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uch like online review sites, where only the unhappiest of customers take the time to write a comment, I often find myself writing about my latest frustration with the practice of medicine.

How I repeatedly mutter, “I hate insurance companies,” how tedious it is to secure prior authorizations and how patients would rather believe the latest issue of the National Enquirer than their physicians. That isn’t what I signed up for when I became a physician.

But two very different recent patient encounters reminded me once again of the beauty and art that is the practice of medicine.

The other day, I saw a patient I had inherited from another endocrinologist. His reputation of being an anxious person preceded him. He doesn’t allow us to check his blood pressure because he gets so worked up at doctors’ offices that his BP is often sky high.

In truth, he has very little need to see an endocrinologist. His thyroid issue resolved itself years ago, but he wants to keep an eye on it, so he still comes every few months. We reviewed his labs and were finished quickly. I asked him if there was anything else he needed to discuss. He said, “I know this isn’t your area, but maybe you can help me. I hate flying, but my wife booked us a vacation in the Caribbean. I’m afraid I’m going to get on the plane and freak out.”

Well, he is correct. This is not my area of expertise, but I am a frequent traveler. I am also someone with an irrational fear of heights. I told him that while my phobia is different than his, I understand what it’s like to intellectually know something is safe and yet still be deathly afraid of it.

We talked a little about the safety of flying and some coping mechanisms. He said after talking to me, he already felt better.

On a sadder note, hours before I wrote this, I sat by the hospital bed of a patient who was recently diagnosed with pancreatic cancer. He was a little cranky when I first walked in, probably because I woke him. He was annoyed that his glucose had gone too low the night before. He complained of the side effects of his chemotherapy.

He said, “They haven’t made any
great strides in treating pancreatic cancer. I know I am going to die. Why are they making me take 15 pills? My family gets upset that I don’t want to take the pills because they make me sick. They say, ‘If you don’t take them, you’ll die.’ Well, I’m going to die, anyway.”

I got him some tissues, and I held his hand while he cried. It took all my strength not to cry with him.

After a time, I explained to him about palliative care and asked for permission to recommend a consult. I told him that giving him quality of life is most important right now.

And he’s right: Some things don’t matter. His glucose doesn’t need to be perfect. It’s OK for it to be a little high. He can eat what he’d like because he needs his strength.

He looked at me and told me I was the only one who came to visit every day. I was the only one who understood, and he appreciates that.

Physicians are often painted as pill pushers or smart but with no heart.

Physicians are often painted as pill pushers or smart but with no heart. There are times that our current healthcare system forces some physicians to behave that way.

Physicians are often painted as pill pushers or smart but with no heart. There are times that our current healthcare system forces some physicians to behave that way.

I know darn well that taking the time to ease someone’s anxieties doesn’t pay the big bucks. But you know what? This is exactly what I signed up for and why I still practice medicine.

Melissa Young, MD, is sole owner and solo practitioner at Mid Atlantic Diabetes and Endocrinology Associates, LLC.
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Practices dealing with more bad patient debt, study shows

Patients are finding it increasingly difficult to pay off their medical bill balances, and that is forcing more physician practices to chase after bad debt.

According to a new report from global payments company TSYS, about 68 percent of patients in 2016 failed to pay off medical bill balances, up from 53 percent in 2016 and 49 percent in 2014.

The survey found that 47 percent of Americans said they would be unable to pay for an unexpected medical bills of $100 or more without going into debt.

As a result, more physician practices are dealing with bad patient debt. According to the report, 22 percent of physician practices said that at least 10 percent of their patient accounts have bad debt tied to them. In addition, a majority of practices (54 percent) said between 3 percent and 9 percent of their accounts go to bad debt.

This requires practices and healthcare organizations to go after the debt, and 56 percent of practices surveyed said debt recovery could take three months or longer.

The TSYS report provides some strategies physicians can use to boost payment collections and reduce accounts receivable. They include:

- Focus on online payments: Although patients prefer to pay their medical bills online, less than half of practices surveyed offer online payment options.
- Offer a card-on-file program: Easy payments means faster payments. In the report, TSYS said it worked with one practice to implement a card-on-file program that reduced accounts receivable by 28 percent in six months.
- Provide payment plan options: Offer patients with delinquent accounts a way to pay the debt through payment plans. Even higher-income patients value these options. The report found that patients with incomes exceeding $75,000 actually use payment plans more frequently than patients who earn less.

"Multitasking is a myth, or better yet, a misnomer. When we multitask, we actually shift our attention rapidly between multiple tasks. Our brains are built to single task. When we task-switch, we interrupt ourselves and lose time in the process."  
— Rich Joseph, MD, MBA, and Elizabeth Harry, MD, on why multitasking is bad for physician wellness.

"In order to address this shift in generational healthcare, it's important that we understand why this disconnect is happening in the first place."  
— Dana Carne, MD, MBA, on how new generations of patients approach primary care differently than previous generations

To view, visit bit.ly/13-reasons-for-claim-denials
Dealing with the death of a patient

An inevitable occurrence in any physician’s practice is the death of a patient. But in family medicine, deaths are an unfortunate part of the territory. They happen all the time.

I think an important question to ask yourself is: “How do I as a physician respond to the death of one of my patients?” It’s a pertinent question because you have become a valued, respected member, yet peripherally, of the family. You have taken care of most of the family for years delivering their babies, giving them shots, treating their strep throats, pneumonia, broken wrist, caring for Grandma’s fractured hip, and holding their hands through chemotherapy. Now one of them has passed on. How do you respond to the family’s grief? How do you express sympathy for their loss?

It’s possible you were there when your patient died, but if you weren’t, I think there are three ways you can show how much you share in their family’s loss. These are things I did while in practice and have continued to do after retirement.

One, call the family on the phone and personally express your condolences, answer any pressing questions, offer prayers if requested, and offer emotional and physical support.

Two, I no longer live where I practiced so each day I scan the obituaries of my old town’s newspaper for familiar names and make a point to send the family a hand-written note expressing my sympathy and sharing in their grief.

Three, if the deceased has a funeral calling, make a visit and speak to as many family members as possible. Attending the funeral is an even better gesture. I have never had a family react negatively to my presence, and most express sincere appreciation and introduce me to family members who live elsewhere.

Of course, each of us has his/her own way of expressing sympathy to grieving families. But I think calling, writing, or being there are important ways you can express your concern and help a family deal with the death of a loved one. Cynically, one might say I’m “grandstanding.” I completely disagree with that insinuation. Families hold their physician in high regard, and practicing the courtesies I mentioned are always met with thanks and endless praise.

Showing kindness and concern almost never has negative consequences. Giving of yourself can only help and is very much appreciated by those on the receiving end.

William M. Gilkison, MD
CAVE CREEK, ARIZ.

Physicians should work fewer hours

Jenifer Frank, MD, in “How we can defeat burnout” (The Last Word, May 25, 2019, issue) mentions the main culprits behind burnout: long hours, poor remuneration, electronic health records, EHR, quality metrics, and tort law.

Until we doctors can find the courage to unite and confront the many forces aligned against us (which may be many years from now, if ever), the best remedy for burnout is to simply work fewer hours.

Of course working fewer hours may be an economic impossibility for most. Putting APRNs and PAs into the health system may be the only solution.

Edward Volpintesta, MD
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6 conveniences patients expect from today’s medical practices

Today’s patients expect the same conveniences from medical practices that they receive from restaurants or retailers. If they don’t get them, they will find another doctor. If practices want to compete in today’s healthcare environment, they need to offer patients convenience. Here are the top things patients expect from their doctor’s office, according to experts interviewed by Medical Economics:

**EASY ONLINE APPOINTMENT-SETTING**
Patients can order anything from a book to a mattress at any time with a few clicks on their smartphone. They don’t want to spend 15 minutes on hold to make an appointment. Practices need to offer online scheduling to patients to make it easier for them to book an appointment.

**SHORT WAIT TIMES**
Patients expect the doctor to see them within about 15 minutes of their appointment time. They have little tolerance in their own busy schedules for physicians who run late or overbook. To mitigate the issue, consider implementing a system that texts patients updates on wait times.

**QUICK RESPONSES TO QUESTIONS**
Patients expect a response to questions posed via email or an EHR portal in 24 hours or less. This timeframe is basic business protocol established by the retail and service industry, and medical practices must embrace it as well.

**TRANSPARENT PRICING**
Patients expect guidance on how much services will cost, what will be covered by their insurance and what will not. If a referral is made, the patient should be informed whether it will be in network or out of network. Any bill sent by the office (or better yet, presented online), should be easy to read and understand.

