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CHRONIC CONDITIONS
Smoking cessation: Help patients and improve outcomes
IT'S MORE COMMON THAN YOU MAY THINK

Replication of the HIV-1 virus is error prone, resulting in millions of mutations, like M184V, each day.\textsuperscript{1-3} Based on reports to the US National HIV Surveillance System, as of 2016, approximately 1 out of 5 treatment-naive patients in the United States had at least one acquired drug-resistant strain of an HIV-1 virus.\textsuperscript{4*}

SERIOUS, IRREVERSIBLE IMPLICATIONS

If the virus is resistant to a drug, it may be resistant to other drugs of the same class. HIV drug resistance may result in fewer treatment options for your patients, meaning fewer ways to achieve and maintain viral suppression. Plus, if a patient has a drug-resistant virus, they could pass it to their partner.\textsuperscript{3,5,6}

A TREATMENT WITH A HIGH BARRIER TO RESISTANCE IS IMPORTANT

Treatment regimens with a high barrier to resistance require a greater number of critical mutations to make treatment ineffective. Patients who aren’t on a drug with a high barrier to resistance and have sub-optimal drug levels have a greater chance of developing resistance.\textsuperscript{7} Factors that contribute to sub-optimal drug levels include poor treatment adherence, food effects, and drug-drug interactions.\textsuperscript{8-10}

\textsuperscript{*Data from drug-resistance tests for any transmitted drug-resistance mutation performed within 3 months of HIV diagnosis were analyzed in 36,288 cases that were reported to the US National HIV Surveillance System.

Almost all physicians strive to provide exceptional care to each patient. Usually, we focus on clinical acumen, diagnostic accuracy and appropriate and effective treatment choices. However, patients and their families often will make their own judgments about the quality of care based on the quality of physician communication.

In my role as a physician leader, I am frequently asked to review cases in which a patient or family member complained or expressed concern about some aspect of care. Unfortunately, I sometimes determine that clinical care was lacking. In other circumstances, the physician provided the standard of care but what was lacking was communication or establishing a therapeutic relationship with the patient.

There are some general themes that emerge from years of reviewing these concerns. Sometimes, the physician accused of substandard care just happens to be the bearer of news that is upsetting. Delivering bad news well is not only a skill but a necessary competency for any physician. Patients and their loved ones often remember the moment they hear the dreaded diagnosis or prognosis. Without meaning to, we can deliver that news with seeming callousness or impatience. This poor delivery can be confused with poor care.

In other situations, the patient is sent on an odyssey of diagnostic testing and treatment attempts, sometimes without any real benefit. Even if everything is done correctly from a medical standpoint, patients and families can misinterpret the testing and treatment trials as evidence of inexperience or ignorance on the part of their physician. While physicians are highly trained and very knowledgeable, the human body is the most complex machine ever made, rendering medicine an inexact science. Answers are not always discoverable.

I also repeatedly see what I call the “aha” diagnosis. A physician benefiting from all the previously conducted tests and treatments, including tincture of time, makes the elusive diagnosis. That physician can choose to explain how a new diagnosis doesn’t necessarily mean that something was missed, but that doesn’t always happen. This can leave patients wondering why doctors who previously treated them didn’t arrive at the same diagnosis.

When we are talking to a colleague, I believe we each bear an equal responsibility to communicate clearly. When we are talking to patients and families, our responsibility is even greater. Our patients are sick, may be in pain, may be afraid and are trying to process complex information. We owe it to those who place their trust in us to deliver bad news with compassion and grace, explain what our plans and what we are thinking and provide clarity around how diagnoses are made.

It is essential that we first do no harm. When our clinical care deviates from the standard, we owe it to our patients to confess, explain and rectify the situation.

When our clinical care deviates from the standard, we owe it to our patients to confess, explain and rectify the situation.

Jennifer Frank, MD is a family physician and chief medical officer in northeastern Wisconsin.

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LAST WORD
Time to make EHRs useful
Today’s EHRs aren’t tools physicians can use. Instead they are tasks physicians must overcome, writes Jay Anders, MD.

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IN EVERY ISSUE

Interactive
Your Voice
Vitals
Our Advisers
Funny Bone

Cover: Skórzewiak/Stock.Adobe.com
A study conducted by Primary PartnerCare ACO and Primary PartnerCare Management Group found that diabetes patients who receive four hemoglobin A1c per year have much lower hospitalization costs than those who receive three or fewer tests. The savings can amount to thousands of dollars per patient annually.

The American Diabetes Association (ADA) recommends four annual hemoglobin A1c tests, but many primary care physicians reduce the testing to two times per year if the patient has a normal hemoglobin A1c test, indicating that the patient’s blood sugars are in control.

The study examined ACO patients diagnosed with diabetes, and were divided into five cohorts based on the number of hemoglobin A1c tests performed.

The results show a direct correlation between the number of hemoglobin A1c tests and the hospitalization costs of the Primary PartnerCare ACO patients, with patients with zero tests incurring hospital admission costs of $4,103.32; patients with one test, $3,281.67; patients with two tests, $2,870.98; and patients with three tests, $2,762.31. Those who follow the ADA recommendation for testing four times per year had an average inpatient hospital cost of $2,358.37, a 28 percent less than those only tested once per year, and a 43 percent decrease in costs compared to those who were never tested.

Diabetes affects over 30 million Americans, with an estimated cost of diagnosed diabetes in 2017 of $327 billion, including $237 billion in direct medical costs, according to the ADA. After adjusting for inflation, the economic costs of diabetes increased by 26 percent from 2012 to 2017, creating a tremendous financial burden on society.

People with diagnosed diabetes have average medical expenses two to three times higher than what the expenditures would be in the absence of diabetes, with the largest expense being hospital inpatient costs. According to research conducted in 2017 by Boston University’s School of Public Health, diabetes-related mortality is far underreported and may actually be the third-leading cause of death in the United States.
The pharmaceutical industry is not an unregulated free market

In the Legally Speaking feature of your May 10, 2019 issue, Dr. Goldberg makes many excellent points about the lamentable state of pharmaceutical pricing in the United States. However, on one point I would push back. The suggestion that the pharmaceutical industry is an “unregulated free market” due to the absence of price ceilings is an overstatement.

The pharmaceutical industry is composed of profit-seeking firms like many other industries in a modern market economy. In markets such as consumer electronics and automobiles, we continually see prices fall as quality improves. This is common across many markets and contrary to what is seen in the pharmaceutical industry.

This variation in outcomes across industries, all of which are populated by profit-seeking firms, should give us pause. Despite having similar motivations, firms are behaving differently due to the incentives they face. Many markets are characterized by intense competition that drives prices down and encourages innovation.

The distinction is important because we can all agree that more effective, cheaper drugs should be the goal. Figuring out how to get there needs to be based on a solid understanding of why we are getting these adverse outcomes.

For example, in large volume practices, the personal connection that patients want from their doctors is often lacking. Patients frequently complain that their doctors are often rushed and distracted and they leave their doctors’ office with unanswered questions to their concerns and a sense that their doctors didn’t seem interested in them.

The disappearance of the human factor in primary care may not be as quantitative as volume, but who would deny that it is as important to the quality of care as much as any other factor?

The only way to deliver both quality and volume is to train primary care MDs quicker, say, in seven years instead of 10 or 11; and by getting more advanced practice nurse practitioners into the workforce.

David Campbell, PhD
Johnson City, Tenn.

Quality and volume in primary care are equally important

I disagree with the statement by George T. Barron, MD, in “A pay-for-performance bill of rights for primary care physicians,” (Your Voice, July 10, 2019 issue) that quality is not more important than volume.

The problem is that most primary care doctors are pressured to see too many patients, and quality in many instances suffers.

Quality in healthcare requires a sound scientific basis; but there is also an important human factor attached to it.

“The problem is that most primary care doctors are pressured to see too many patients, and quality in many instances suffers.”

