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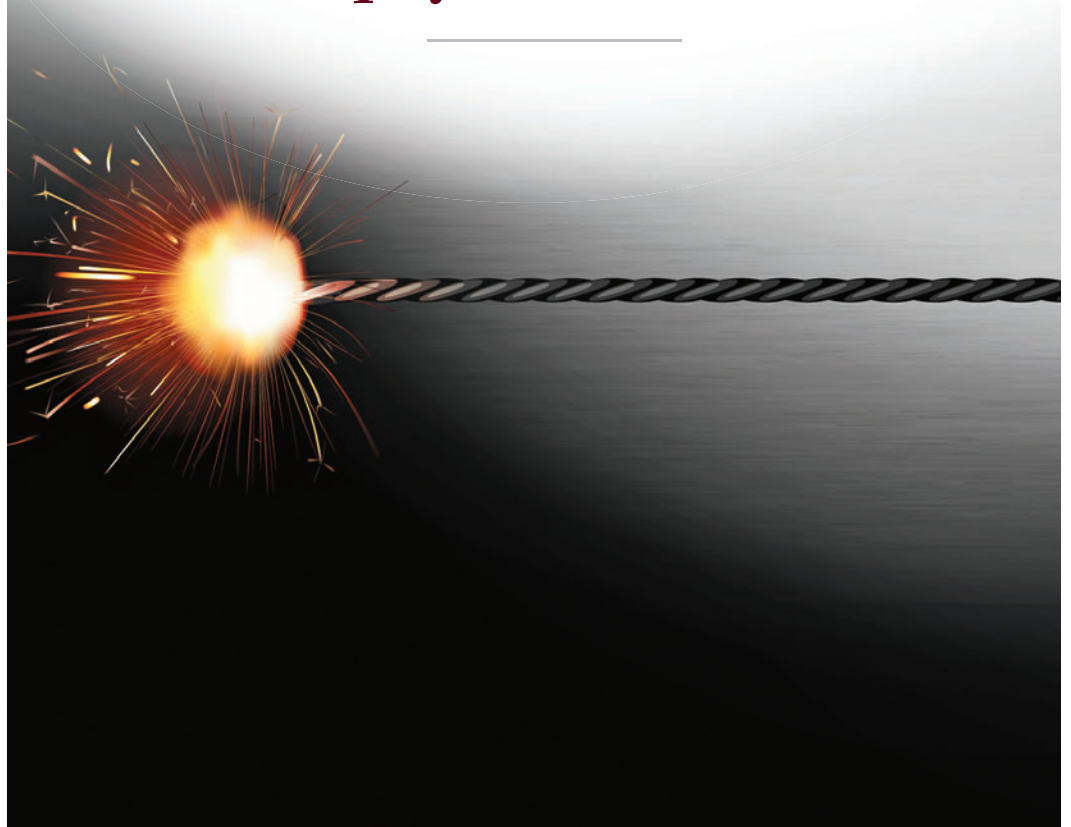
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SMARTER BUSINESS. BETTER PATIENT CARE.

IN DEPTH

Tech ✦

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New technology is poised to change the precertification process, although shift may depend on how healthcare is reimbursed.

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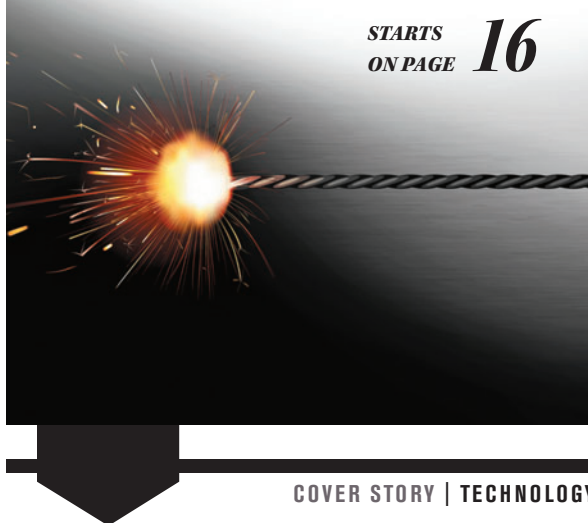
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MISSION STATEMENT

Medical Economics is the leading business resource for office-based physicians, providing the expert advice and shared experiences doctors need to successfully meet today's challenges in practice management, patient relations, malpractice, electronic health records, career, and personal finance. *Medical Economics* provides the nonclinical education doctors didn't get in medical school.