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**STREAMLINED PAPERWORK**
Today’s patient expects a smooth and easy visit. The more forms that can be filled out electronically and in advance of an appointment, the better. No one wants to sit in a waiting room filling out forms on a clipboard that could easily have been done the night before. Checkout should be just as easy, with little to no time spent standing in line.

**AVAILABLE**
Patients don’t get sick only during business hours, and offering a few Saturday appointments no longer caters to their busy lifestyles. If a practice doesn’t adapt its schedule to its patients, they’ll get their care from a place that does.
We are seeking stories from physicians about the moments that made you a better doctor. We want to hear your stories about: a memorable patient experience, the mistakes that taught you a valuable lesson, great advice from a mentor, an idea that transformed how you practiced, and anything else that made you better!

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ANTI-VAX CRISIS
How physicians can fight misinformation

by LAURA RAMOS HEGWER Contributing author

Amid a resurgence of measles across the country, many physicians aren’t sure how to talk with patients whose confidence in vaccines has wavered as a result of the anti-vaccination movement.

Today, patients’ concerns about vaccinations fall along a spectrum, with some refusing all vaccines while others are more hesitant about specific immunizations like the MMR vaccine or receiving several vaccines at once.

As vaccines have eradicated illnesses, some patients no longer view these diseases as threats. They may believe that real or perceived adverse events from vaccinations are a bigger threat than the illnesses themselves, says Saad Omer, MBBS, MPH, Ph.D., director of the Yale Institute for Global Health in New Haven, Conn., and a vaccination researcher.

Mistrust of government, drug companies, and healthcare providers as well as misinformation about vaccines spread by anti-vaccine advocates are also factors fueling
Trends

Anti-vax crisis

vaccine hesitancy. Along with access and insurance issues, they could be contributing to a downward trend in vaccination rates.

CDC data show the percentage of unvaccinated children is rising, with 1.3 percent of children born in 2015 not receiving any recommended vaccinations, compared with 0.9 percent of children born in 2011.

FACING INCREASED RELUCTANCE

Douglas DeLong, MD, FACP, chair of ACP’s Board of Regents and chief of general internal medicine at Bassett Medical Center in Cooperstown, N.Y., says his general internal medicine practice has not been affected by the anti-vaccination trend to the extent that many pediatric or family medicine practices have.

“Even at that time, we were fast approaching the herd immunity threshold at the national level,” he says, adding that recent outbreaks could be a sign that vaccine refusals are making it more difficult to maintain herd immunity in the U.S.

If measles vaccination coverage dips below the herd immunity threshold of 92 percent, the consequences could be significant, not just for individual patients’ health but for the entire country. In the March 26, 2019, issue of the Journal of the American Medical Association, Omer and his co-authors estimate the cost of responding to a single case of measles to be as high as $142,000. Measles outbreaks strain health providers and the public health infrastructure, requiring resources to test suspected cases, quarantine patients, manage post-exposure prophylaxis, and conduct public outreach, the article explains.

The communities most at risk are in states that allow parents to opt out of vaccinations. While every state requires school immunizations with exemptions for medical reasons, all but three—California, Mississippi, and West Virginia—also allow religious exemptions. In addition, 16 allow for philosophical exemptions, according to the National Conference of State Legislatures.

Sean O’Leary, MD, associate professor of pediatrics and infectious diseases at the University of Colorado Anschutz Medical Campus in Aurora, Colo., worries that communities in his state could be the next Clark County, Washington, or Williamsburg, Brooklyn, both sites of recent measles outbreaks. According to a 2018 CDC report, Colorado had the lowest kindergarten vaccination rate of 49 states reporting data. Only 88.7 percent of kindergarten students in Colorado received two doses of the MMR vaccine, compared with the national average of 94.3 percent.

“You won’t get absolute vaccine refusers with [presumptive announcement], but you will get a lot of parents who are on the fence. By taking that presumptive approach, you’re emphasizing vaccination as the social norm.”

—SEAN O’LEARY, MD, ASSOCIATE PROFESSOR OF PEDIATRICS AND INFECTIOUS DISEASES, UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS, AURORA, COLO.
Still, he has sensed increasing reluctance among some of his patients to receive immunizations, particularly the influenza vaccine, which some erroneously believe causes the flu.

Like many practices aiming to boost immunization rates, DeLong’s office sends patient reminders when vaccinations are due, as well as recall notices when patients are overdue for their shots. When he encounters a patient who is reluctant to receive an immunization, he tries to discuss the science behind vaccines but says this strategy often fails to change minds.

**EMPHASIZING VACCINATION AS THE NORM**

So which techniques can improve physicians’ chances of getting their patients vaccinated? One is by making a presumptive statement that assumes the patient will be vaccinated.

For example, rather than asking parents if they are ready for their child to get a shot, a physician might say, ‘It’s time for Johnny to get vaccinated.’ Such an approach doesn’t take away the parents’ choice to say no, says Yale’s Omer. “What it is doing is framing it as a routine procedure, which it is, based on its safety profile.”

Some studies have shown this technique can improve vaccine uptake.

Of course, presumptive announcements are not a solution for every patient. “You won’t get absolute vaccine refusers with this approach, but you will get a lot of parents who are on the fence,” says Sean O’Leary, MD, associate professor of pediatrics and infectious diseases at the University of Colorado Anschutz Medical Campus in Aurora, Colo. “By taking that presumptive approach, you’re emphasizing vaccination as the social norm.”

**ASKING PERMISSION TO SHARE FACTS**

If presumptive announcements fail, physicians can try motivational interviewing, in which they try to elicit the reasons why patients are refusing vaccines and then ask permission to share facts.

O’Leary explains how it works: The physician might ask an open-ended question such as, ‘What concerns do you have about the vaccine?’ After parents share why they are hesitant to vaccinate their child, the physician rephrases their concerns, then might say, ‘I’ve looked into this a great deal. Would it be OK with you if I shared what I’ve come to find out?’

“Simply asking that question makes people more receptive to the information that you are then going to impart,” O’Leary says.

In randomized trial results published in 2018 in *JAMA Pediatrics*, O’Leary and colleagues found that motivational interviewing helped improve HPV vaccine series initiation by 9.5 percent among parents who were resistant to vaccinating their teens.

Currently, O’Leary is collaborating on an NIH-funded study to investigate combining presumptive announcements and motivational interviewing to improve uptake of the infant series of vaccines.

**BUSTING MYTHS**

O’Leary cautions that physicians should be careful when seeking to debunk vaccine myths because this strategy can backfire.

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In fact, talking too much about a myth can have the opposite effect of reinforcing the misinformation, experts say.

Yale’s Omer adds that when physicians want to counter a myth outright, they should be clear about labeling the myth as such. Then they can explain why it’s not true and offer an alternative explanation.

For example, if a parent believes that the MMR vaccine causes autism, the physician should say this is a myth. Then the physician can reference the wide body of evidence, mention that several genes have been linked to autism, and connect the increasing prevalence of autism to better diagnosis and monitoring of the disorder, Omer says.

Another strategy Omer suggests is for physicians to focus the discussion on the disease the vaccine prevents, not the vaccine itself. This helps build their credibility as disease experts. “If you’re talking about the disease, you’re on stronger ground than if you are going through the nitty-gritty of countering every myth,” he says.

CLOSING THE DOORS TO NON-VACCINATED PATIENTS

Eliminating non-medical vaccine exemptions

In light of the recent measles outbreaks, it is likely that more states and localities will move to eliminate non-medical vaccination exemptions, says Lawrence Gostin, JD, professor and director of the O’Neill Institute for National and Global Health Law at Georgetown Law in Washington, D.C.

“The more measles is in the headlines, the more likely the government will be compelled to act,” says Gostin, who responded to questions via email. Oregon, for example, is considering eliminating non-medical exemptions, while cities such as Los Angeles and New York City now require vaccinations on university campuses and in Orthodox Jewish communities, he adds.

But state vaccination mandates will be ineffective if physicians fail to advise their patients to be vaccinated, actively discourage vaccination, or provide misleading information.

“After California eliminated non-medical exemptions, the number of medical exemptions went way up,” Gostin says. “Physicians are clearly not honestly filling in exemption forms and ignoring the overwhelming scientific consensus that vaccines are safe and effective.”

Federal policymakers are also stepping up efforts to combat the anti-vaccination movement. At press time, a bipartisan bill introduced by two physicians in the House of Representatives, Reps. Kim Schrier, MD, (D-Wash.) and Michael Burgess, MD, (R-Texas) would provide federal funding to monitor vaccine hesitancy and educate the public on vaccines. The bill is supported by American College of Physicians, the American Association of Family Physicians, the American Academy of Pediatrics, the American Osteopathic Association, and other groups.