Edward Volpintesta, MD
Bethel, Conn.
Who does—and doesn’t—use patient portals

Despite the widespread availability of online patient portals, only 15 to 30 percent of patients use them, according to the U.S. Government Accountability Office. For a study published in *Health Affairs*, researchers sought to learn more about who is and isn’t using portals. They looked at the characteristics of 2,235 respondents in a national survey according to whether the respondent had or had not used a portal during the previous year. Here are four takeaways for physicians looking to improve their portal usage:

1. **OFFER IT TO PATIENTS**

   - **Patients who used portal access who were NOT offered it.**
     - 41%
   - **Patients who were offered portal access.**
     - 60%
   - **Among those offered portal access who used it.**
     - 95%

2. **GIVE MALE PATIENTS AN EXTRA NUDGE**

   - Gender of patients who said they used a portal in the last year.
     - 41% MEN
     - 59% WOMEN

3. **RURAL PHYSICIANS SHOULD PAY ATTENTION**

   - Of those who’d used a portal in the prior year...
     - 89% LIVED IN AN URBAN AREA
     - 11% LIVED IN A RURAL AREA

4. **STRANGELY ENOUGH, REMIND YOUNGER PATIENTS**

   - Patients aged 18–30 used the portal the LEAST
     - 16%
   - Patients aged 51–64 used the portal the MOST
     - 28%
The cost of a patient visit
A useful metric to track

One of my favorite questions to ask is “how much does it cost to see a patient?” I know it’s a generic question, but it is a starting point for today’s medical practice. Understanding the cost of doing business is essential with value-based and other payment models emerging.

The simple way to start is to identify total visits (all E&M codes) for a period and divide by total expenses (typically without the physician). If you have 6,250 annual visits as a solo provider and your total costs are $365,761, the cost per visit is $58.52. You can then decide to break this down further for new patients vs. established patients. Or you could chose to identify costs per total relative value unit (rTRVU).

There are other options as well. Eventually you will want to break the cost into smaller, workable parts.

Breaking down the visit
One of the most interesting approaches is to identify how much it costs for each category of care provided in the patient visit cycle (e.g., check in, triage, provider time, follow up, and check out). You can look at the cost associated with the triage area: Vital signs, questions on prescriptions, documentation for the visit, and the like. Let’s assume that it takes 10 minutes for this to occur.

If you are paying the medical assistant $15.00 an hour and there is a $2.00 additional cost per hour for benefits, the total cost per minute needs to be calculated. At 2,080 hours worked per year, the total cost at $17.00 per hour would be $35,360. The total minutes worked would be $124,800. The cost per minute is $0.28. The cost for triage is $2.80 just for time.

Add in the direct cost for supplies and allocate costs for space and equipment, and it adds up. If you undertake this process for each category of service in the cycle you gain a better understanding of the cost for the visit. Once this is understood, you can ask if there are activities done at the time by the right individual and is it worth the cost of doing that activity. Further, is it best to do that activity at that time.

Time-driven accounting
This approach is called time-driven activity based cost accounting (TDABC). It may seem like a lot of work but in our experience an exercise of this nature creates an awareness that results in improving the management of the patient visit cycle. The improved management of that flow produces several options for management to consider.

First, the support is more efficient for the provider, which allows the provider to spend more valuable time with the patient, either relationship building or specific to the treatment plan development. More efficiency may lead to seeing one additional patient per day for that provider, which at current Medicare rates will net additional income of ~$18,000 with very little added expense.

Better control of staff time leads to reduction in overtime. Better control of all times contributes to all getting out of the office on time, which leads to a better work-life balance.

Step one is accepting the need to understand the cost of providing service to the patient. Once a basic understanding is arrived at, taking a page from other industries, utilizing TDABC, as initially complex as it may seem, is an effort that produces some important results.
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The future of value-based pay

by TODD SHRYOCK Managing Editor

Value-based care has created a conundrum: pretty much everyone in healthcare likes the idea of paying for outcomes, but no one is sure how to fairly implement it. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) introduced a new world of value-based care to many physicians and was a major step away from fee-for-service. Gone was the Sustainable Growth Rate, replaced with a program that was supposed to drive costs down by reimbursing for quality patient outcomes.

“Congress had revised the Sustainable Growth Rate many times over the past 20 years, and everyone was fatigued by it,” says Larry Kocot, JD, head of KPMG’s Center for Healthcare Regulatory Insight and a former CMS official. “Physicians were willing to take something new to not have to go through that exercise again.”

Doctors suddenly found themselves trying to navigate new MACRA acronyms like...
MIPS and APMs to figure out where they fit as Medicare started moving away from fee-for-service in a bid to contain costs and improve care quality.

At the same time, more private payers began to embrace the possibilities of value-based care, working incentives into contracts that rewarded physicians who could use data to show patients were healthier and avoiding unnecessary hospitalizations. But fee-for-service contracts are still the norm.

Meanwhile, physician organizations began to push back against MACRA as their members rebelled against the cost of the technology needed to comply and the complexity of the reporting measures. CMS responded by exempting hundreds of thousands of physicians, causing some to question the value of the program and if it was improving patient care or saving money.

With MACRA now a few years old, experts are looking at how it might be reformed, and what value-based care might look like in the future.

MACRA: A MISSTEP TOWARD VALUE

MACRA has not worked to the extent policymakers hoped, says Frederick Southwick, MD, a practicing internist and healthcare researcher at University of Florida Health.

“The goal was to drive a significant wedge in payments between those willing to step up and use Alternative Payment Models and those who remained on the sidelines,” says Southwick. “We’ve seen physicians take a shot on some things they might not have done in the past to get a bonus payment, but they have not reached the point where they’ll feel pain if they don’t. The MIPS side of this was supposed to be painful to physicians, but it’s mostly a big nothing-burger because so many have been excluded.”

As a result, there isn’t much money in the budget-neutral program to move from the poor performers to the good performers, eliminating much of the incentive. According to CMS, in the 2019 payment year (based on 2017 performance data), 71 percent of MIPS participants received a positive payment adjustment with a bonus for performance, 22 percent received a positive payment without the bonus, 2 percent didn’t receive a positive or negative adjustment and only 5 percent received a negative adjustment.

“The more physicians that are excluded, the harder it is for those in the program to win,” says Kocot, noting that the maximum payment adjustment anyone received was 1.88 percent, while the maximum penalty was 4 percent.

MIPS was intended to be the incentive to get physicians into some form of risk-sharing APM, but MIPS isn’t accomplishing that and the 5 percent positive payment adjustment APM participants can earn expires in 2024.

“What is the incentive to get people into MIPS and into an APM as we move further down the line?” asks Kocot.

MIPS also faces the problem of how to define “quality”.

“Healthcare is so complicated, that’s hard to do,” says Chris Dawe, vice president of Evolent Health, which helps providers and health plans transition to value-based care, and a former health policy adviser in the Obama administration. “The best way would be through knowledgeable consumers who would ask questions about the cost-benefit and is it worth it to their health and wellbeing. The problem with that is patients don’t go to medical school.”

Even if patients were making decisions, they would still have difficulty determining who the best doctor is because of the lack of objective information, and in many regions, the absence of choices in hospitals or physicians.

MIPS participants have scored well on quality measures, but many doctors argue that the measures don’t have any connection to real-world medicine. The time spent reporting on quality has also proven burdensome for many, who say it takes more time away from patients and redirects money toward IT projects.

“All of these initiatives require a tremendous amount of data accumulation and manipulation,” says William Spratt, Jr., JD, partner in the healthcare practice of Akerman LLP in Miami. “There are so many different metrics...
CMS has announced a new set of payment models focused on primary care. The Primary Cares Initiative is intended to deliver better value for patients, reduce administrative burdens for physicians, and empower them to spend more time caring for patients.

The initiative will provide primary care practices and other providers with five new payment models under two paths: Primary Care First and Direct Contracting.

Here’s what you need to know:
CMS expects these five new payment models to:
- Have more than 25 percent of all Medicare beneficiaries participate, with nearly 11 million included in the new programs.
- Offer new payment options for an estimated 25 percent of primary care physicians.
- Create new coordinated care opportunities for many of the 11 to 12 million beneficiaries dually eligible for Medicare and Medicaid, specifically those in both Medicaid managed care and Medicare fee-for-service.

