside doctor hired by a service. Secure texting or online messaging is often the first step. Then the patient completes an online form, provid-
Telemedicine is most often used to diagnose and treat minor acute problems like influenza, low back pain, conjunctivitis, and urinary tract infections. Some practices are also using telemedicine for routine follow-ups on chronic conditions.

“Virtual health has been great for my diabetic patients. … For routine follow-ups on diabetes, it’s very well done.”

—DONNIE AGA, MD, MEDICAL DIRECTOR OF HEALTHCARE INNOVATION, KELSEY SEYBOLD, HOUSTON

Kelsey Seybold and Kaiser Permanente also use telemedicine routinely for post-op follow-ups, and other groups plan to follow suit. In such a virtual visit, Aga says, “Our PA will say to patients, ‘take off the bandage so I can look at the wound, let’s look at your mobility and how does it feel,’ etc. Sometimes, post-op patients are taking pain medicine, so they don’t need to be driving to the office.”

Telemedicine is especially well suited to behavioral health, notes James Korman, Psy.D., chief of behavioral health and physician wellness for the Summit Medical Group, based in Summit, N.J. Besides doing teletherapy and medication management with patients who have difficulty getting to the office, Korman notes, Summit has established a virtual therapy program in conjunction with its primary care offices. Primary care physicians can consult with therapists, or have patients do video visits with them in the office.

Physician-to-physician virtual consults are an integral part of Kaiser Permanente’s approach, says Richard Isaacs, MD, CEO and executive director of the Permanente Medical Group. For example, a primary care doctor who is seeing a patient with a skin lesion can immediately pull a dermatologist into a virtual video conference, show him the rash and ask him what to do.

“It’s all about care without delay,” Isaacs notes. “If you connect a primary care doctor [to a specialist] immediately via smartphone technology, that drives a lot of efficiency.”

TECHNOLOGY PLATFORMS

Some groups use an internal telemedicine platform that incorporates their EHR. Kelsey Seybold, for instance, uses the virtual care platform in its Epic EHR for both video visits and “e-visits” based on online messaging through the EHR’s patient portal. When a physician encounters a patient in a scheduled video visit, the doctor sees the patient on one side of the screen and views and documents in the EHR on the other side.

The video encounters with primary care physicians can be scheduled within a day; if a patient’s doctor isn’t available, he or she can visit another physician. A dedicated team of rotating physicians handles the e-visit requests, usually within 10 minutes of a call, Aga says.

Austin (Tx.) Regional Clinic’s telemedicine service uses an outside platform from a telemedicine vendor, says Jacob Childers, MD, medical director of the service. The platform allows video, voice and text messaging.

After sending a text about his or her problem, the patient is quickly connected to a doctor. A group of 20 clinic doctors handles these requests 24/7. Some do it on their own time for extra money; others fit video visits between in-person clinic visits.

Intermountain Healthcare, based in Salt Lake City, uses a hybrid technology approach. While the group deploys its own clinicians for scheduled virtual visits, it uses
American Well’s telemedicine platform, which is integrated with the scheduling module in Intermountain’s iCentra EHR (a modified form of Cerner’s software). Summit Healthcare also uses an outside platform integrated with its athenahealth EHR.

**VALUE-BASED CARE TRACK**

An important value of telemedicine to large practices is that it supports population health management, says Richard Trembowlcz, a principal with ECG Management Consulting. Groups that are taking on financial risk can use telemedicine to increase patient engagement and improve their access to care. Moreover, practices can use it to expand the number of patients their primary care providers see, he adds.

Penso of AMGA says, “If a group is taking financial risk, it’s in their interest to manage the care as effectively and as efficiently as possible—and to meet the patient’s needs, because patients have a choice of whether to stay in your network or program. For those groups, it can be very worthwhile to have telemedicine as another option.”

But most practices still receive a lot of fee-for-service income, and they may be located in areas where telemedicine is not ordinarily covered by insurance. Prevea Health in Green Bay, Wisc., for instance, uses telemedicine mainly for online messaging and video visits with its urgent care centers, says Ashok Rai, MD, president and CEO of the group.