“It is very important that we increase vaccination rates, because vaccines have been arguably the most important public health measure in modern medicine,” says Douglas DeLong, MD, FACP, chief of general internal medicine, Bassett Medical Center, Cooperstown, N.Y. “It is important for us as physician-scientists to make that message loud and clear.”

“Vaccines have been arguably the most important public health measure in modern medicine. It is important for us as physician-scientists to make that message loud and clear.”

—DOUGLAS DELONG, MD, FACP, CHIEF OF GENERAL INTERNAL MEDICINE, BASSETT MEDICAL CENTER, COOPERSTOWN, N.Y.
For practicality, patient safety or other reasons, some physicians are dismissing existing patients or refusing new ones if parents do not agree to follow the recommended vaccination schedule.

Paul Ehrmann, DO, medical director for the Family Health Care Center, a family practice in Royal Oak, Mich., is upfront with patients about maintaining a traditional immunization practice that requires full vaccinations. As such, the practice does not take new pediatric patients if their parents do not want them vaccinated.

Ehrmann estimates that he has declined fewer than a dozen patients. However, he has not dismissed the handful of patients in his practice who are not immunized and joined the practice more than 30 years ago when the practice did not have specific guidelines.

His practice’s website describes its vaccination philosophy, and office staff are trained to convey it respectfully and without judgment on the phone with prospective patients. “We try to set the tone before we see the patient,” Ehrmann says.

When talking with patients who have concerns about vaccinations, Ehrmann favors a low-key approach that focuses on the benefits of vaccinating based on the research. “I try not to be argumentative or contentious in any way,” he says. However, he wants to make sure that there is no misunderstanding his pro-vaccine position.

When asked, Ehrmann will sometimes stagger shots for children under age two whose parents are reluctant to have them receive several shots at one time. “I respect that and don’t push that, but I try to get the kids caught up as soon as we can,” he says.

In Oakland County, where Ehrmann practices, more than 40 cases of measles had been identified at press time, but none in his practice. Given the threat of future outbreaks, he believes physicians have a responsibility to do what they can to improve immunization rates.

“We respect patients’ feelings, however, we are stewards of not only our patients but also the public health and community at large,” he says.

**COLLABORATING ON SOLUTIONS**

Of course, physicians are not the only ones who can reverse the anti-vaccination trend, experts say. Employers could offer on-site flu shots. Payers could start reimbursing providers for vaccine counseling even when a vaccine is not administered. The federal government could withhold health or education funding to states that do not eliminate non-medical vaccine exemptions. Social media platforms could step up their efforts to curtail false information about vaccines.

Although coordinating such efforts will not be easy, Yale’s Omer is optimistic about the outlook in the United States compared with European countries such as Germany, France, Great Britain, and Italy that have had national outbreaks of measles. He credits school-entry vaccine requirements and public health agencies for maintaining immunization rates and quickly responding to measles outbreaks in the United States, as well as professional medical societies for their strong vaccine advocacy.

“There are a lot of things we don’t do well,” Omer says, “but this is one thing we do very well.”

“If you’re talking about the disease, you’re on stronger ground than if you are going through the nitty-gritty of countering every myth.”

—Saad Omer, MBBS, MPH, Ph.D., Director, Yale Institute for Global Health, New Haven, Conn.
Hospital observation billing: clearing up confusion

Q: Is the reporting of Current Procedural Terminology (CPT) codes 99218-99220 restricted to a single physician? Or may these codes be reported by a second physician, who provides care for a separate problem?

A: According to the CPT guidelines, only the physician or non-physician practitioner (NPP) placing the patient in observation status (and subsequently discharging the patient) may report the appropriate initial observation code (99218, 99219, 99220). This refers to the initiation of observation status and the supervision of the care plan for observation. Encounters by physicians/NPP’s other than the supervising (admitting) physician for same day services may be reported with outpatient consultations codes (99241-99245) or subsequent observation codes (99224-99226), as appropriate.

Be sure to check with your payers to verify that they follow CPT guidelines. Some Medicare contractors and other payers may instruct to bill outpatient office visit codes (99201-99215) to requirements to qualify for a particular level of E/M service.

Q: If a patient is admitted to observation status and remains under observation for two days before finally being admitted, is it appropriate to report the initial hospital care codes?

A: If a patient is admitted to the hospital on a date subsequent to the date of observation placement, the hospital admission may be reported with the appropriate initial hospital care code (99221-99223). The initial hospital care level of service reported should include all evaluation and management (E/M) services provided to that patient in conjunction with that admission on the same date by the admitting physician. This means that an observation discharge should not be billed on the same date that the initial hospital care code is billed.

Q: Does code 99226 require medical decision making of high complexity?

A: Not if both of the other two components (history and exam) in the code are performed. When subsequent observation care is reported, at least two of the three key components (history, exam and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M service.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient’s hospital floor or unit.

Two of the three key components must be met or exceeded for the level of service selected. Time may be used to select the level of service when counseling and coordination of care are documented as at least half of the time spent face-to-face with the patient.

Be sure to check with private payers regarding specific reporting and payment policies.

Renee Dowling, CPC, is a billing and coding consultant with VEI Consulting in Indianapolis, Ind. Send your coding and billing questions to medec@ubm.com.
More than malpractice: The other types of insurance doctors need

by JAMES F. SWEENY Contributing author

When physicians think about buying insurance they tend to focus on medical liability coverage, and understandably so: It’s probably the largest premium they’ll pay and it applies to the risk that usually worries them the most.

But doctors may overlook other types of insurance that can be just as crucial to protecting their assets and livelihood—coverage for everything from fire and hacking to employee theft. In some states, certain forms of coverage are required by law, a mandate of which practices might be unaware.

“I find coverage holes all the time,” says Richard Weston, CIC, a senior account executive at Physicians Insurance Agency of Massachusetts. “Practices don’t know what’s required or what they need until it’s too late.”

HIGHLIGHTS

» In addition to other kinds of insurance, physicians should consider umbrella policies to safeguard against catastrophic awards that exceed the limits of other policies.

» Premiums for property insurance depend on a variety of factors, including the size, age, and condition of the building and the value of the contents.
“There is a comfort level in using the same broker for all of your policies; however, is the broker contracted with the right companies?”

—PATRICK LAWN, OWNER, PHYSICIANS INSURANCE CONSULTANTS

Insurance needs vary among practices and not every practice needs every type of coverage, but here is a guide to some of the common forms, beginning with two often required by law:

**WORKERS’ COMPENSATION**

Regulations vary from state to state, but many require small businesses with more than a certain number of employees to provide workers’ compensation coverage. This covers medical expenses and a portion of lost wages for employees who become ill or injured on the job. Coverage can also include employee rehabilitation and death benefits.

This type of coverage is relatively inexpensive, says Weston, who estimates the annual cost at 28 cents per $100 of payroll.

**ERISA**

The Employment Retirement Income Security Act sets rules and standards for private sector employee benefit plans, such as 401(k)s, and the people that manage and invest their assets. ERISA requires fund managers to be covered by a fidelity bond to protect the plan from losses due to fraud or dishonesty. The coverage is specific to a practice’s retirement plan with the amount of required coverage at the lesser of $500,000 or 10 percent of plan assets. A bond typically lasts three years and can cost less than $500, Weston says.

**GENERAL LIABILITY**

This protects against claims for bodily injury and property damage arising out of operations, premises, and products. These policies are often required by landlords as a condition of leasing.

**COMMERCIAL PROPERTY**

This covers damages to buildings, so a practice would obtain this type of insurance if it owns its own building. But even if a practice leases space, it needs this insurance to protect against loss of medical and office equipment, fixtures, and furniture due to theft, fire, water damage caused by broken pipes, etc.

Property insurance often is bundled with general liability in a business owners policy (BOP), says Patrick Lawn, owner of Physicians Insurance Consultants, an independent brokerage in Pennsylvania. A BOP also can be expanded to include worker’s compensation, cyber, and other forms of coverage, he adds.

Premiums depend on a variety of factors, including the size, age, and condition of the building; value of the contents; whether the building has fire sprinklers etc. A typical policy for a small practice might cost about $2,000 a year, Lawn says.

**CYBER**

This is a relatively new form of insurance, but it’s becoming a necessity, even for practices that might think they’re too small to attract hackers. It covers losses and damages resulting from patient data being stolen, exposed, improperly shared, or held for ransom. It covers deliberate actions, such as hacking or ransomware, as well as accidents, such as a lost laptop containing unencrypted patient information or a coding error that exposes patient data.

A comprehensive policy will cover paper records as well, since so much information is still stored in physical files. It also should include first-party and third-party coverage. First-party coverage pays for damages suffered by the policy holder, while third-party coverage compensates for damages caused to others by the data breach, such as legal costs incurred from lawsuits filed by affected patients.
Malpractice and general insurance policies often include some cyber coverage, but usually not enough, Lawn says.