Primary Care First
- Provides payment to practices through a simplified monthly reimbursement that allows physicians to spend more time with patients.
- Incentivizes providers to reduce hospital utilization and total costs of care through performance-based payment awards.
- Focuses on key outcome-based clinical quality measures, such as controlling blood pressure, managing diabetes mellitus, and screening for colorectal cancer.

Primary Care First – High-Need Populations
- Has the same features as Primary Care First, but offers higher payments to practices that specialize in care for high-need patients, including those with complex chronic conditions and seriously ill populations.
- Both Primary Care First models will be tested for five years, beginning in January 2020.

Direct Contracting
The Direct Contracting models aim to engage organizations that have experience taking on financial risk and serving larger patient populations, such as Accountable Care Organizations, Medicare Advantage plans, and Medicaid managed care organizations.

Direct Contracting – Global
- Allows healthcare providers to take greater control of managing costs of care for Medicare fee-for-service beneficiaries.
- Focuses on care for patients with complex, chronic needs and seriously-ill populations.
- Allows beneficiaries to use the healthcare provider of their choice.
- Reimburses providers with a fixed monthly payment that can range from a portion of anticipated primary care costs to the total cost of care, but the provider assumes all financial risk.

Direct Contracting – Professional
- Has the same features as Direct Contracting – Global except that the financial risk is shared with CMS.
- Participants can choose from varying levels of financial risk, providing more predictable revenue streams and reducing provider burden commensurate with the level of financial risk they assume.

Direct Contracting – Geographic
- This model is still under development and CMS is seeking public comment on how it should be structured when it launches in 2021.
- The geographic, population-based option is designed to offer innovative organizations the opportunity to assume responsibility for the total cost of care and healthcare needs of a population in a defined target region.
- CMS says driving accountability to a local level empowers communities to devise strategies best designed to meet their healthcare needs.
Value-based care

and different ways to modify and manipulate the data in order to determine whether they are meeting various criteria or not, it’s challenging.”

For physicians without the support of a larger organization, the challenges are even greater. “It’s introduced an awful lot of complexity into the practice of medicine,” says Spratt. “It’s hard for them to change their practice administration in order to measure and hit those targets.”

An unintended consequence of that difficulty has been an increase in physicians affiliating with health systems and hospitals so as to shift the reporting burden.

“It’s probably strengthened the hand of the health systems and offers them another carrot for the primary care physician,” says Southwick. “They aren’t necessarily acquiring them, but at least getting them in the network. I don’t think this is what Congress had in mind.”

He adds that a lack of vision has hampered the success of programs like MACRA, because no one understands the end goal.

“I’ve never heard anyone from the White House articulate what this should look like in five to 10 years,” says Southwick. “Doing so would help the market work toward that and be ready for this new world. Instead, we are just going from one program to the next. It would be a benefit if CMS would say what this would look like at the end.”

THE FUTURE OF VALUE-BASED CARE

Still, while MACRA may not be working out as envisioned, many experts say it is an important first step toward implementing value-based care. “MACRA started the conversation,” says Spratt. “It has started moving medicine toward more value-based payment and away from the traditional fee-for-service model, which I think most policymakers realize is a good approach.”

Despite the struggles of MACRA, experts say physicians should understand that their revenue from fee-for-service will continue to decline.

“From what I have seen, the transition to value-based care is a given,” says Andrei Gonzalez, MD, assistant vice president at Change Healthcare, a company that helps payers and providers move to value-based care. “It’s more about what are the right models and how are we going to get there?”

With CMS rolling out its new Primary Care First initiative, Gonzalez says their intent is clear. “They want to blow up fee-for-service, and the primary care initiative is a big step in that direction.”

“The MIPS side of this was supposed to be painful to physicians, but it’s mostly a big nothing-burger because so many have been excluded.”

— FREDERICK SOUTHWICK, MD, INTERNIST AND HEALTHCARE RESEARCHER, UNIVERSITY OF FLORIDA HEALTH

The initiative encompasses a variety of models. It is expected to cover about 25 percent of Medicare beneficiaries, and include removing coding requirements for primary care physicians by paying a monthly per-patient fee or a flat per-visit fee.

Private payers are creating similar programs, and large employers are asking commercial plans to use some of CMS’s strategies to save money. As a result, more private payer contracts are including value-based incentives.

“I do think the private sector push will make it easier as clinicians see value-based care as the new normal and are subject to quality and cost targets that are not fee-for-service,” says Kocot. “That’s absolutely essential to the transition.”

Both public and private payers realize they need multiple plans in order to succeed, says Gonzalez.

“Our research has shown that different models work for different conditions and different regions,” he says. In areas where there is a lot of consolidation among providers and health systems, ACOs or full capitation—where physicians receive a flat monthly fee for each patient—will make the most sense. In less-consolidated areas, models like the Patient-Centered Medical Home may be the primary option.

While capitation was tried in the early days of HMOs, Gonzalez says the industry is a lot savvier on how to do it now.
Payers and providers both are going in with more caution. Physicians are managing a patient population, but understand they will need to meet quality and cost metrics, although not the full risk burden like in the past.

Spratt says smaller practices may need to affiliate with a hospital or health system, because payers see value in partnering with organizations with large numbers of physicians, ancillary services and even urgent care centers, because it gives them more control over the insured and better management of the premium dollar.

“At the end of the day, it’s all about integration and the coordination of care,” says Spratt.

Care coordination includes practices being more proactive with helping patients to lead healthier lifestyles and not just waiting for the patients to reach out to them.

“A lot of practices already have this mentality, but it creates the need for a different set of aptitudes within the practice,” says Gonzalez. This could include, for example, having a nurse monitor COPD patients and ensuring they come in for regular visits.

Future value-based care models will also have a greater focus on the social determinants of health.

“One thing value-based care leads us toward is a sort of untethering of the physician from historical medical tools and allowing them to think more holistically,” says Spratt.

“Physicians will need to start figuring out how to help patients manage their conditions, how to navigate the health system and manage the social determinants of health,” says Gonzalez. “It’s not as big of a change as it seems, because not every patient requires assistance, but practices need the ability to identify who needs extra help.”

**THE ROLE OF THE PRIMARY CARE DOCTOR**

No matter what models emerge, experts see the primary care physician as the team leader. Dawe says the patient-centered medical home, with a primary care physician working with one or two NPs or PAs, a nursing staff and someone that goes into the community to help educate patients on how to manage their diseases is a good model, as is an ACO.

“I think the basic structures for a good model are already in place,” says Southwick. “You can go a long way to creating a new payment ecosystem just on the basis of a primary-care based model, which is basically an ACO.” If that is combined with bundled payments for specialists, Southwick says, those two models work very nicely together.

“The primary care physician has to be central to any aligned payment and care coordination working with the patient from start to finish,” says Kocot.

But primary care doctors should also expect to take on more risk-sharing with payers, whether it’s through an ACO or some other payment model. He warns the transition must come with assistance.

“There’s a lot happening that primary care physicians have to process on a daily basis,” he says. “The transition needs to be moderated so we don’t lose them in the process. The CMS burden reduction program is very positive, but we have to strike the right balance of incentives and push, and I don’t know that we have yet.”

Experts say that value-based care will continue to become more prominent in contracts, even though programs like MIPS might be revised or replaced in the future. But one thing is for sure: there is no hiding from it.

“The move to value is alive and well,” says Kocot.
Using and recommending patient health apps

There are several steps physicians can take to make the task of selecting, recommending, and using apps at the point of care less daunting. Consider these steps.

1. **Assess the efficacy**

Did the app developer solicit physician input, and can you rely on the accuracy of the content? Physicians should download the app first to get a sense of whether it’s clinically sound and something patients will use, says Ashish Atreja, MD, MPH, FACP, chief strategy officer at RxHealth, a platform for prescribing curated apps and digital therapeutics.

Is it easy to set up an account? And read user feedback and reviews. Do patients find the app valuable, and does it help them improve their health?