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ONLINE EXCLUSIVE

NEW STUDIES FUEL DOUBTS OVER MOC'S IMPACT

Two studies in the December 10 *Journal of the American Medical Association* are raising questions over the effectiveness of maintenance of certification (MOC) requirements for physicians. The studies found little difference in outcomes among patients cared for by internists grandfathered out of the American Board of Internal Medicine's recertification requirements and those who had to recertify. Read full details at ow.ly/GITVF



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#3 MU PENALTIES BEGIN TO BITE
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“Providers should not reduce the cost of care by waiving or forgiving a copay or deductible for a patient.”

—Renee Dowling CODING CONSULTANT

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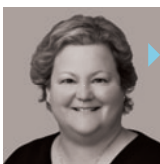
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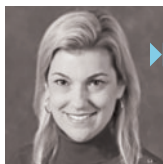
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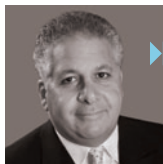
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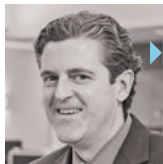
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from the *Trenches*”

“ Free-market, fee-for-service competition gets the patient with their own value system making the [care] decision. Inexpensive catastrophic insurance, with companies competing across state lines with multiple options, pays the big illness bills. Everybody wins when...private companies compete for consumers' business.

Craig Wax, DO, MULLICA HILL, NEW JERSEY

FREE-MARKET COMPETITION WILL REIN IN HEALTHCARE PRICES

Everyone agrees that health insurance and healthcare services are generally way over-priced. Direct physician costs are the smallest part of our systemic problem. Take a look at so-called health insurance. It no longer fits the definition of insurance as it has become prepaid care with huge administrative costs and company profits.

Profit in and of itself is not a bad thing unless there is little or no competition to keep it lean. Obamacare destroys competition by limiting which insurance companies can participate in the state and federal healthcare.gov marketplace. Further, it limits effective and efficient insurance, like indemnity plans, and low-cost, high-deductible plans coupled with health savings accounts.

Furthermore, government subsidies with taxpayer money artificially make premiums seem cheaper for certain government selected populations, which amounts to massive income redistribution, tantamount to legalized theft. Whenever government gets involved in an industry or market, it distorts it, creating winners and losers that differ from those of competition and natural selection.

Hospital health systems and insurance companies play a massive repricing game

with all parties. Hospitals have learned over decades that the higher their prices are, the more they can justify high, unrealistic prices for government and third-party insurance payers.

Insurers and government either cut the bill payment by more than 50% or set some artificially unrealistic price. Again, hospitals raise list prices to compensate while insurance brags to employer or individual that they are getting a 50% price cut, but on a pie-in-the-sky price.

Our local radiology group charges \$128 for a scoliosis spine X-ray series. The insurer cuts it down to the bone and passes on a low-ball price of \$38 to the patient consumer. The same X-ray series with the same CPT code at children's hospital of Philadelphia charges a "facility fee" of \$1,100, plus a \$40 radiologist reading fee. Insurance then halves the exorbitant facility fee to \$550 to make the patient feel like she got a discount.

Imagine a self-pay patient getting the entire bill. When the hospital can't collect it, they call it "uncompensated" care and beg the state to make it up with taxpayer dollars.

Free-market, fee-for-service competition with posted prices gets the patient with their own value system making the decision. Inexpensive catastrophic insurance, with companies competing across state lines with multiple options, pays the big illness bills. Everybody wins → 12

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“ Losing certification is akin to being dishonorably discharged from the armed forces. It is an act that shames and humiliates the physician who was boarded. This harms reputations and is a threat to livelihood, for some hospitals are using certification as a requirement of admission to the medical staff.