When shopping for cyber insurance, be sure the carrier is required to provide a comprehensive range of assistance in event of a breach, such as paying regulatory penalties, hiring IT experts to find and fix the breach, hiring attorneys to defend patient lawsuits, and paying ransom to free hijacked data.

**BUSINESS INTERRUPTION**
This provides income in the event that a practice cannot function or bring in revenue because of an event such as a fire or natural disaster. It differs from property insurance in that it covers lost income.

**THEFT AND EMPLOYEE MISCONDUCT**
No practice likes to imagine misconduct from an employee, but it happens, says Kenneth Hertz, FACMPE, principal consultant with Medical Group Management Association. He advises practices to have every employee who handles money, whether cash or credit card payments, be bonded because “you never know when theft is going to raise its ugly head.”

**EMPLOYMENT PRACTICES**
This policy protects a practice if it’s sued for reasons such as discrimination and sexual harassment. Coverage protects the physician owners as well as claims against the staff, such as an HR manager. A 10-person practice might pay $1,500 a year for a $1 million policy, Weston estimates.

**DISABILITY**
This coverage comes into play if a physician or other significant revenue generator is disabled and unable to bring in revenue. In that case, the policy replaces that income. This is...but don’t forget malpractice

**Tips on shopping and updating your policy**

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

“I’ve seen doctors who are looking to save expenses, but they don’t bother [comparison shopping] one of their highest overhead expenses,” says Patrick Lawn, owner of Physicians Insurance Consultants.

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

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

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

- Adding a provider
- Starting a joint venture or new business
- Forming a new entity
- Changing employers
- Any changes in practice parameters, such as new services or using new equipment
particularly important for smaller and solo practices where the loss of one physician could threaten its existence.

Any policy should define disability as a physician no longer being able to work as a physician, rather than as complete disability, says Lawn. That is to prevent an insurer from denying a disability claim if a physician could perform a different job.

These umbrella policies, so called for the way they shelter everything beneath them, typically provide an additional $1 million in coverage. They can be written to cover a range of claims and cost roughly $500 a year for $1 million of coverage, according to Weston.

NECESSARY VS “NICE TO HAVE”

Does a typical independent practice need every policy listed above? Not necessarily, says Hertz, who warns against buying so much coverage that a practice becomes “insurance poor.”

Some forms of coverage, such as worker’s compensation and ERISA, are required by law while others, such as general liability, employee health, and property are fundamental to a practice’s ability to operate.

Every practice must decide what other coverage it requires based on its exposure, tolerance of risk and ability to pay, Hertz says. He advises physicians seeking guidance to talk to colleagues about their coverage and experiences.

HOW TO SHOP FOR INSURANCE

Shopping for so many different types of insurance can be daunting and time-consuming. Many insurers offer most or all types of policies and it can be easier to go with as few vendors as possible. Insurers also sometimes offer discounts for bundling multiple policies.

Weston recommends using an independent insurance broker who specializes in medical practice coverage. “A lot of generalists aren’t as well versed in the risks presented by a medical practice,” he says.

But research the broker, adds Lawn: “There is a comfort level in using the same broker for all of your policies; however, is the broker contracted with the right companies? Your broker may not be able to provide you with the best priced carrier as they may not be contracted to represent them.”

Don’t be afraid to ask for discounts and use comparison quotes to negotiate a better deal, says Hertz, who adds, “You don’t get what you don’t ask for.”

And buying policies doesn’t require staying with the same carriers forever, adds Lawn, who recommends comparison shopping every few years to ensure the best pricing and adequate coverage.

“I find coverage holes all the time. Practices don’t know what’s required or what they need until it’s too late.”

—RICHARD WESTON, CIC, SENIOR ACCOUNT EXECUTIVE, PHYSICIANS INSURANCE AGENCY OF MASSACHUSETTS
Unlike in healthcare where every certification and qualification is earned, anyone can call themselves a financial planner. There are no required certifications, exams, registrations, or coursework. That means there are a lot of unqualified planners out there.

Here’s how to find the right planner for you:

1/ Hire a Certified Financial Planner (CFP).
To earn the CFP designation, a planner must pass a test administered by the Certified Financial Planner Board of Standards and commit to continuing education on financial matters and ethics.

A CFP is the financial equivalent to a primary care doctor, dealing with the client’s overall financial health.

Another important designation is Registered Investment Advisor (RIA). It means the adviser is registered with the Securities and Exchange Commission (SEC) and provides investment advice for a fee.

2/ Make sure the planner is a fiduciary.
Many planners earn money from selling investments and other financial products and it is perfectly legal for them to sell something that is not optimal for a client, but that earns them a commission. Their standard is “suitability,” meaning an investment should be appropriate, but doesn’t have to be the best or conflict-free.

A fiduciary is legally obligated to act in the client’s best interest at all times. Beginning Oct. 1, 2019, all CFPs must adopt the fiduciary standard.

3/ Understand how the planner is paid.
Planners earn their money either from commissions or by charging hourly or flat fees. A commission is a fee paid when a financial product is bought or sold, and this can create an incentive for planners to push unnecessary sales and purchases.

Other planners charge a fee for advice. This can be a flat fee for a specific task, such as developing a financial plan, or an annual fee, such as 1 percent of all assets under management.

The fee-only system is a better way to receive unbiased advice.

4/ Hire a planner who works with other doctors.
The planner doesn’t have to work solely with healthcare providers, but they should be experienced in the issues physicians face, such as student loan debt.

5/ Run a background check.
- Ask if the planner has ever been convicted of a crime or been investigated by a regulatory body or industry group.
- The Financial Industry Regulatory Authority has a page that explains each adviser professional designation and links to the organizations that issued the designation. Clients can check for complaints on the organization pages.
- The SEC also has a site which allows clients to check the credentials and disciplinary record of advisers.
- Ask for references of current clients with goals and finances similar to yours.
- Check to make sure credentials are current.

6/ Ask around.
Consult with colleagues to find out if they are happy with their planners. Look for those in financial situations similar to your own (children, career stage, etc.)

7/ Beware of boasts.
Avoid planners who claim they always beat the market or who promise extraordinary returns. They’re either exaggerating, or worse, likely to take unwelcome risks.

Jim Sweeney is a contributing author. Send your financial questions to medec@ubm.com.
n a previous column, I discussed how doctors can help patients obtain low-cost generic medications by operating an in-house dispensary. One barrier to in-house dispensing occurs when patients need brand-name drugs—particularly for patients who are uninsured or underinsured.

My direct primary care practice focuses on care for such patients: 75 percent of our patients either have no health insurance, or only a high-deductible catastrophic policy, including some Obamacare policies which may have deductibles up to $6,650 for individuals and $13,300 for families. Many of these patients will be unable to afford brand-name drugs, even when medically necessary.

Fortunately, there are ways to help. The first thing to do is to consider whether the patient’s brand-name medication can be changed to something generic, or even be stopped completely. Now, this may sound like a “Captain Obvious” suggestion, but with so much to do during a brief office visit, sometimes medications just get automatically renewed without much consideration of cost.

For example, a patient may have received samples of the latest-and-greatest drug. When the samples run out, their physician sends a prescription to the pharmacy without realizing just how expensive the medication is. In some cases, a less-expensive older version of the same class of medication will work just as well.

It is also helpful to consider what medications may be able to be “depréscribed”; for example, if they are no longer medically necessary or consistent with the patient’s care goals.

But let’s imagine that you have determined that a patient really and truly needs an expensive brand-name medication, and there is no reasonable generic substitute. Here is what I do.

**RELY ON SAMPLES**

I don’t get as many pharmaceutical sales visits as I used to when I had a larger Medicare and insurance population. But when I do see my sales reps, I hit them up for as many samples of my most-needed medicines as I can get. I also visit manufacturer websites and request samples through their online forms—this is particularly helpful for obtaining insulin samples for patients. Of course, the downside to samples is that eventually the demand may exceed your supply. In that case, the next step is to turn to coupons and special programs.

**USE COUPONS**

The best thing about free trial coupons is that anyone can use them, even patients with Medicare and Medicaid. The downside is that these coupons can usually be used only once, and they aren’t offered for all medications. Nonetheless, it’s worth checking the drug maker’s website to see if they have a free month’s trial for the medication you are seeking—and write for a stronger dose of the medication for the patient to split when possible.

Discount manufacturer coupons or copay assistance cards are usually most helpful for patients with commercial insurance. They cannot be used by patients with any government insurance like Medicare, Tricare, or Medicaid. In the case of a high-deductible insurance plan, they may not be useful at all, as the assistance is usually capped at a certain annual amount—but it is often worth trying the card to see how low the price can go.