“A lot of these app developers are small companies looking to gain traction,” says Niko Skievaski, co-founder and president of Redox, a healthcare data standardization company in Madison, Wisc. “They’re very approachable. Ask them to convince you that it’s going to work for your patients.” He also suggests that physicians look to see whether any medical journals have published clinical studies about the app, he adds.

2. **Integrate the app with your EHR**

Integration allows providers to make use of continuous monitoring and predictive analytics, says Yauheni Solad, MD, internist and medical director of digital health and telemedicine at Yale New Haven Health System in New Haven, Conn.

Although EHR vendors are increasingly working with app developers to enable interfaces that allow for seamless data transmission, the majority of apps currently do not integrate, he adds. However, if a physician is passionate about using a particular app, Solad suggests asking the developer whether it would consider working with the EHR vendor to enable integration. Developers may be willing to do so if it means they can expand their user base, Solad says.

Integration may also present revenue opportunities for certain apps—particularly those that measure physiologic data and are FDA-approved. When using these apps, providers may be able to report CPT code 99091, for which Medicare pays approximately $59. However, physicians should find out whether their local Medicare and Medicaid administrative contractors and commercial payers will pay this code for the review of consumer app-derived physiologic data before they try to bill it.

Even if the app doesn’t have an interface with your EHR, it may have a dashboard that aggregates and presents the data in a meaningful way—and this may be as useful as integration in some cases.

3. **Integrate the app with clinical workflow**

There are several ways in which physicians can integrate a consumer health app into their workflow. If the app doesn’t already integrate with the EHR, consider asking patients to simply open the app on their mobile device at the time of the visit, says Solad. A nurse or medical assistant can review the most recent data (or look at the dashboard if the app includes one) before the physician enters the exam room and then enter that data into the EHR, says Atreja. Another idea is to review the data when care coordinators contact patients receiving chronic care management services.

Lisa A. Eramo is a contributing author. Send your technology questions to: medec@mmhgroup.com
If there’s one constant surrounding the American Board of Internal Medicine’s (ABIM) maintenance of certification (MOC) program, it’s controversy. Physicians galvanized by the cost, time, stress, and perceived irrelevance of the requirements of ongoing certification have donated more than $290,000 to a GoFundMe campaign, sponsored by Practicing Physicians of America (PPA). The fundraiser supports three federal class action lawsuits seeking an end to MOC pending against the ABIM, the American Board of Radiology, and the American Board of Psychiatry and Neurology.

As reported by Medical Economics in December 2018, one of the suits—filed on behalf of approximately 100,000 internists—alleges that the board illegally ties its initial certification to its maintenance of certification process. The suit also claims that ABIM has used “various anti-competitive, exclusionary, and unlawful actions to promote MOC and prevent and limit the growth of competition from new providers of maintenance of certification for internists.” In January 2019, the complaint was amended to include racketeering and unjust enrichment claims.

According to Marianne Green, MD, who became chair of the ABIM’s board of directors in July 2019, “the lawsuit has no impact on fulfilling our mission.” Via email she continues, “Each and every day we strive to serve physicians and patients by developing standards that reflect the latest in medical science and the experience of physicians, as well as the means for assessing physicians in upholding these standards.”

Nonetheless, in a statement responding to the December lawsuit, the ABIM said it would “vigorously defend itself, recognizing that doing so will consume resources far better dedicated to continuous improvement of its programs.” Indeed, the ABIM filed a motion to dismiss the suit in March 2019. The plaintiff attorneys promptly opposed the motion, disputing the ABIM’s use of two franchise analogies citing Krehl v. Baskin-Robbins Ice Cream Co.
to demonstrate that initial certification and MOC are not separate products.

"Physician care is not Baskin Robbins ice cream, and patient treatment is not a Subway sandwich. Hence, the notion that ABIM can force MOC on internists in service of an illusory nationwide standard unilaterally imposed by ABIM offends the free market principles that are the hallmark of medical care in this country," the plaintiffs stated in an April 30 memorandum.

NEW PATHWAYS UNDERWAY
In the meantime, ABIM has made some changes in response to long-standing criticism of post-1990 MOC requirements.

For example, ABIM and the American College of Cardiology announced in March an alternative option for cardiologists to maintain their board certification. The Collaborative Maintenance Pathway includes five annual performance assessments, each covering about 20 percent of the field of cardiovascular disease. The first assessments will be administered this fall, and physicians will have two chances to pass the exam.

"Over the past several years I think ABIM has done a much better job of engaging with the internal medicine community, and that work has enhanced our programs," Green says.

"In 2020, a new option for medical oncologists, being created in collaboration with the American Society of Clinical Oncology (ASCO) will become available," Green adds. The ABIM/ASCO Medical Oncology Learning & Assessment will replace ABIM's Knowledge Check-In in Medical Oncology that had been planned for 2020. The new pathway will allow diplomates to take a shorter assessment every two years, with topic-focused exam modules and related educational materials provided before, during, and after exams.

Physicians will be able to select from a choice of a general medical oncology, breast cancer, or hematologic malignancies modules, with more modules slated for 2022.

"These new offerings will increase choice, flexibility and relevance board certified physicians have asked for," Green says.

CHANGES TOO SLOW FOR SOME
Mark Lopatin, MD, has been a vocal opponent of ABIM's MOC process for several years, but says that these new options are similar to changes he'd like to see in his subspecialty of rheumatology. His 1986 board certification in internal medicine is still considered valid, even though he hasn't practiced in the field for 30 years, he says. But because rheumatology boards were not available in 1989, he took and passed the exam in 1990—one year too late to achieve grandfathered status—and has gone through the MOC process every 10 years since.

He won't be taking a fourth exam in 2020, however. "To take rheumatology boards means that I have to spend about three months preparing—at least three months—studying rote memorization of facts, esoteric stuff, trivial pursuit kinds of stuff that is not relevant to what I do on a day in, day out basis," he says. "I'll be 63 years old at that time, so if I took it and retired at 65, it buys me another year or two. It's not worth it."

While pleased to see ABIM collaborating with medical societies in some subspecialties, Lopatin says the testing component is still fundamentally flawed. "They're still focused on that high-stress, timed exam that needs to be passed. What really needs to be measured is due diligence," he says.

And despite his impending exit from medicine, Lopatin has already donated twice to PPAs GoFundMe campaign. "I've been very outspoken about this, and this is my chance to put my money where my mouth is," he says. "I am stopping my career because of this. To me, that's a pretty strong statement about how I feel about what ABIM has done and is doing."

FEEDBACK ABOUT KNOWLEDGE CHECK-IN
Recent changes to MOC also include an alternative to the traditional 10-year exam known as Knowledge Check-In (KCI). ABIM launched the KCI, a shorter, every-other-year online assessment option for physicians in internal medicine and nephrology in 2018. In 2019, eight more specialties were added, including gastroenterology, rheumatology, cardiovascular disease, geriatric medicine, hematology, pulmonary disease, infectious disease, and endocrinology.

"Overall, we've received good feedback from those who have taken it. We mostly
Internists to get new option for maintaining board certification

by Jeffrey Bendix Senior Editor

Internists can look forward to a new path for maintaining their board certification.

The American Board of Internal Medicine (ABIM) announced on its blog August 23rd that it plans to develop a “longitudinal assessment” option for internists to maintain certification. The new certification option will offer “a self-paced pathway for physicians to acquire and demonstrate ongoing knowledge,” according to the blog post.

In addition, the new option will immediately inform test-takers whether their response to a question was correct, along with the rationale and links to educational materials. This process assures doctors that their medical knowledge is up-to-date and provides “learning activities to address gaps,” according to the post, which is signed by Marianne M. Green, MD, FACP, chair of the ABIM’s board of directors, and Richard Baron, MD, MACP, president and chief executive officer.

The announcement includes no date for when the new option will be offered, but in an e-mailed response to a query Baron said, “We understand there are questions about when the longitudinal assessment option will be available, and ABIM plans to share more details about a timeline later this fall.”

In developing the longitudinal assessment option, the announcement says, the ABIM is recognizing that some doctors prefer a continuous educational process that better integrates into their lives, and allows them to learn at their own pace while accessing the resources they use in their practice.