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→ 10 when competitive private companies compete for consumer business.

Obamacare must be fully repealed, government must divest from big-brother market distortion, insurance companies must compete, and hospitals must compete on price as never before. Then, and only then, will government market distortion, crony capitalism, and the insurance-hospital repricing scheme no longer abuse all parties.

Craig M. Wax, DO

MULLICA HILL, NEW JERSEY

MOC REQUIREMENTS ARE MORALLY FLAWED

Re "MOC needs revision before physicians recognize value" (eConsult, November 17, 2014): Apart from the usual complaints about MOC [maintenance of certification] including the cost, the time wasted, the irrelevancy of a great part of the exams, and the anxiety, there are three moral issues involved that are never discussed, yet in my estimation should be at the center of this debate:

(1) At their inception at the beginning of the 1990s the boards were voluntary and until recently remained so. Physicians' organizations would never have supported the boards if they operated under a mandatory status. But the boards and MOC have become *de facto* mandatory.

This represents a betrayal of the trust that physicians have placed in them. An organization that was supposed to help them now has become an organization that is a source of anxiety and has the potential to infringe upon doctors' rights to practice. For if the boards are to become a requirement for re-licensure, it is highly likely that some good physicians will have their licenses revoked.

The irony is that there is no preponderance of evidence to show that MOC-doctors provide significantly better or safer or more cost-effective care.

(2) After a physician receives initial certification he/she should never lose it. Losing certification is akin to being dishonorably discharged from the armed forces. It is an act that shames and humiliates the physician who was boarded. This harms reputations and is a threat to livelihood, for some hospitals are using certification as a requirement of admission to the medical staff.

(3) The punitive approach to MOC is wrong. There are several ways to help doctors keep current. Self-assessment programs, booklets, video presentations are just a few of these.

Clearly MOC is morally flawed and it is disappointing that while they have received abundant criticism the moral issue has been ignored.

Edward Volpintesta, MD


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the Vitals

Examining the News Affecting
the Business of Medicine

IS ANOTHER ICD-10 DELAY LOOMING?

Medical societies, spearheaded by the American Medical Association (AMA), are urging their members to write Congress to request a two-year ICD-10 delay.

The AMA, along with many regional medical societies, is urging Congress to include another ICD-10 implementation delay to a stalled appropriations bill during the current lame duck session. If unsuccessful, the medical societies could lobby to tack the ICD-10 delay onto Medicare Sustainable Growth Rate (SGR) legislation in the first few months of 2015, according to Politico. Last April, a one-year ICD-10 delay was a last minute addition to SGR patch legislation passed by Congress and signed by President Barack Obama.

The Texas Medical Association posted a form letter on its website that members can send to Congress, requesting an October 2017 launch date for the new code set.

Advocates for keeping the ICD-10 implementation date at October 2015 say that another delay would be costly and leave the healthcare community with an outdated system.

ONC REPORT: INCENTIVES BOOSTED EHR ADOPTION

Financial incentives, and penalties that come later, have proven successful in motivating physicians to adopt electronic health records (EHR).

A report from the Office of the National Coordinator for Health Information Technology commissioned to investigate the efficacy of EHR incentive programs has revealed that EHR adoption has increased significantly since financial incentives began to be offered.

Physicians who adopted their EHR systems between 2010 and 2013 say financial penalties or incentives played

a large role in their decision to adopt. In fact, 62% of adopters between 2010 and 2013 say financial incentives or penalties swayed their decision, compared to only 23% of adopters prior to 2009.

Solo physicians were the most likely to say they were uncertain or never plan to adopt an EHR system. Among all specialties, surgical specialists had the highest rate (9%) of physicians who had no plans to adopt an EHR.

BY THE NUMBERS

8 OUT OF 10

Physicians who are now using an EHR system or plan to start using one.

1 OUT OF 10

Physicians who don't plan to use an EHR

Reasons physicians don't have an EHR system

67%

Their practice lacks the resources in time and staff.