**PATIENT ASSISTANCE PROGRAMS**

Almost every pharmaceutical company offers medications for free to those who financially qualify. Each company has its own application and requirements—the best thing to do is to go directly to the manufacturer’s website and find their application. Don’t go through advertised programs that are supposed to help you find patient assistance programs—these are usually middlemen and are sometimes promoting discount cards.

Patient assistance programs usually require that applicants have proof of limited or no prescription coverage, financial need, and U.S. residency. Patients with Medicare Part D who have hit the “donut hole” or whose drug
expenses are more than 5% of their household income may also qualify.

The financial criteria depend on the company and can vary from 200% below the Federal Poverty Level (equivalent to about $25,000 per year for an individual, or $51,500 for a family of four) to 500% of the Federal Poverty Level for other drug-makers (about $50,000 for an individual and $103,000 for a family of four).

The amount of proof required can be as simple as a checkbox acknowledging that the patient meets the qualifications or may require paperwork like a tax return or check stubs, depending on the company’s policy.

In general, physicians must fill out a portion of the patient assistance program application and sign the form. The forms are usually quite simple, and the programs often have excellent customer assistance. Medications are either shipped to the physician’s office or to the patient directly. In some cases, patients receive a card or voucher to take the pharmacy to receive their medication. I have had incredible success in helping my patients obtain free medications from multiple pharmaceutical companies, including year supplies of diabetes medications, biologic agents for autoimmune disease, and even two patients who received free treatment for Hepatitis C ($80,000 value per treatment) and are now cured of the disease.

Rebekah Bernard MD is a family physician and the author of How to Be a Rock Star Doctor and Physician Wellness: The Rock Star Doctor’s Guide.

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Chronic care management

Delivering effective, profitable services

by RAY PELOSI Contributing author

Chronic care management (CCM) has an overarching clinical goal—improving the health of Medicare patients with multiple chronic conditions.

Besides knowing the service parameters, pay rates and usage requirements for CCM codes, physicians must understand how to effectively bill for CCM in order to profitably achieve that goal.

THE CODE PARAMETERS

Medicare pays for CCM (typically, non-face-to-face) services to patients with multiple chronic conditions that are expected to last at least one year and present a significant risk of death, acute worsening of those conditions or functional decline. Three primary codes define this type of billable care:

- **CPT 99490** – Patients receive CCM services through at least 20 minutes of clinical staff time each month. The provider must also create a dynamic comprehensive health plan – i.e., an electronic care plan that assesses patient factors (physical, mental, cognitive, psychosocial, functional and environmental) and inventories all available care resources. The vast majority of Medicare claims are billed under this code.
- **CPT99487** – Similar to the first code, except that the patient receives complex CCM services, minimum monthly clinical staff time is 60 minutes, and the necessary medical decisions are moderately or highly complex. (Complex and non-complex CCM services differ in the amount of clinical staff time, care planning, and billing practitioner work.)
- **CPT99489** – This covers each additional 30 minutes of clinical staff time each month and also applies to complex services.

Primary CPT code rates run from $42.17 for 20 minutes (CPT 99490) to $92.95 for 60 minutes (CPT 99487), with the rate for the extra 30 minutes under CPT99489 being $46.49.

Providers ordinarily can bill for CCM services under only one code per month, though services for both complex codes can be billed if the practice meets each code's reporting time requirement. CCM can’t be billed in a month when the patient receives home health or hospice care supervision or services involving certain end-stage renal care, transitional care management or prolonged evaluation and management services.
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Before billing for CCM services, providers must satisfy these basic preconditions: Patients must give verbal or written consent and pay 20 percent for coinsurance; the billing practitioner must make an initial visit with the patient within 12 months of the first CCM claim; provide 24/7 access to care; use a certified EHR to aggregate all patient health information; and establish continuity through a designated care team member who works with the patient to implement a dynamic plan that spells out the patient’s key prevention and treatment goals and strategies.

**REAPING FINANCIAL BENEFITS**

By billing for CCM, practices can cut expenses and boost revenues. A Mathematica Policy Research Group study found that providing CCM services reduced growth in total monthly expenditures by $74 per patient over 18 months while averaging revenues of $18 whenever a patient received healthcare services for a specific condition within a month. CCM program savings were $95 per beneficiary per month when beneficiaries received healthcare services more than once in that month.

The report, which tracked costs for patients enrolled in CCM programs vs. costs for non-CCM beneficiaries between 2014 and 2016, also suggests that practices adopting CCM will score very well in the cost category of the Merit-based Incentive Payment System’s performance scores.

These results largely flow from the improved care that CCM has delivered by increasing patients’ connections with their primary care provider and decreasing hospital and emergency department visits, and, per the Mathematica study, from an approximately tenfold increase under CCM in the rates at which patients establish advance care directives with their providers.

Yet Martie Ross, JD, a founding partner in the healthcare management consulting practice PYA, in Overland Park, Kan., says the formula for Medicare reimbursement rates—adding physician work effort and practice expenses—makes it tough for most practices to offset the infrastructure investment needed to make CCM work.

Practices that have discovered how to make CCM profitable “have some things in common—most importantly, the primary care provider directly introduces the services by engaging the patient in an initial conversation about CCM” instead of handing out a descriptive form or recruiting patients by phone, she says.

Membership in an ACO can ease that infrastructure cost burden, because the ACO can efficiently provide CCM services through a hub serving multiple practices. For instance, an ACO that PYA advises has provided 30,000 CCM services through a team of health coaches across 30 rural Kansas counties through a centralized team of care managers under the supervision of a physician who also handles all CCM billing.

“In this model, the peer managers all have access to the practice’s EHR, so they can see the electronic health record of the patient for whom they’re providing CCM and also enter data and maintain the care plan within the patient’s EHR,” Ross explains. Moreover, ACOs can give multiple providers access to the data analytics required to manage patients in a value-based contract.

**ADOPTING THE RIGHT MINDSET**

Fee-for-service (FFS) billing is still used by most practices. But if practices are to cope with CCMs administrative, clinical, documentation and billing requirements, they must change their FFS mindset, says William Mills, MD, ABIM, founder of Chronic Care Management, Inc., a Solon, Ohio consulting firm that helps providers implement CCM technology and services.

“The groups that do the best with CCM have buy-in from their leadership team to start taking a population health management (PPM) approach to their chronically ill patients and also are interested in a new per-patient, per-month revenue stream,” Mills says. In his view, an individual physician or practice with anywhere from 500 to 2,000 or more patients could develop a very significant gross revenue stream by billing 42 to 90 or so dollars per patient per month.

Effectively furnished and profitably billed CCM also requires an advanced technology platform to enable CCM workflows. It needs to use evidenced-based tools to assess risks such as emerging functional, social or psychological complications, acute care utilization, and the concurrent usage of multiple drugs to treat a condition. It also should generate a comprehensive care plan and an audit trail to ensure compliance with CMS rules.

—MARTIE ROSS, JD, FOUNDED PARTNER, PYA, OVERLAND PARK, KAN.
THE IMPACT OF PROGRAM SIZE
If a practice’s CCM program is big enough, it can even contribute to CCM enrollment among healthcare professionals outside of the practice. CareMount Health Solutions, the physician-owned Medicare coordination subsidiary of CareMount Medical, a multi-specialty practice in six New York counties, is doing just that.

While CareMount has targeted up to 10 percent of its own 25,000 Medicare beneficiaries for CCM services delivered by its own primary care providers, “We’re also starting to branch out and educate our specialists, who may not be following patients who have primary care physicians within our group, but are still following patients who are quite ill and eligible for CCM services,” says Lisa Bardack, MD, chair of CareMount’s department of internal medicine. “Those specialists are now interested in utilizing the CCM platform we developed.”

At the same time, CareMount’s scale and CCM platform sophistication have positioned them to help practices—at a competitive cost—that can’t do CCM on their own. “We’re looking at capturing smaller medical groups or individual providers outside of our organization who may want our assistance in participating in a program like this,” adds Bardack. Clinical care coordination, quality improvement, population health and data analytics are among the services CareMount may offer in this regard.

THE OUTSOURCING DECISION
Given the administrative challenges of CCM billing and the expertise needed to aggregate and analyze data available with an advanced EHR platform, it may be that most practices don’t have the bandwidth or experience to operate CCM themselves.

Non-physician providers can help lower care costs for complex patients

By Jeffrey Bendix Senior Editor

In recent years, nurse practitioners and physician assistants have been taking on ever-greater roles as primary care providers, especially for patients with chronic complex conditions. Their expanded use has been driven largely by the shortage of primary care physicians.