Internists hear that they appreciate the shorter testing experience and the convenience of being able to take it at their home, office, or test center,” Green says.

However, Lopatin argues that this option is still incongruent with the way physicians actually practice, which includes looking up information about a patient’s condition without a time limit and consulting with other physicians when necessary. “They’re more worried about people cheating than they are about providing a good educational tool,” he says.

CME CONCERNS

In addition to the requirement of passing an exam every 10 or two years, physicians must also acquire 100 MOC points every five years through a combination of activities geared toward practice or quality improvement and continuing medical education (CME).

In 2015, ABIM announced a partnership with the Accreditation Council for Continuing Medical Education to expand the options available to physicians to receive MOC credit. As of June 30, 2019, 156,104 ABIM board-certified physicians had earned 13,453,817 million MOC points, Green says. To date, 27,854 activities have been registered for MOC points by 445 CME providers.

However, some physicians argue that these options are still too restrictive. Paragraph 53 of the class-action complaint notes, “Importantly, MOC differs from CME because if physicians do not see value in particular CME courses or classes they are free to purchase other CME offerings; there is no such meaningful option regarding MOC.”

ANTI-MOC LAWS CONTINUE TO SPREAD

Theoretically, MOC is voluntary in all states. However, most hospital privileges and insurer credentialing is contingent upon a physician being board certified. As described in paragraph 39 of the original complaint, Blue Cross Blue Shield, which covers roughly one-third of Americans and contracts with 92 percent of physicians, requires physicians to participate in MOC to receive a panel of patients in their plans or be included in their networks.

Patients of internists that do not purchase MOC have been told that their physicians are no longer preferred providers, and that they should look for another primary care doctor or be subject to higher out-of-network coinsurance rates.

In 2016, Oklahoma became the first state to pass legislation preventing hospitals, licensing boards, insurance companies, and health systems from requiring MOC. The list has since grown to include Georgia, Maryland, Missouri, North Carolina, Oklahoma, Tennessee, and Texas. Bills in several other states are under consideration.

“States retain the right to set licensing requirements and other standards,” notes Green. “Physicians, patients, hospitals, and insurers see MOC as a means of conveying important information, but MOC is and has always been voluntary.”

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A patient’s social media post ruined my reputation

A physician has been in practice for decades. He works hard, does no advertising, and does not even have a Facebook page. He is aware of peers who spend an extensive amount on marketing and social media; however, he has had no interest. One day he finds out that a disgruntled patient has slandered his reputation on social media. In fact, he has been slandered on Facebook, Instagram, Yelp, and Google.

This patient not only accused him of poor medical practice, but also videotaped his staff drinking beer in their nurse’s lounge. Even worse, the video has gone “viral” and has been seen by thousands. Our physician is concerned this malicious act may ruin his career. The internet and social media are nothing more than a curse, in his opinion. Is there anything he can do?

Because of privacy laws, unfortunately, a physician has little recourse when an anonymous patient places a scathing review on a website. The reality is that even physician review sites are as likely to misinform as they are to inform. If a patient complains online that his surgical excision opened only two days after surgery, there is no way for anybody to know whether the patient has performed strenuous exercise. Reviewers of these sites are generally not patients. There are known instances of dentists being accused online by their competitors of being child molesters. Similarly, laudatory online comments can be written by the physician himself.

One way to try to work around such frivolous online statements is to have patients sign a waiver promising that, in case they are not happy with their care, they will not post online comments to that effect.

The way such contracts are enforceable is as follows: In general, websites acting as platforms for outside commentary are not liable for defamation suits. They are, according to North Carolina neurosurgeon-attorney Jeffrey Segal, MD, JD, subject to copyright laws. Waivers can be written to assign copyright to the treating physician.

If the treating physician asks the patient to sign such a “copyright” waiver, the physician can claim ownership of any anonymous review of the practice and demand that the online review be removed. There are now examples of website posts removing such deleterious copyrighted comments. Needless to say, not all patients will agree to sign such a waiver. Some may feel such waivers are simply “gag orders.” The reality is that disgruntled patients are free to speak with family, friends, other physicians, lawyers, hospital peer review committees, or credentialing committees. There are a wide range of appropriate and inappropriate places where patients can express their views.

Barring anonymous sites would be ideal. However, this is unlikely to happen. At the very least it would be ideal if internet sites could verify that the “reviewer” is, in fact, a patient of the physician he or she is criticizing (or praising). Even more, to prevent an extreme opinion—positive or negative—from skewing impressions, websites should hold off from posting such reviews until they have at least 10 or more representative views.

In an ideal situation reviews would focus on those areas in which a patient would be expected to be knowledgeable. These would include issues such as waiting time, appropriate parking, or being treated rudely by the physician and/or staff. Commenting on physician technique or results is an entirely different issue.

Without any signed waiver in place, our physician is in no position to stop his patient from posting the negative online comments.
Bars A line of credit is the perfect way to bridge cash-flow gaps, especially when insurance companies stretch claim reimbursements out to 60 or 90 days, sometimes leaving practices in a pinch to meet their everyday expenses.

Other practices may use a line of credit to hire temporary employees, replace or fix equipment—occasions when the funds are only needed for a few months.

Max Reiboldt, president and CEO of the Coker Group, a business consultancy for the healthcare industry, says the first thing a physician looking for credit needs is a pro forma financial projection, which must include a description of how the funds will be used.

“This is the first thing any lender will ask for because they want to know you have a business plan and projections,” he says.

THE BEST SOURCES OF CREDIT
Reiboldt notes traditional banks and lending institutions are still the best sources of credit as they have the most competitive rates.

Additionally, if it’s a local bank, they will have a vested interest...
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in the success of the practice. “While that doesn’t mean they will cut them any special deals, it allows for a more friendly and amicable relationship,” he says. “Sometimes they will provide better terms, such as interest-only payments or a balloon payment at the end.”

He explains interest-only payments will allow for an initial period when the practice is trying to ramp up its services and volume of work, to have less obligations to fulfill financially. Normally, this is for a defined, limited period of time, though that is when the balloon payment comes into play.

The balloon allows a similar ramp-up period to accommodate a lack of cash flow to the new practice/healthcare entity. Often, it is then restructured from the balloon to a longer-term loan that requires a principal payment each month or at least within a defined period of time.

Reiboldt warns that mezzanine financial lenders and sub-lenders might not be so willing to work with individual clients. These are simply “bridge” lenders, meaning that they might come into play for a limited period as the business ramps up and also supplement the primary lender.

“They may take a portion of the total capitalization needs and then look to be taken out sooner as the business can afford to do so and/or go through a loan restructuring, again when its future seems more certain,” Reiboldt says. “They may take on an element of risk that a traditional lender would not want or be as comfortable with, and not surprisingly, they would require higher interest and some stricter terms, including even more collateral than traditional lenders.”

So mezzanine lenders/sub-lenders fulfill a necessary role to mitigate the risks of the primary lenders and to take on some of the capitalization requirements. However, things to look out for, he says, are high interest rates, upfront fees and unfavorable terms.

The easiest way to check rates is to compare them to the prime rates that banks set and update periodically. Additionally, banks will effectively charge more interest by charging a commitment fee, which is nothing more than interest paid up front to give the bank some assured return on their money at the point of closing.

Some banks have medical divisions that focus on providing capital to medical practices and work with the physicians if things don’t go as planned, so Reiboldt recommends going to these institutions first.

GETTING APPROVAL
A. Michael La Penna, principal of The La Penna Group Inc., a Kentwood, Mich.-based financial consultant, says a line of credit is easiest to obtain for a practice with established patients, billings, and collections.

“A doctor would need some time in practice and a track record of solid financial performance with documented accounting and bookkeeping,” he says. “The easiest avenue for credit would be through the doctor’s bank at which he or she does their commercial business.”

David Zetter, CHBC, president of Zetter Healthcare Management Consultants, says a practice should be able to explain why it needs the line of credit or an existing line increased.

“It could be a lack of cash flow at the beginning of each year when deductibles aren’t met and operating expenses are more than cash flow, or they may be looking to expand their practice,” he says.