57%

Can't afford it

21%

No system that fits their specialty needs

Source: ONC

Healthcare spending growth slows on heels of ACA implementation

▶ OVERALL HEALTHCARE

spending reached \$2.9 trillion in 2013—that’s \$9,255 per person—but growth has slowed, particularly when it comes to physician fees.

According to a new report from the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), the healthcare spending rate increased by 3.6% last year, one-half percentage point lower than in 2012. CMS reports that the annual growth rate has hovered between 3.6% and 4.1% for the last five years.

The lower growth rate matches slower overall economic growth, which has averaged 3.9% since 2010. The CMS report attributes the most recent slowdown to decreased private insurance and Medicare spending.

Private health insurance premium growth dropped 1.2% from 4% to 2.8% from 2012 to 2013, while health insurance benefits slowed from 4.4% to 2.8% over the same period. Medicare spending also dropped, from 4% in 2012 to 3.4% last year. Savings were attributed to lower fee-for-service payment updates and adjustments in Medicare Advantage benchmark payment rates. CMS attributes the slowed growth to slower enrollment, ripple effects from the Affordable Care Act’s implementation and federal budget

sequestration in 2013.

Medical price growth slowed as well, according to the report, with medical prices increased by 1.6% in 2012, followed by just 1.3% in 2013. Medical pricing includes physician and clinical services, as well as hospital care, nursing home facilities, home health care and the net cost of insurance. Generally, prices across the economy, prices of consumer goods grew by 1.5% in 2013, signaling a decline in medical-specific price inflation.

“The key question is whether health spending growth will accelerate once economic conditions improve significantly. Historical evidence suggests it will.”

“The key question is whether health spending growth will accelerate once economic conditions improve significantly,” says Micah Hartman, a statistician and lead author of study. “Historical evidence suggests it will.”

Use of medical services also declined, from a 1.2% annual increase in use in 2012 compared to 1% in

2013. This was primarily attributed to slower growth in the use of hospital services, according to CMS.

Conversely, Medicaid spending increased by 6.1% in 2013, along with a 2.7% enrollment increase attributed to early Medicaid expansion in some states. Spending per enrollee also increased in 2013 by 3.3% compared to 2.1% in 2012.

And while expenditures for hospital care increased across all payment models, its growth slowed from 5.7% in 2012 to 4.3% in 2013. CMS says slower growth in product prices in hospitals, as well as a 1.6% decline in inpatient days contributed to the savings. The study notes that patient cost-sharing efforts and higher deductible plans are contributing to efforts to slow growth in hospitalization costs.

Finally, physician cost growth grew by less than 0.1% in 2013—signaling the slowest growth since 2002 due to reduction Medicare payments to providers from the sequester and a zero percent payment update in 2013.

But with all the slower growth, there must be some increase. Spending growth on retail prescription drugs grew by 2.5%, compared to 0.5% in 2012 when a large number of blockbuster drugs lost their patent protection and became available as generics. ■

MORE PRACTICES TO OFFER DIGITAL SCHEDULING IN NEAR FUTURE

Soon patients will be able to interact with physicians the same way they buy clothes or music—online. In the next five years, 64% of patients will book doctor appointments digitally, according to a report by Accenture.

By 2019, 66% of health systems will offer self-scheduling options to patients, and 38% of doctor appointments will be self-scheduled, according to the study. Currently, only 11% of doctor appointments can be scheduled digitally, and only 2.4% of patients are using those options.

When it comes to using digital tools to simplify the patient experience, healthcare has long lagged behind other industries. When patients can schedule their own appointments, it saves time and money for practices. It takes nearly eight minutes for a patient to make an appointment by telephone. Many of those calls (63%) are routed through third-party schedulers from office staff.