A new study suggests that they can also reduce the costs of caring for these patients. The study, published in the June issue of Health Affairs, focuses on approximately 47,000 medically complex patients with diabetes who received care at Veterans Affairs facilities in 2013. It compares the costs and outcomes of those who had physicians as their primary care provider with those who received care from an NP or PA.

About half the patients were older than 65. On average, patients receiving care from physicians had 6.9 chronic conditions, while NP and PA patients had 6.7 and 6.8 conditions, respectively.

The study found that patients getting care from NPs and PAs had fewer emergency department visits and in-patient stays than those who were cared for by physicians. That, in turn, led to lower inpatient, outpatient and pharmacy expenditures. Inpatient spending was 8.7 percent lower for patients of NPs and 6 percent lower for patients of PAs. For outpatient expenditures the differences were 2.9 percent and 5.3 percent, respectively, and for pharmacy the differences were 8.9 percent and 7.7 percent.

Overall, expenditures on patients of NPs were 6 percent lower than on patients of doctors, while for PAs the difference was 7 percent. That translates to a difference of $2,000 and $2,300, respectively, in annual per-patient healthcare costs.

The authors say their findings refute the belief held by some physicians and administrators that using NPs and PAs to treat complex patients drives up care costs, because these providers are less able to handle acute illness exacerbations than doctors, and therefore their patients are more likely to require expensive ED visits or hospital admissions.

Consequently, they say, the study “provides further evidence that NPs and PAs be appropriately used as primary care providers, as opposed to being limited to supplementing the care of physicians within primary care settings.”
Operations

Chronic care management

“The groups that do the best with CCM have buy-in from their leadership team to start taking a population health management (PPM) approach to their chronically ill patients and also are interested in a new per-patient, per-month revenue stream.”

—WILLIAM MILLS, MD, FOUNDER, CHRONIC CARE MANAGEMENT, INC., SOLON, OHIO

says Mills. Going in-house might seem economical, yet it’s expensive to recruit, train and equip qualified people who can manage the care and provide full, accurate documentation and billing. But Mills cautions that “a disadvantage of outsourcing can be that unless there is a good bilateral agreement between the practice and the CCM enabler (vendor), the identified patient risks and care gaps are difficult to address.”

According to Mills, it’s up to the practice to close any such gap that the vendor identifies, but since the vendor doesn’t practice medicine, developing a workflow that effectively addresses those gaps “depends upon good collaborative communication and workflow setup.”

Failure to detect and eliminate those risks and care shortfalls can delay the interventions necessary to prevent a hospitalization or other care crisis and keep patients from accessing support services that complement their medical care. To make certain that both parties are on the same page, the practice may want a services agreement that commits the vendor to furnishing services that establish round-the-clock care coordination, such as conducting monthly reviews to refresh the care plan; ensuring that patients receive all of their recommended preventative care; operating an online care management portal to inform and answer questions from the patients and their families; reminding patients about upcoming visits and therapy through texts and phone calls; and facilitating the delivery of community resources when necessary.

Beware of third-party vendors who promise significant revenue from CCM, warns Ross. “Instead, what makes sense is finding a third party partner who helps you more effectively reach and manage patients that demand a lot of your resources and staff time—and who can help you cut your CCM management costs.”

Nor should practices equate outsource value with how many of their patients the vendor can call every month. When River Bend Medical Associates, a family practice in Sacramento, Calif., began its CCM program in 2015, it started small, targeting about 100 of its sickest, highest-need patients, and sought an outside vendor that aligned with that approach and would assist, rather than run, its program.

But most of the companies the practice approached wanted to take over the program, take 50 percent of River Bend’s CCM reimbursements “and just hit as many of our patients each month as possible,” recalls Francisco Garcia, MD, the practice’s leader. Instead, River Bend hired a vendor who charges much less and risk-stratified patients by acuity levels, with highest-acuity patients getting at least one call each month and those with lowest acuity getting quarterly calls.

That, and a relationship-based strategy assigning a care coordinator to each CCM patient has resulted in high patient satisfaction, minimal disenrollment and a sustainable operation.

Taking a value-based approach to CCM that combines robust enrollment, the aggressive and correct documentation of billable activities, and the efficient, needs-based delivery of services to patients can give practices a CCM program that reduces the total cost and increases the overall quality of patient care.
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From the publishers of Medical Economics
A recent fine serves as a continued lesson for providers and medical practices to conduct a comprehensive risk analysis, one that can mitigate their risk of penalty from the U.S. Department of Health and Human Services (HHS)’s Health App FAQs.

In late May, Medical Informatics Engineering, Inc. (MIE), an Indiana-based medical records service agreed to pay $100,000 and take corrective action to settle potential violations of the HIPAA Privacy Rule and Security Rule after a cyberattack affected 3.5 million people. HHS’s fine appears to reflect the new penalty amounts.

The company self-disclosed the cyberattack July 23, 2015. Nearly four years later, the Office for Civil Rights’ investigation revealed that “MIE did not conduct a comprehensive [enterprise-wide] risk analysis prior to the breach” as required annually under 45 C.F.R. § 164.308(a)(1)(ii)(A). This particular section of the Security Rule requires an annual risk analysis to assess the potential risks and vulnerabilities associated with the confidentiality, integrity and availability of the data.

This breach and the associated legal, compliance and reputational costs could have been avoided through a comprehensive risk assessment.

Taking this recent action as a “learning moment,” here are two lessons that providers should take to heart. First, if providers read the resolution agreements associated with the imposition of HIPAA penalties as well as class action lawsuits, they will see one of the top areas of non-compliance is not conducting a risk analysis. Second, in light of the HHS Health App FAQs, a comprehensive risk analysis and adequate due diligence with an app (or other technology) company can mitigate the wrongful disclosure of protected health information, penalties and legal costs.

One of the FAQs poses the following concern:

Does HIPAA require a covered entity or its EHR System developer to enter into a business associate agreement with an app designated by the individual in order to transmit ePHI to the app?

The short answer: It depends.

The long answer: “HIPAA does not require a covered entity or its business associate (e.g., EHR system developer) to enter into a business associate agreement with an app developer that does not create, receive, maintain or transmit ePHI on behalf of or for the benefit of the covered entity (whether directly or through another business associate). However, if the app was developed to create, receive, maintain or transmit ePHI on behalf of the covered entity, or was provided by or on behalf of the covered entity (directly or through its EHR system developer, acting as the covered entity’s business associate), then a business associate agreement would be required.”

Because a business associate would be required in these circumstances and business associate agreements are contracts, which by their very nature require the parties to agree that they are respectively in compliance with the Privacy Rule and Security Rule, it follows that a material statement is being made that a risk analysis has been conducted along with other technical, administrative and physical safeguards.

Therefore, providers should take this opportunity to learn from MIE’s fine and consider the implications of not conducting a risk analysis for their own medical practices.

Rachel V. Rose, JD, MBA, advises clients on compliance and transactions in healthcare, cybersecurity, corporate and securities law. She also teaches bioethics at Baylor College of Medicine in Houston. Send your legal questions to medec@ubm.com.
What’s being done to stop EHR data blocking?

by MARY K. PRATT Contributing author

The federal government is pushing forward with regulatory action that it hopes will end data blocking and promote more sharing of patient information.

The latest move on this front came in February, when the Office of the National Coordinator for Health Information Technology issued its proposals for implementing the provisions against information blocking that were laid out in the 21st Century Cures Act. More specifically, ONC is defining what does and does not constitute information blocking by detailing the seven specific scenarios it believes are legitimate reasons for clinicians withholding electronic health information (EHI).

Experts say they see ONC’s move as signaling clinicians to more readily share EHI in all circumstances except for these seven exceptions it is outlining—a message that experts believe has the potential to greatly improve the free flow of patient data needed to ensure the best quality of care.

“This is a big deal for providers, because you can’t be successful in the world of value-based care if you don’t have good information,” says Joel White, executive director of the Health Innovation Alliance (formerly Health IT Now), a nonprofit group promoting the use of information technology in healthcare.

DATA BLOCKING EXCEPTIONS

The Cures Act, passed in December 2016, seeks to encourage freer flow of EHI. To do that, the act tasked the U.S. Department of Health and Human Services, of which ONC is a part, with establishing the limited scenarios under which clinicians could withhold sharing of EHI.

ONC in March published the details of the seven activities that it says should not be considered information blocking. HHS is accepting public comments on this proposal through June 30 before finalizing the regulations.

ONC proposes that clinicians are not engaged in information blocking if they are

- preventing harm
- promoting the privacy of EHI
- promoting the security of EHI
- recovering costs reasonably incurred
- responding to requests that are infeasible
- licensing of interoperability elements on reasonable and nondiscriminatory terms
- maintaining and improving health IT performance.