Prevea charges patients $35 per virtual visit because their health plans don’t usually cover it. For the same reason, the group has not yet extended telemedicine to its primary care offices.

Rai hopes the new Medicare Advantage telemedicine option will help change that.

“We can do a lot of care virtually if patients don’t need to come into the office and their care is covered as part of the premium. Things would be more efficient and more timely for our chronic care. In the end, it’s good for the patient, it’s good for the physician, and it’s good for reducing costs in the overall healthcare system.”

**OPTIONS FOR SMALLER PRACTICES**

While fairly few small practices have used telemedicine, they should definitely start considering it, especially now that Medicare Advantage covers virtual visits, says David Zetter, CHBC, a practice management consultant in Mechanicsburg, Pa. For one thing, he says, telemedicine could help practices expand their business.

He cites a solo family physician in a rural area who is using telemedicine to provide after-hours care. For a fee that is automatically applied to their credit card, patients can have a virtual visit whenever the doctor is available. “He’s definitely filled his practice up a bit and increased revenue,” Zetter notes. Many psychiatrists in small practices, are doing virtual mental health visits, he adds.

Grace Terrell, MD, a North Carolina internist who founded the Cornerstone Medical Group, now part of Wake Forest Baptist Health, is a big supporter of telemedicine and believes the Medicare Advantage core benefit could prove highly important.

“Telemedicine should open up business models that aren’t based on a patient being in a facility in front of a doctor,” she says. “There are a thousand use cases out there that could redesign medicine in many ways. Over time, it could re-engineer the healthcare system so that expertise is delivered in more convenient ways through technology.”

One new business model that small
practices could try, she says, involves providing care to more patients without increasing overhead costs or overburdening physicians. In a typical primary care practice, she notes, providers must see a certain number of patients each day to cover their overhead costs. But if the practice hired additional doctors or midlevel practitioners and they provided virtual visits without patients needing to come into the office, the average overhead per patient would decrease, and profitability would increase.

“The problem with small practices now is that they want to fill their exam rooms, and that’s why they view virtual visits as one off top of that,” she says. “But you can imagine a situation where you have twice the number of doctors for the space you’ve got, and half the doctors are not using the space.”

**TELEMEDICINE CHALLENGES**

To participate in telemedicine, Zetter says, practices first must determine which kinds of patients are likely to use the service and which of their payers cover it. If a patient’s insurance doesn’t cover telemedicine, practices must tell them that there’s an out-of-pocket cost.

It’s also important to understand each state’s regulations on telemedicine, including what kinds of services plans must cover and whether they have to cover telemedicine-provided services that are comparable to in-person services, he points out. Thirty-one states and the District of Columbia require full parity, and two other states have partial parity laws. In addition, all 50 states have some Medicaid coverage for telemedicine.

Zetter warns against simply doing video chats with patients on their smartphones because of HIPAA security and privacy considerations. Fortunately, a wide range of secure messaging and videoconferencing software is available, he notes, and some of it is not expensive.

The AAFP offers a virtual visit platform based on software from Zipnosis. Designed for minor acute issues, the platform includes a questionnaire for patients to fill out. In most cases, a doctor can diagnose their problem and prescribe a medication based on their answers, Waldren says. Patients can also request a video visit and conduct it on the platform.

The cost of AAFP Virtual Care is $159 per month per authorized user. Patients pay practice-determined fees for the service, but the platform can be linked to a practice’s EHR for billing purposes, he adds.

**WORKFLOW CHANGES**

Cindy Dunn, RN, FACMPE a consultant with the Medical Group Management Association, is skeptical about the suitability of telemedicine for small practices. She notes that the practice must look at the workflow changes required to accommodate virtual visits. They also have to figure out how to document these encounters. And their billers have to learn which codes to choose for insured telemedicine services.

However, she concedes that telemedicine could work well for post-op visits, which are frequently bundled into surgical fees; as a result, surgeons earn nothing for office follow-up visits. In addition, she says, virtual visits could free up slots for doctors to see patients with more complex conditions in person. And telemedicine could help practices extend their hours.

“In the long term, telehealth will become just as much a part of care as doing routine child checks and those kinds of things,” she says. “We’ll also move from telemedicine’s current acute care focus to chronic disease management and wellness as part of value-based care. Telemedicine is going to become a big component of medicine moving forward.”