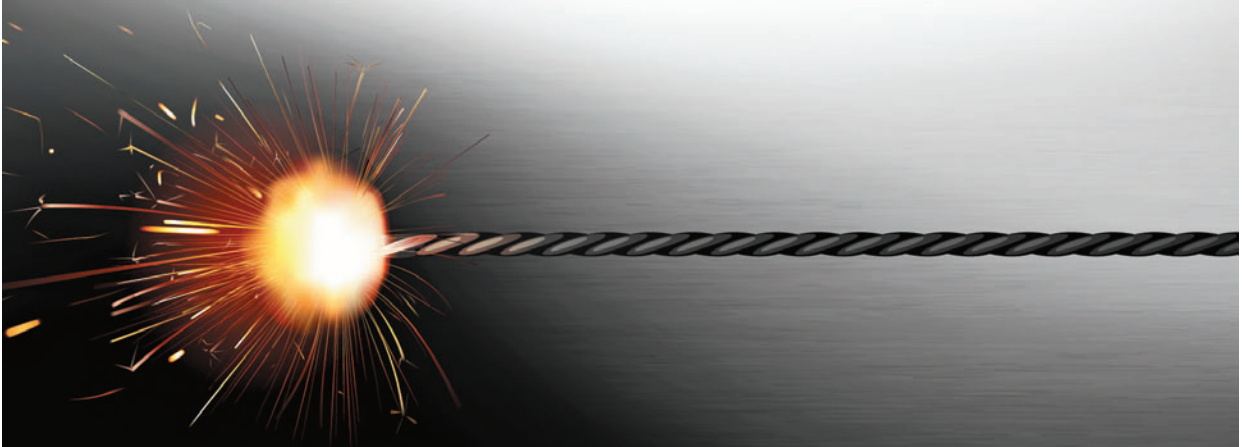
According to Accenture, by 2019, 986 million appointments will be scheduled by patients digitally, and it could save \$3.2 billion in healthcare costs.

MU2: *Mission Impossible*

Ill-conceived government mandate places unnecessary burden on physicians

by **KEN TERRY** *Contributing editor*

Despite protests from stakeholders, Meaningful Use stage 2 (MU2) has continued to fall like an avalanche on physicians. The Centers for Medicare and Medicaid Services (CMS), while delaying some deadlines and adding some flexibility to the program, by and large has not responded to the cries of distress from the healthcare industry. →17





→ 16 Several factors, including the tardiness of electronic health record (EHR) vendors in upgrading their systems, a 12-month reporting period in 2015, and, above all, the lack of interoperability among EHRs, have impeded the ability of even veteran EHR users to attest to MU2.

Many physicians feel they're between a rock and a hard place. If they're participating in the Medicare side of the Meaningful Use program, have attested before, and don't attest to MU2 this year, they'll not only lose financial incentives but will be subject to penalties in 2017.

If their vendor did not supply a 2014 edition upgrade of their EHR in time for them to start their MU reporting on January 1, they can apply for a hardship exception, and 55,000 eligible professionals (EPs) have done that. But if they had their 2014 edition EHR in place last year, they must start reporting now in stage 2 or face penalties.

For many physicians, the penalty phase has already begun. CMS has informed 257,000 EPs that their Medicare payments will be cut by 1% in 2015 for failure to meet the Meaningful Use requirements in previous years. Appeals are being accepted through the end of February.

A few months ago, *Medical Economics* documented the problems that doctors were encountering in meeting MU2's requirements. The biggest challenges were exchanging care summaries electronically with other providers and getting patients to view, download or transmit (V/D/T) their electronic health information. These roadblocks are continuing.

"I can't get my patients to communicate with me online," says Bernd Wollschlaeger, MD, a solo family physician in North Miami Beach, Fla. "That's the first challenge. The second is getting my EHR to interface with the state vaccination registry and the public health and other systems. We're hardly able to communicate with physicians who have different systems. We're still relying on printed out reports from an EHR that are emailed or faxed to me so I can input them into my system."

As of December 1, 2014, only 16,455 eligible providers (EPs) and 1,681 eligible hospitals (EHs) had attested to MU2, which launched on January 1, 2014. CMS says it expects a last-minute surge that will raise these numbers signifi-

→ 18

FIXING MU2 TO HELP PHYSICIANS

While the U.S. Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) have made tweaks to the meaningful use (MU) program to help physicians attest to stage 2, many physicians are still struggling with the burden. In October, the American Medical Association (AMA) and other physician advocates, including the American Academy of Family Physicians and the Medical Group Management Association, have asked for a number of fixes to make the program less burdensome on physicians.