The information a physician will need to show a lender includes three years’ worth of tax returns (both personal and business); three years of balance sheets and income statements from the practice; and a complete personal financial statement.

“Ther personal financial situation and the practice financial situation are important. If the practice is not run profitably, the bank will not see [a line of credit] as an option,” Zetter says. “The bank wants to be able to see from the financials that the practice

“Those obtaining a line of credit should be aware of their credit rating with reporting agencies and know the practice’s financial situation so they can be honest with any lender.”

—DAVID ZETTER, CHBC, PRESIDENT, ZETTER HEALTHCARE MANAGEMENT CONSULTANTS
Take a proactive approach to bad patient debt

By John Marchisin and Ravi Kumrah

Changes to the way many Americans select insurance—and the plans they ultimately choose—have introduced a number of new factors to the payment equation making the issue of bad debt ever more pervasive for medical practices. In an AArete survey, over 90 percent of hospital chief financial officers report selling debt to multiple collection agencies, recouping only a portion of what is rightfully owed to them.

More Americans are on high-deductible healthcare plans through both employer-provided and Affordable Care Act coverage. Consumer Reports said two-thirds of eligible U.S. residents purchased low-premium, high-deductible plans through ACA exchanges in 2016.

This means more healthcare costs fall directly on patients—and this is happening on a significant scale across the country.

For physicians, the shift means a new patient population, the under-insured, is now accumulating additional bad debt. This is a situation that must be addressed head-on to avoid serious financial pitfalls.

Addressing avoidance

Given the right tools and institutional mindset, practices can adopt a strategy and goals to move past the current back-end-focused approach to bad debt, and more reliably collect the money they are owed. While acquiring the technology—tools to establish payment plans, financially clear patients, and perform other tasks—is relatively straightforward, creating the necessary organization-wide cultural shift in attitude toward bad debt isn’t.

It’s critical for practice leaders to understand why this attitudinal change is so vital, and what benefits it can bring.

As Medicare moves to a value-based care reimbursement model where payments are tied to patient satisfaction, a positive patient experience has a direct impact on physicians’ bottom line. Executive teams are investing heavily in improving the patient experience to both protect their branding strategies and meet the challenges of patients as consumers.

“As Medicare moves to a value-based care reimbursement model ... a positive patient experience has a direct impact on physicians’ bottom line.”

And since a patient’s final interaction with the clinician will be the financial settlement of what they owe, their entire perception of the quality of care, and their experience will be largely influenced by the aftercare settlement. We have found that engaging up front with the patient, in an honest and transparent manner that avoids financial surprises, is one successful strategy to shape a positive patient experience.

Financial clearance

Not many hospital executives report that financial clearance—a practice that ensures patients’ ability to pay before they arrive for an exam or procedure—is part of their facility’s operations. This process guarantees patients have access to funds, sometimes beyond insurance and direct payment, to compensate the hospital. Financial clearance can mean having your facility’s financial counselors work with patients to find alternative resources such as charity and community sponsorships, low- or no-interest loan options from the facility, or simply setting up a payment plan.

For independent practices, it can mean developing programmatic or manual processes to screen for a patient’s ability to pay, and verify insurance prior to scheduling visits and rendering care. Proactive bad debt avoidance is especially critical here as it likely be more difficult to track bad debt as an expense for the medical practices. Financial clearance is thus focused on ensuring that the right payment information and resources are presented in a way that helps both the practice and the patient—an attitudinal shift that moves beyond collection to education.

Making a cultural shift in terms of patient payments and bad debt isn’t easy. However, from a top-down perspective, a change that ensures a significantly higher degree of revenue capture while still giving patients options is better for everyone involved.

John Marchisin is a managing director, and Ravi Kumrah is a director in the healthcare practice of AArete, a global consultancy specializing in data-informed performance improvement.
and owner will be able to make monthly payments without an issue."

Zetter says every practice should have access to a line of credit to be prepared for any sort of emergency or opportunity that comes up and navigate liquidity issues in a pinch.

"Those obtaining a line of credit should be aware of their credit rating with reporting agencies and know the practice's financial situation so they can be honest with any lender," he says. "After finding a lender willing to work with them, it’s vital to be aware of all the terms of the deal, including interest rate, length of term, required payment amounts and whether it is renewable."

**CREDIT IN PRACTICE**

Linda F. Delo, DO, a family physician in Port St. Lucie, Fla., looked for credit when she started her practice 28 years ago. But she believes there are similarities between what she went through and what those looking for credit today go through.

"Like many students, I had a high debt load and it wasn’t easy to get any money from a bank," she says. "There was a new hospital in town who came in and co-signed for me, and I believe those type of deals are still out there. I was able to get my first loan, which was for $20,000."

Over the years, Delo has needed more credit to grow her practice and even to make payroll on occasion. She has a good relationship with her bank and a line of credit, using her business real estate as collateral.

But she doesn’t always go to the bank when she needs money. Delo has several personal credit cards with as much as $50,000 available and, thanks to low interest rates, she finds this is a better short-term solution than a loan. She’s used this method to buy equipment and fix her floors.

La Penna says there can be such a thing as too much credit. Just because a bank approves a substantial line of credit does not mean it should be used.

Depending on the physician’s relationship with the lender, they may need to provide collateral for the line of credit, which will be in the form of practice assets, accounts receivable, etc. The lender also may require personal guarantees and personal assets as collateral depending on a practice’s situation.

"Be careful how many bankers you submit to because a credit inquiry by many banks can possibly affect your credit ratings," Zetter says.

**ALTERNATIVE LENDERS**

Meredith Wood, vice president of marketing for Fundera, a New York-based financial resource for small businesses, connects physicians with lenders outside of traditional banks.

She explains that lenders typically will request four to eight months of bank statements as well as the most recent tax return for the business, and it’s always a savvy idea to look for a line of credit while a practice is doing well.

"Many practices will come to us when they’re experiencing serious cash flow issues and their financials are hurting; it’s much more difficult for us to help secure capital at that point," Wood says. "My recommendation would be to secure a line while things are going well so that it’s in your back pocket when those unexpected shortfalls come up."

She says a line of credit won’t cost the practice anything until they need to use it because most lenders do not have any fees associated with keeping a line open without it being used, meaning interest will only be charged if a physician draws on the funds. A revolving line of credit term is anywhere between 12 and 24 months.

Most line of credit lenders report to commercial credit bureaus, meaning that simply by having the line open, a practice is establishing business credit.

"We recommend a line of credit when the practice needs to hold the funds for a few months at a time," Wood says. "Depending on the lender, holding a line of credit out to its full term can be expensive in comparison to a term loan or other alternatives."

— MEREDITH WOOD, VICE PRESIDENT OF MARKETING, FUNDERA
The patient, a smoker for 50 years, told her doctor she was afraid quitting would kill her.

Her mother had smoked her entire life, the patient explained, finally quit, then died of a heart attack three months later. Quitting cigarettes had killed her mother, the patient believed, and she was sure the same thing would happen to her.

Her doctor, Richard Bryce, DO, could have given up in the face of that illogical stubbornness, but he persisted. And, after a year of treatment and encouragement, the patient quit.

“You’ve got to plant that seed,” says Bryce, chief medical officer at Community Health and Social Services Center in Detroit. “If you allow the frustration to change the way you practice as a doctor, that’s a problem.”

**TREATING THE COMPULSION**

Smoking is no longer as severe a health crisis it once was. Smoking rates have been declining for decades and those who do smoke are smoking less. Smoking bans in public and private places means smoking has become less of an annoyance for non-smokers.

The opioid crisis gets more headlines and congressional hearings than smoking does.

But it’s still one of the most serious health problems in the nation.

According to the Centers for Disease Control (CDC), cigarette smoking is responsible for more than 480,000 deaths a year in the United States, more than 10 times the number of opioid deaths in 2017. Nearly 38 million American adults, or 15.5 percent, smoked in 2016 and the CDC reports tobacco use is on the rise among middle and high school students, largely due to vaping.

For decades, physicians have been scolding, educating, pleading and more in an effort to get their smoking patients to quit, but it doesn’t always work. So, what should a doctor do? Frank Leone, MD, MS, thinks physicians who try to scare patients into quitting are going about it the wrong way.