ONC also established the conditions clinicians would have to meet under each of those seven scenarios to show that they’re not engaged in information blocking.

WHAT IS INFORMATION BLOCKING?

Information blocking (sometimes also called data blocking) happens for various reasons related to policy decisions, business practices, and technical challenges, says Jeffery Smith, M.P.P., vice president of public

HIGHLIGHT

Vendor policies can also block information sharing, experts say, as some clinicians find that when they want to switch EHR vendors they have to pay steep fees to their former vendor to have the patient data transferred.
Opinion: It’s time to go bigger on health IT policy  

By JOEL WHITE

The Trump administration recently released the much-anticipated proposed rules designed to facilitate interoperability among healthcare systems and stem the harmful practice of information blocking, which occurs when vendors or providers willfully impede the flow of health information.

It was a long time coming. The Health Innovation Alliance (formerly Health IT Now), where I am privileged to serve as executive director, first made the Office of the National Coordinator for Health Information Technology (ONC) aware of these problems plaguing the healthcare system in 2011.

From there, we led the effort to secure inclusion of tough language in the 21st Century Cures law to end information blocking (Section 4004).

While a step in the right direction, the administration’s proposed rules are a reminder that the federal government’s treatment of health IT remains underwhelming.

After all, these proposals are a years-delayed response to the challenges of today. Such reactive, better-late-than-never policymaking leaves scant room for laws and regulations that anticipate the technologies of tomorrow, or that challenge our health care system to live up to its fullest potential.

Today, the health-care marketplace is ripe with disruptors who are ready to lead us into the future, but we’re asking them to shoehorn these ideas into a fragmented system that is stuck in the past.

EHRs are nearly ubiquitous but instead of transforming care, they’re de-personalizing it; consuming nearly 40 percent of doctors’ time meant for patients.

We’ve witnessed the vast potential of telehealth, but traditional Medicare spends less than one percent of its budget on such services.

We talk ourselves in circles about interoperability and, still, only 4 in 10 hospitals can send, receive, find, and integrate information the way consumers expect of other industries.

It’s time to go bigger on health IT policy.

At the Health Innovation Alliance we are assuming this task in several new areas, including: modernizing patient privacy laws to keep pace with the information age; leading the charge to expand the role of technology and data in value-based care; and reimagining a healthcare system that is built around the patient, rather than the care setting.

MODERNIZING PATIENT PRIVACY LAWS

To start, the Health Insurance Portability and Accountability Act (HIPAA)—the privacy law governing patients’ medical records—was enacted more than 20 years ago and is showing its age. Today, HIPAA can be a backdoor means of information blocking. It relieves patients to reams of paperwork for simple requests, acts as a barrier to care coordination, and lacks meaningful enforcement. It was built for the era of the fax machine, not the iPad.

In the year 2019, no patient should be forced to accept a false choice between privacy and seamless access to their healthcare information. Both are possible and necessary, and we will use the full power of our coalition.
in order to keep patients within their own institution.

Vendor policies can also block information sharing, experts say, as some clinicians find that when they want to switch electronic health record (EHR) vendors they have to pay steep fees to their former vendor to have the patient data transferred.

Information blocking is not a new problem, he adds. White recalls working with clinicians in an emergency department in 2011 that couldn’t get needed EHI from a radiology department within its own healthcare system even though both were using the same EHR system. The reason? The radiologists had closed its application programming interface (API), a software tool that allows information to flow from one source to another.

**IMPACT OF PROPOSED ONC RULE**

The proposed ONC rule outlining the seven allowable reasons for not sharing data could go into effect in some form later this year, after ONC reviews the comments it receives and makes any changes.

Although health IT advocates say the government efforts could indeed promote more sharing of patient data, some also worry that the rules could be confusing, cumbersome, or costly—and possibly all three—for physicians. “These may create new challenges and overhead costs for

“Today, the healthcare marketplace is ripe with disruptors who are ready to lead us into the future, but we’re asking them to shoehorn these ideas into a fragmented system that is stuck in the past.”

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**EXPANDING THE ROLE OF TECHNOLOGY IN VALUE-BASED CARE**

Further, our newly relaunched organization will lead a conversation on the role of data and technology in accelerating the system-wide march towards value-based care. This discussion should include a major focus on emerging companies and technologies, such as artificial intelligence, data, and the role both can play in augmenting value.

The Health Innovation Alliance will champion measures such as enacting new incentives allowing hospitals to donate technology to clinicians in their community for value-based programs without running afoul of fraud laws.

If we are to have a robust, value-based system in healthcare that rewards positive health outcomes, we need the technology in place to measure these outcomes effectively. Federal laws should help—not hinder—the process.

**RE-CENTERING HEALTHCARE AROUND THE PATIENT, NOT THE CARE SETTING**

We must also tackle obstacles that leave patients saddled with a health-care system built around the care setting, instead of the individual.

For example, licensing barriers and Medicare originating site requirements too often limit the use of telehealth to those in designated rural areas, when every patient should have access to virtual care.

Our members will work to secure reimbursement of care delivered via digital networks of peer supporters. Americans spend an average of 11 hours a day looking at a screen, so let’s put it to good use by allowing patients to receive safe, confidential counsel through these same tools. We should see to it that federal health programs recognize social media platforms as viable settings where patients can connect with a peer-support program or discuss their treatment with a physician.

These efforts will be part of a broader strategy to ensure that patients receive care on their own terms, at the best available cost, and by the most appropriate healthcare practitioner, irrespective of geographic boundaries.

It should alarm us all that the United States is a global science and technology leader while remaining a healthcare quality and access laggard.

Health Innovation Alliance will use the former to change the latter. We will go beyond “meaningful use” to total transformation.

Our members have a vision for a modernized, 21st century healthcare landscape in which technology and data are used to deliver meaningful value, allow for the seamless exchange of healthcare data, and keep consumers at the center of their care.

Now, we are putting that vision into action.

Joel White is Executive Director of Health Innovation Alliance
“If physicians can get the right technology in place and fit it into their workflow so that they can share information, it could mean a lot of better data in the hands of the physician—and that means better healthcare for their patients.”

—ROBERT TENNANT, MA, DIRECTOR OF HEALTH IT POLICY, MGMA
Doctors looking to get involved in the meaningful (and lucrative) world of healthcare technology should take time to pursue their dreams—the right way. Here’s how:

1. **Identify a big problem to solve**

   Start with the problem, not the solution or the product. Successful entrepreneurs tend to focus more on what people need than the best way to fulfill that need. Things change quickly in both healthcare and tech, which means no potential solution is safe from disruption. The most successful healthcare tech companies solve really big problems.

   Have a plan, but don’t over-plan. At our company, we use the Lean Canvas, which helps founders create blueprints for a business model in about 20 minutes. This forces you to think through your entire business model around the big problem you are solving and the assumptions you are making with the new business.

   Keep in mind that you will get lots of things wrong and that this document will evolve as you iterate on your business model.

2. **Become CEO or find a partner**

   Many doctors are better suited to product development or even roles like chief science officer or chief medical officer than positions in business operations. When that’s the case, find a smart person to handle the critical task of guiding the company forward.

   If you’ve got the business chops from running your own practice, grab the reins. Just remember that no company will last long with a founder who’s too proud to see his or her own limitations.

3. **Raise and allocate starting capital**

   In the pre-seed stage, most money comes from personal accounts or investments from friends. We call the “first money in” on most venture deals the “three F’s” money: friends, family, and fools. These are often the only people who will bet on you at the start.

   This first funding round is more about selling the idea and getting people to believe in you making it happen.

   Don’t raise too much—only what the business needs to get started and to get you to the next stage, which we call a seed round. Raising too much too soon can lead to “down rounds” at the seed stage or taking too much dilution at a really low price.

4. **Learn the rules of fundraising**

   With the company up and running, don’t assume everything will work out on its own. Make a point to learn the checkpoints between each fundraising gate, and then make the right efforts and capital allocations to move forward.

   Building a company for venture capital puts it on a different path than if you plan to grow it organically (what we call bootstrapping), but it gives you the ability to capture the market and create more value in a much shorter period of time.

5. **Make the right opening moves**

   The world of tech moves quickly and takes no prisoners, which means you should collect knowledge first. To get you started, consider reading “The Lean Startup” by Eric Ries to learn how to turn an idea into a reality.

   Once you know more, make a plan, and then get products into the hands of customers as quickly as possible. Validate or invalidate your business model assumptions, learn, iterate, and repeat.

   Don’t go build a product for two years, release it, and pray that mass markets accept it—that is a recipe for failure in tech.

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Zach Ferres is CEO of Coplex, a nationally ranked Venture Builder that partners with industry experts to start high-growth tech companies.