BETTER FLEXIBILITY

- Remove the program's "all or nothing" approach to attestation. The AMA recommends adopting a 50% threshold for incurring a penalty and a 75% threshold for earning an incentive in MU2.

ADJUST CORE MEASURES

- The government should make optional the measures that have been the most challenging for physicians, including:
 - View, download, and transmit
 - Transitions of care
 - Secure messaging

EXPAND HARDSHIP EXEMPTIONS

- Provide an exemption from the MU quality reporting requirements for physicians who successfully participate in the Physician Quality Reporting System (PQRS)
- Expand the ability of physicians to use the "unforeseen circumstances" hardship
- Provide an exemption for physicians who are nearing retirement

IMPROVE QUALITY REPORTING

- Improve the MU program's alignment with the PQRS program
- Ensure public input for new electronic clinical quality measures
- Continue allowing physicians to report on menu measures
- Develop a process to eliminate measures that no longer follow the latest clinical evidence

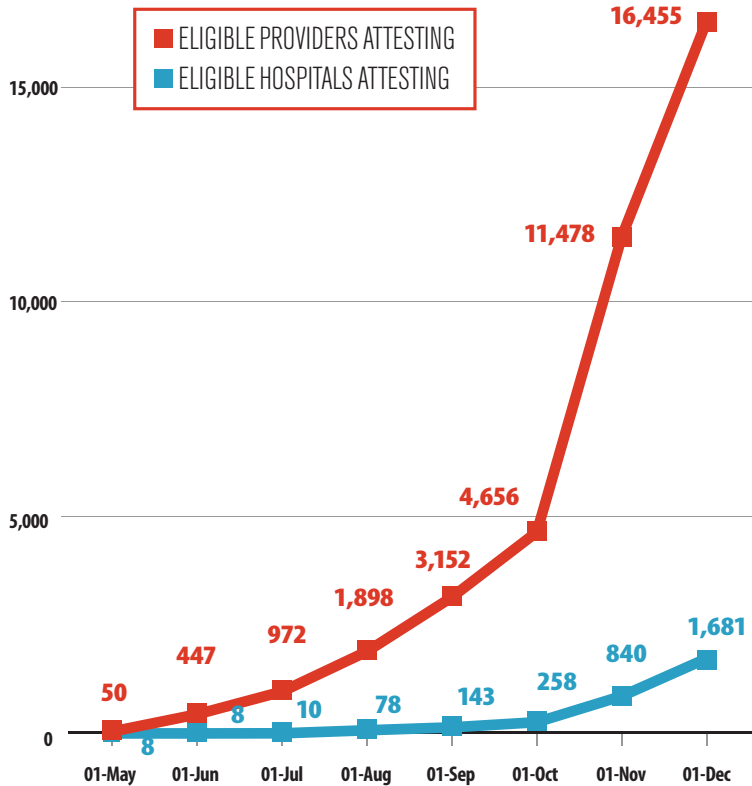
ADDRESS USABILITY CHALLENGES

- The government should adopt the Health IT Certification/Adoption Workgroup's recommendation to revamp the vendor certification program to focus exclusively on:
 - Interoperability
 - Quality measure reporting
 - Privacy and security
- Remove the requirement that only licensed medical professionals and credentialed medical assistants are allowed to enter orders

Source: Center for Technology and Aging, 2010



MEANINGFUL USE 2 ATTESTATION RATES, 2014



→ 17 cantly by the end of February, when attestations from the fourth-quarter reporting period are due.

But Michelle Holmes, MBA, a Seattle-based principal with ECG Management Consultants, is seeing more and more of her clients “de-prioritize” the Meaningful Use program. “They’re preparing for the inevitability that they may not be successful and even starting, in some cases, to budget for that,” she says.

Holmes expects the dropout rate from Meaningful Use—which was 16% from 2011 to 2012 and 19% from 2012 to 2013—to continue rising. “The dropout rate will increase even more if they stick to the 12-month reporting period,” she says. “That could be the straw that breaks the camel’s back” that may persuade CMS to restore the 90-day reporting period, she adds.