“The message has been to turn up the heat on the patient. Constantly reiterating the negative effects of smoking—no one should expect it to make a difference,” says the director of the University of Pennsylvania’s Comprehensive Smoking Treatment Program.

Most smokers know smoking is bad for them and want to quit, Leone says, but
they’re unable to because the compulsion to smoke, which is largely due to nicotine addiction, is simply too strong. The solution, he says, is to separate the compulsion from the smoking and treat the compulsion as an addiction.

“The motivation bucket is already full. It’s what’s on the other side of the scale that’s the problem,” he says.

Doctors should treat smoking the same as they would any other addiction, which means anticipating incremental progress with inevitable setbacks and sporadic improvement, he says. Too often, Leone says, smoking cessation is treated as an all-or-nothing proposition, rather than a treatment program like those designed for chronic conditions like asthma or diabetes.

SCOLD OR ENCOURAGE?

Most smokers want to quit. According to a 2015 report in Morbidity and Mortality Weekly, 68 percent of adult smokers wanted to stop smoking and 55.4 percent had attempted to quit in the past year.

For years, pictures of smoke-blackened lungs and warnings of lung cancer were standard scare tactics for doctors trying to get smokers to quit. However, that approach largely has been abandoned in favor of gentler means.

“Nagging never works. It just makes people mad,” says Windel Stracener, MD, a family practitioner in Richmond, Ind. “I think our job is to encourage them in quitting. Reassure them that they’re not the only ones to relapse and then help them get back on track.”

Doctors say they try to understand why patients smoke and address those reasons, if possible. Stracener says he will not nag a smoker who’s not ready to quit, but will keep revisiting the subject. “One of those times you go to the well you might get what you’re looking for,” he says. “When I’ve had success, it’s been when I’ve used a positive approach.”

Bryce says the key to success is to not be discouraged by the patient’s inevitable relapse, but to keep providing encouragement and never abandon a smoker as a lost cause. “Even if the (success rate) is only one percent, it’s worth my time,” he says.

And patients do listen, says Steve Schroeder, MD, director of the Smoking Cessation Leadership Center at the University of California, San Francisco. While smokers probably have been told numerous times to stop smoking, research shows they are twice as likely to do so if they hear it from their doctor, he says. “People trust physicians,” he says. “We carry a lot more impact than their mothers-in-law.”

Who smokes?
A breakdown by race and gender (2017)

14% of all adults (15.8% of men, 12.2% of women)
21% of people with mixed-race heritage
24% of Native Americans/Alaska Natives

Source: Morbidity and Mortality Weekly Report
Doctors differ on whether to wait until patients say they want to quit to begin treating them. Stracener says a smoker will not quit until ready, but Leone says anti-smoking medication can within weeks bring patients to the point where they’re ready to stop. “The idea of ‘Are you ready to quit?’ is a big obstacle,” he says. “Create the readiness.”

GETTING OUTSIDE HELP
Helping patients stop smoking can be a long, frustrating and time-consuming process for physicians, not all of whom have the time to manage it or the patience for the inevitable relapses and setbacks. However, that doesn’t excuse inaction on the part of physicians. “To do nothing is malpractice,” says Schroeder.

Some physicians use office staff to check in with patients who are in the process of quitting. Others refer them to the numerous online cessation programs and organizations like the American Cancer Society and American Lung Association. Stracener has referred patients to social workers in the Federally Qualified Health Center where he works.

Busy physicians often advise smokers to call 1-800-QUIT-NOW. Available in all 50 states, the quit lines are staffed by National Cancer Institute-trained counselors who take patient histories, create personalized cessation programs and offer ongoing counseling.

NICOTINE THERAPY
The days of having to rely solely on patient willpower to stop smoking are long gone. A variety of effective medications are available.

There are two types of anti-smoking medications: controllers that prevent cravings, such as varenicline tartrate (Chantix), bupropion (Zyban) and nicotine patches (Nicoderm); and relievers that fight immediate urges by delivering nicotine through less harmful methods than smoking. These include gum (Nicorette) and lozenges, as well as prescription inhalers and nasal sprays.

Doctors should not give up hope if a single medication doesn’t work, Leone says, adding that it often takes a combination of medicines or medicines and therapy to succeed.

VAPING
E-cigarettes and vaping devices have not been around long enough to generate the body of research that smoking has, but those in the field say there is reason to worry about their addictive properties.

Like regular cigarettes, e-cigarettes deliver doses of nicotine but, unlike cigarettes, their use is increasing dramatically. A 2016 study found that 10.8 million adults in the U.S. are vaping and more than half also were smoking tobacco cigarettes. Use among teens also is increasing. According to the CDC, vaping went up among middle and high school students from 2011 to 2018. Nearly one of every 20 middle school students (4.9 percent) reported in 2018 that they had used electronic cigarettes in the past 30 days. That figure was 20.8 percent for high school students.

Vaping also could make it more likely that users graduate to tobacco cigarettes. A 2017 study from the University of Southern California found that 40 percent of teens who vaped started smoking tobacco cigarettes, compared to 10 percent of the youth who did not smoke at all.

Vaping is hard to quit, Leone says, because the devices are good at delivering nicotine. His treatment center has just started seeing high school students who want to quit vaping and who are surprised they are unable to. 

More than 16 million Americans are living with a disease caused by smoking.
Smoking increases risk for tuberculosis, certain eye diseases and problems of the immune system, including rheumatoid arthritis.
On average, smokers die 10 years earlier than nonsmokers.
Worldwide, tobacco use causes more than 7 million deaths a year.

Source: CDC

See “Billing and coding advice: tobacco cessation counseling” on the next page.
Billing and coding advice: tobacco cessation counseling

By Renee Dowling Contributing author

Tobacco cessation counseling codes (99406-99407) have been included in the Current Procedural Terminology (CPT®) book since 2008, and, since 2016, they may be reported separately and in addition to other evaluation and management (E/M) services. There are several guidelines for these codes, so it is important to bill and document them appropriately. The codes for tobacco cessation counseling are:

- **99406** Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- **99407** intensive, greater than 10 minutes

These codes are covered in the outpatient and inpatient setting for Medicare patients with the disorder(s) listed to the right.

**Additional Billing Information**

In addition to at least one of the disorders above, patients must also use tobacco (regardless of whether they exhibit signs or symptoms of tobacco-related disease) and be competent and alert at the time of counseling, and the counseling must be furnished by a qualified physician or other non-physician provider (NPP). Counseling sessions may be performed “incident to” the services of a qualified practitioner.

Medicare will cover two cessation attempts per year. Each attempt may include a maximum of four intermediate or intensive counseling sessions. The total annual benefit covers up to eight smoking and tobacco-use cessation counseling sessions in a twelve-month period. The patient may receive another eight counseling sessions during a subsequent year after eleven months have passed since the first cessation counseling session was performed.

Medicare will not cover tobacco cessation services if tobacco cessation is the primary reason for the patient’s hospital stay.

Medicare waives copay/coinsurance and deductible for these services.

**Required Documentation**

Since these are time-based codes, documentation needs to include the time spent counseling the patient and the counseling detail. It is also important to note that additionally-reported E/M services must be distinct, and the time spent performing the tobacco cessation counseling service may not be used as a basis to select the E/M code level.

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Ind.