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“**It’s all about care without delay.**

**If you connect a primary care doctor [to a specialist] immediately via smartphone technology, that drives a lot of efficiency.”**

— RICHARD ISAACS, MD, CEO AND EXECUTIVE DIRECTOR, THE PERMANENTE MEDICAL GROUP
The average physician’s practice sees no-shows rates of 23 percent—and those numbers can be significantly higher depending on your specialty. That’s almost one in every four patients just not showing up! Each one of those lost appointments is expensive, ranging from $140 to $310, depending on specialty, according to the Agency for Healthcare Research and Quality.

Fortunately, there are things you can do to help alleviate no-shows and cancellations.

1. **Consistently remind patients of appointments.** The most common reason to miss a doctor’s appointment—36 percent of all no-shows—is that the patient simply forgot. Reminders make a big difference in helping jog those memories. A study found that no-show rates fell 26 percent after sending a reminder. Automating these reminders is a key piece to making sure reminders go out at the right time and to the right patients.

2. **Use the most effective reminder.** Sending a reminder via the communication method that patients prefer is one of the best ways of ensuring they actually show up. This means that some reminders will need to go out via text message, some through email, and others with an old-fashioned phone call. On all of your intake forms, in emails, or even in person, be sure to ask each patient how they want to be contacted—and then use that method.

3. **Actively use a wait list.** Experts have found that about one in four scheduled appointments will end up being canceled by patients. These cancellations create headaches for staff and losses on your balance sheet. The best way to tackle last-minute cancellations is to keep an active wait list. Track those patients that would like to be seen earlier and then, when an appointment becomes available, send those patients a quick message seeing if they’d like to fill it. It’s easy and effective.

As you focus on both increasing the number of new patients and maximizing the appointment attendance of current patients, your practice can expect to see significant improvement in its bottom line. Consider implementing one or two of these methods at a time and then continue to add additional strategies over time. As you do so, you will start to see the improvements in your revenue that you are aiming for.

Josh Weiner is chief operating officer of Solutionreach. Send your practice management questions to medec@ubm.com.
**What is your favorite vacation destination?**

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<td>Family Medicine Randolph, Wis.</td>
<td>“Somewhere I’ve never been, preferably with a beach.”</td>
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“Virtual health has been great for my diabetic patients.”  

DONNIE AGA, MD, KELSEY SEYBOLD, HOUSTON

40% reduction in readmissions for one hospital after using analytics data  

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“In a world of fee-for-value, the key is not necessarily to generate revenue, it’s to protect against loss of revenue.”

OWEN DAHL, MBA, HEALTHCARE CONSULTANT, THE WOODLANDS, TEXAS

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Build your cybersecurity plan

Physician practices are increasingly being targeted by hackers looking for coveted protected health data. In this article we will detail how to prepare and protect your practice from emerging digital threats, and what your action plan should be in the event of a breach or hack.
HIV TREATMENT: HOW FAR HAVE WE COME?

HIV treatment has come a long way since its inception. Over the past 30 years, treatment has evolved from less effective monotherapy and single-class dual therapy to now widely recommended triple therapy.¹ ³ Today’s regimens offer sustained virologic efficacy, better tolerability and toxicity profiles, and relative ease of use. In fact, according to the DHHS Guidelines, a regimen that includes all 3 components that is taken one time a day is easier for patients to use.⁴

Let’s explore how triple therapies were proven over time:

THEN

1995

As the highly active antiretroviral therapy (HAART) era begins, monotherapy regimens are being phased out¹

NOW

2018

TREATMENT POW3R

DHHS recommends 3 components for treatment-naïve patients⁴

2 nucleoside reverse transcriptase inhibitors (NRTIs) + 1 integrase strand transfer inhibitor (INSTI) for achieving and maintaining virologic suppression⁶

WHAT IS YOUR CURRENT TREATMENT APPROACH?

STOP THE VIRUS.

Working together to help stop the virus.

To explore the benefits of choosing a complete triple-therapy HIV regimen, visit hivetreatmentpower.com.