Send your tech questions to medec@ubm.com.
In a value-based care environment, the responsibility to control costs and improve the outcomes for high-risk patients falls on physician practices. These population health management (PHM) duties can be major burdens on practices with limited resources and support staff, as they often require more than routine office visits to manage successfully.

Likewise, consumer expectations are changing. Patients want greater care accessibility and communication from their physicians. They are demanding information and answers when and where they want them. The key challenge for most practices is to continue innovating and working to further enhance the quality of care while keeping patients engaged and costs in check.

Maintaining engagement before, during, and after office visits requires practices and healthcare organizations to monitor patients’ activities outside of the practice, in real time. Activities include nonclinical events and factors that may influence outcomes.

Fortunately for time-strapped practices, data-driven workflows and tools can help care managers and other clinicians more efficiently intervene with high-risk patients while increasing engagement and satisfaction for all.

**CHANGING CONSUMER EXPECTATIONS**

The growth of high-deductible health plans and mobile internet-connected technology has changed patients’ expectations about healthcare. Patients experienced an 11 percent increase in out-of-pocket costs from 2016 to 2017, up to $1,813, according to findings from TransUnion Healthcare. Greater direct financial responsibility has caused many patients to consider new ways of reducing their costs and avoiding office visits—even if appointments are preventive or needed for chronic condition management.

In fact, 40 percent of Americans reported skipping a recommended medical test or treatment and 44 percent said they did not seek care when they were sick or injured in the last year because of cost, according to a recent survey from NORC at the University of Chicago and West Health Institute.

Simultaneously, smartphone adoption rate has grown to 77 percent for all Americans and nearly half (46 percent) for Americans age 65 and older, according to the Pew Research Center. Smartphone adoption growth also means patients can use their devices to cost-effectively learn about and manage their chronic conditions, which can be helpful—or dangerous—considering the abundance of inaccurate and deceptive health information available on the internet.

While smartphones present a challenge for increasing engagement, they also offer an ideal opportunity for practices to better engage patients.
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“Maintaining engagement before, during, and after office visits requires practices and healthcare organizations to monitor patient’s activities outside of the practice, in real-time.”

Maintaining engagement before, during, and after office visits requires practices and healthcare organizations to monitor patient’s activities outside of the practice, in real-time. American consumers check their phone on average 47 times a day, according to Deloitte’s 2017 Global Mobile Consumer Survey. This means before a visit, automated health status surveys and reminders can be sent to patients’ via their phones.

If a patient has not visited the practice within a predetermined amount of time, a text message urging the patient to schedule an appointment, complete a survey, or read educational materials can be effective at sustaining or reigniting engagement.

HOLISTIC VIEW OF PATIENTS
Empowered with the right data, care managers can improve engagement during the office visit as well by ensuring that all of patients’ relevant health concerns are discussed and their questions are answered. To guide this discussion, electronic health record (EHR) data is foundational, but practices need broader insight into patients’ activities and behaviors.

A holistic view of patients includes information about their physical environment such as air and water quality, housing type, transportation, parks or walking access, and proximity to grocery stores. Behavioral information may be included in the EHR, but clinicians at the point of care need reliable insight such as care plan adherence, healthy attitude, or behavior modifiability to optimize care plans.

Social data is also crucial and may include information about the patient’s education, literacy, employment and fi nancial history, family, and social support.

Data sets for these and other social determinants of health off er a view of patients that enables more relevant and effective care before, during, and after appointments. A better understanding of a high-risk patient’s social determinants of health also helps care managers overcome obstacles that may be affecting more than just one patient.

AUTOMATION AND COMMUNICATION ESSENTIAL
Perhaps the most challenging time for practices to sustain engagement is after patients’ appointments. Advanced PHM technology can alert practices to outside clinical activities through integration to a hospital’s admission, discharge, and transfer (ADT) feed. This saves clinical support staff from checking the fax machine, sifting through multiple piles of paperwork, or manually entering hospital data into the practice’s EHR.

When ADT data and documentation from other area practices are captured, an advanced PHM platform can automatically analyze the information and alert the relevant care managers which patients require urgent follow-up. Such alerts can also help practices that do not have PHM-dedicated clinicians to better multi-task and maintain productivity while improving quality.

Automated alerts can also be created through PHM technology to notify care managers if, for example, a patient misses a referral appointment or neglects to refill a prescription within a predetermined time frame.

Once again, outreach and responses through the patient’s smartphone can then be run through a rules-based algorithm to help the practice’s care manager decide how to further intervene, such as a phone call, mobile survey to gather more information, educational materials, or in-person care.

THE SHIFT TO PROACTIVE CARE
As the industry has shifted its focus from acute to preventive care, physicians’ practices have had to take the lead. The increase in out-of-pocket spending, however, has made patients reluctant to visit the doctor or take advantage of benefi ts that are often covered under their health plans.

Identifying potential health problems through integrated data analytics and launching automated outreach is helping practices take that leadership role a step further by shifting the focus from preventive to proactive care that boosts engagement and optimizes outcomes.

Gary Hamilton is chief executive officer of InteliChart.
Build employee trust with effective communication

“How you communicate information is a reflection of your character.”

Trust is foundational in any relationship, and leadership is merely another type of relationship. Often, trust is a feeling, a gut instinct, or something we know when we see it. We don’t spend a lot of time trying describing trust, and, in my opinion, we don’t spend enough time building trust. As you lead those in your organization, realize they will trust you based upon your character, ability, and vision of the future. One of the best methods you can employ to build that trust is through communication.

Communication is essential aspect for you as a leader. How you communicate information is a reflection of your character. Communicating shares more than information about your plans for the practice. It also reveals your management style and leadership ability and, perhaps most importantly, who you are as a person. Leaders who don’t find the right voice can have difficulty inspiring confidence, motivating employees, and connecting how their work directly helps move the practice toward a better and brighter future.

Consistent communication is perhaps the most effective way to help employees instill trust in you and ensure your practice’s success. When you communicate, be open and honest. Do not sugarcoat, spin or make light of something that requires serious attention. Your job is to identify and work on issues facing the organization.

How you communicate with those you lead speaks volumes about your respect for your employees. Honest and upfront communication will show that you value your employees.

Here are four ways to ensure your communication is effective.

BE CONSISTENT
Consistency is one of the most important aspects of communication that build trust. Ask yourself:

- Is your messaging the same all the time?
- Is it regular and timely?
- Is the tone similar in your messaging?
- Are you sharing the information as soon as reasonably possible?

BE CLEAR
Keep your communication simple and straightforward. Don’t complicate matters with unnecessary technical jargon.

Your purpose for communicating is to share information and drive action, not show how smart you are. Ask yourself:

- Is your messaging to the point?
- Is your message full of confusing details?
- Do you know the purpose of your communication?

BE COURTEOUS
If you’re going to implement change, include everyone possible who might be affected. Treat them with respect so they help you bring about the desired change. Ask yourself:

- Is your message respectful?
- Do you know how certain parties might receive and interpret the information?
- Are you communicating to everyone?

BE HONEST
We learned in kindergarten that honesty is the best policy. All those years later, this simple maxim remains true. Ask yourself:

- Is your message truthful?
- Are you sugarcoating or embellishing the situation?

David J. Norris, MD, MBA, is a practicing anesthesiologist in Wichita, Kan. He is the author of The Financially Intelligent Physician: What They Didn’t Teach You in Medical School and a frequent speaker on physician finances.
Best thing said / advice given by a patient

**Maria Young Chandler, MD, MBA**  
Business of Medicine / Pediatrics  
Irvine, Calif.  
“I feel like you’re my sister, not my doctor.”

**George G. Ellis, Jr., MD**  
Internal Medicine  
Boardman, Ohio  
“Listen to your patients to truly understand them.”

**Antonio Gamboa, MD, MBA**  
Internal Medicine / Hospice and Palliative Care  
Austin, Texas  
“Take a good vacation every year (not that I do).”

**Jeffrey M. Kagan, MD**  
Internal Medicine / Hospice  
Newington, Conn.  
“Take time to go boating.”

**Melissa E. Lucarelli MD, FAAFP**  
Family Medicine  
Randolph, Wis.  
“You’re already helping me by just being here.”

**Joseph E. Scherger, MD**  
Family Medicine  
La Quinta, Calif.  
“Attitude makes all the difference.”

**Salvatore Volpe, MD**  
Pediatrics/Internal Medicine / Pediatrics  
Staten Island, N.Y.  
“Spend more time with your family.”

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“The groups that do the best with CCM have buy-in from their leadership.”

WILLIAM MILLS, MD, FOUNDER, CHRONIC CARE MANAGEMENT, INC., SOLON, OHIO

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The average number of times Americans check their phones each day

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