**ICD-10 Codes that Support Medical Necessity**

*NOTE: Additional ICD-10 codes may apply. Contact your Medicare Administrative Contractor (MAC) and private payers for specific codes and coverage guidelines.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F17.210</td>
<td>Nicotine dependence, cigarettes, uncomplicated</td>
</tr>
<tr>
<td>F17.211</td>
<td>in remission</td>
</tr>
<tr>
<td>F17.213</td>
<td>with withdrawal</td>
</tr>
<tr>
<td>F17.218</td>
<td>with other nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.219</td>
<td>with unspecified nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.220</td>
<td>Nicotine dependence, chewing tobacco, uncomplicated</td>
</tr>
<tr>
<td>F17.221</td>
<td>in remission</td>
</tr>
<tr>
<td>F17.223</td>
<td>with withdrawal</td>
</tr>
<tr>
<td>F17.228</td>
<td>with other nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.229</td>
<td>with unspecified nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.290</td>
<td>Nicotine dependence, other tobacco product, uncomplicated</td>
</tr>
<tr>
<td>F17.291</td>
<td>in remission</td>
</tr>
<tr>
<td>F17.293</td>
<td>with withdrawal</td>
</tr>
<tr>
<td>F17.298</td>
<td>with other nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.299</td>
<td>with unspecified nicotine-induced disorders</td>
</tr>
<tr>
<td>T65.211A</td>
<td>Toxic effect of chewing tobacco, accidental (unintentional)</td>
</tr>
<tr>
<td>T65.212A</td>
<td>intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T65.213A</td>
<td>assault, initial encounter</td>
</tr>
<tr>
<td>T65.214A</td>
<td>undetermined, initial encounter</td>
</tr>
<tr>
<td>T65.221A</td>
<td>Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td>T65.222A</td>
<td>intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T65.223A</td>
<td>assault, initial encounter</td>
</tr>
<tr>
<td>T65.224A</td>
<td>undetermined, initial encounter</td>
</tr>
<tr>
<td>T65.292A</td>
<td>Toxic effect of other tobacco and nicotine, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td>T65.293A</td>
<td>intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T65.294A</td>
<td>assault, initial encounter</td>
</tr>
<tr>
<td>Z87.891</td>
<td>Personal history of nicotine dependence</td>
</tr>
</tbody>
</table>
Is it time to redo your practice’s forms?

Exchanging health information is a two-way street. On one side, physicians aim to gather pertinent information from patients. On the other side, patients are looking for clear direction from practitioners.

Sometimes, though, medical personnel can lose sight of the fact that patients are coming from an entirely different perspective. This chasm is often evidenced by the use of substandard or outdated forms that are meant to gather and share critical information between all parties.

It’s important to support medical conversations and instructions with clear documentation using straightforward language on well-thought-out forms. If you haven’t revised the documents you share with patients for a while, perhaps now is the time to review and update them. Here are a few suggestions to help you get started.

**Patient intake forms**

The intake form is usually the first touchpoint patients have with your practice. Whether completed in person, online, through an app, or over the phone, it’s vital to keep this document simultaneously simple and comprehensive.

One thing you may need to refresh is the language used for gathering vital statistics. Do your current forms have a respectful and inclusive tone? Are there appropriate gender classifications? The traditional male/female choice is no longer adequate in today’s diverse society, particularly in medicine, where anatomic and cultural clarity are crucial for effective patient care.

Another consideration is the way you collect the names of patients. Many of us prefer to be addressed by a moniker that is different from our legal name. Make sure your intake form provides space for patients to include their favored name, pronoun, and, if they choose, honorific. And remember to ask for the names and numbers of two contacts, for emergencies.

It’s helpful to include details about your booking and cancellation policies, hours of operation, and contact information on the patient intake form.

**Lab test and radiology forms**

Take a look at the lab, radiology, and other external forms you use on a daily basis. Are the instructions clear? Is there enough information about the location, contact number, and hours? View these forms from a patient’s point of view to see if there are any confusing or vague instructions.

When referring patients to a specialist, it’s thoughtful to write down a few details so they can remember what doctor they’ll be seeing, why they’re being referred, where they’ll be going, when they can expect to hear about an appointment time, and who will contact them to confirm. You may want to consider creating a sheaf of forms solely for this purpose. It could be as small as a prescription pad and may save you and your staff from a lot of questions while saving your patients from a lot of uncertainty.

**Procedure explanation forms**

Patients need to know exactly what to do in advance of and following all medical procedures. The most efficient and reliable way to ensure this is to provide them with simple, detailed, step-by-step instructions. Use bullet points, outline the chronological stages of the procedure (before/during/after), and add a variety of frequently asked questions to help guarantee patient understanding and compliance. You can also provide links to online resources that accurately depict what will be done.

Sue Jacques is a professionalism expert, keynote speaker, consultant, and author who specializes in medical and corporate civility. Send your practice management questions to: medec@mmhgroup.com.
In the earliest days of EHRs, many of us were optimistic that these systems would provide time-saving tools that enhanced the delivery of patient care. Unfortunately, most physicians today feel EHRs are less of a tool than a mandatory task to facilitate billing. Many question the EHR’s overall value to patients and resent having to use inefficient systems that add hours to the workday.

Consider a recent study in *Annals of Family Medicine*, which estimated that primary care physicians spend nearly two hours on EHR tasks for every one hour of direct patient care. Instead of saving time, EHRs have created a world where doctors often work outside of normal office hours to complete EHR-related tasks.

Given the inefficiencies of most EHRs, is it any wonder that a recent *Medical Economics* survey on the burnout crisis found they are a leading contributor?

**TOOL VS. TASK**

Physicians embraced the stethoscope because it was an efficient tool for improving patient care. If EHRs could be fixed so that they were less of a burdensome task and more of an efficient tool, could we minimize the widespread loathing of EHRs and perhaps spark a bit more EHR love?

To answer that question, we would need to commit to enhancing EHRs to make them more usable for physicians.

The issue of EHR usability is complicated. However, to make EHRs more usable for physicians, we must start by seeking input from physician end users. EHR vendors need to involve physicians at the product development level to gain a better understanding of how a physician actually thinks and works in a clinical setting. We can no longer rely simply on computer programmers with minimal clinical experience—however brilliant they may be—to make critical decisions that impact physician workflows.

Vendors and health system administrators must also involve physicians when making key implementation decisions that impact how users interact with the EHR, especially at the point of care. Physicians must be included in discussions about template customization, documentation workflows, and other areas that impact patient care.

**DRIVING EHR USABILITY**

Even with physician input, improving EHR usability isn’t a simple task, in part because usability is a subjective measure. In 2014, the American Medical Association (AMA) issued eight EHR usability standards in an effort to guide EHR vendors on development priorities. While the AMA’s recommendations were solid, the industry has failed to make significant progress achieving these standards.

To fix EHR usability gaps, we should consider mandated standards. Medicare, as the country’s largest payer, is the likely choice to oversee such an initiative, and could include usability standards as part of the EHR certification process.

Alternatively, CMS could appoint an independent organization to define standards and assess EHRs’ adherence to these standards by evaluating workflows and tracking the time required to perform certain routine tasks, such as creating a new prescription or accessing recent lab results.

EHR usability is a major source of physician frustration that continues to fuel physician burnout. It’s time to prioritize fixes for EHRs to transform them from burdensome tasks to effective tools that help physicians deliver better care.

*Jay Anders, MD,* is chief medical officer of Medicomp Systems.
Who are your role models?

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

“My parents.”

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

“My family doctor growing up.”

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

“Steve Jobs, Elon Musk, Warren Buffet, and [University of Texas-El Paso President] Diana Natalicio.”

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

“[Fellow physician] John C. Tapp, MD.”

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

“Mrs. Kobida (my 8th grade math teacher), Marie Curie, and my mom.”

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

“[Neurologist] David Perlmutter, MD.”

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

“My parents.”

The board members that contribute expertise and analysis to help shape content of Medical Economics.
“The MIPS side of this was supposed to be painful to physicians, but it’s mostly a big nothing-burger because so many have been excluded.”

—FREDERICK SOUTHWICK, MD, UNIVERSITY OF FLORIDA HEALTH

PAGE 8

“Because of privacy laws ... a physician has little recourse when an anonymous patient places a scathing review on a website.”

—DAVID J. GOLDBERG, MD, JD

PAGE 17

16 million

The number of American patients who are living with a chronic disease caused by smoking. PAGE 23

“Nagging never works. It just makes people mad. I think our job is to encourage them in quitting [smoking].”

—WINDERL STRACENER, MD, FAMILY PHYSICIAN

PAGE 23
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Managing your money

Over the course of their careers, physicians face several major financial decisions that can have a lasting impact on their financial well-being. In our next issue we will take a look at some of these key decisions and provide strategies for physicians to consider before making them.