Meanwhile, physicians must begin reporting now to avoid penalties. Here are some tips to help you get over the rough spots.

DON'T FALL BEHIND

Assuming the 12-month period stays in effect, you can meet the requirements of MU2 at any time over the course of the year. So if you’re having trouble with a particular objective now, you can catch up later on.

Don’t wait too long, however, or your numerators will not keep up with your denominators, warns Robert C. Tennant, an executive consultant with Beacon Partners in Weymouth, Mass. For example, he says, if an EP has a 50% threshold for a measure—i.e., the EP must meet that requirement for half of the patients he or she sees—and doesn’t record any data for that measure in the first six months, the threshold becomes 100% for the second half of the year.


To ensure that your numbers are on target, you have to track them and check on them regularly, Tennant notes. “Doctors need to understand each measure and what they’re reporting on and how their EHR tracks it. They need a spreadsheet that tracks each of the measures and where they’re at with the numerator and the denominator. Review those weekly, at least, and stay on top of those, increasing where your initial percentages are low.”

Most certified EHRs have a tracking tool for Meaningful Use, but they don’t necessarily supply data on every measure, he warns. Some EHRs have a very basic tracking system that shows only numerators and denominators. Others enable you to find out where the numbers came from in your EHR.

V/D/T/ AND OTHER CHALLENGES

The biggest challenges in MU2 all are related to external communications. These include the exchange of care summaries with other providers at transitions of care, the ability to send data to public health agencies and vaccination registries, and the ability to communicate online with patients.

The stage 2 criteria for patient engagement include providing 50% of patients with continually updated health records and clinical summaries after visits, ensuring that 5% of patients seen during the reporting period “view, download or transmit → 20 to a third party their health in-



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(colchicine, USP) tablets

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STAGE 2 MEANINGFUL USE: *Core and Menu objectives*

17 Core Objectives

- | | | |
|--|---|---|
| <p>1/ Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders.</p> <p>2/ Generate and transmit permissible prescriptions electronically (eRx).</p> <p>3/ Record demographic information.</p> <p>4/ Record and chart changes in vital signs.</p> <p>5/ Record smoking status for patients 13 years old or older.</p> <p>6/ Use clinical decision support to improve performance on high-priority health conditions.</p> | <p>7/ Provide patients the ability to view online, download, and transmit their health information.</p> <p>8/ Provide clinical summaries for patients for each office visit.</p> <p>9/ Protect electronic health information created or maintained by the Certified EHR Technology.</p> <p>10/ Incorporate clinical lab test results into Certified EHR Technology.</p> <p>11/ Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.</p> <p>12/ Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care.</p> | <p>13/ Use certified EHR technology to identify patient-specific education resources.</p> <p>14/ Perform medication reconciliation.</p> <p>15/ Provide summary of care record for each transition of care or referral.</p> <p>16/ Submit electronic data to immunization registries.</p> <p>17/ Use secure electronic messaging to communicate with patients on relevant health information.</p> |
|--|---|---|

6 Menu Objectives

- | | | |
|--|---|---|
| <p>1/ Submit electronic syndromic surveillance data to public health agencies.</p> <p>2/ Record electronic notes in patient records.</p> | <p>3/ Imaging results accessible through CEHRT.</p> <p>4/ Record patient family health history.</p> | <p>5/ Identify and report cancer cases to a state cancer registry.</p> <p>6/ Identify and report specific cases to a specialized registry (other than a cancer registry).</p> |
|--|---|---|

Abbreviations: CEHRT, certified electronic health record technology; EHR, electronic health record.
Source: Centers for Medicare and Medicaid Services.

→ 18 formation,” and ensuring that 5% of patients seen during the reporting period communicate online with their providers.

The technology that most doctors use for this patient interaction is a web portal attached to their EHRs. Wollschlaeger reports, however, that his patients prefer to communicate with him by insecure e-mail or texting. Fewer than 5% use his portal, in part because it is very basic and doesn't go

much beyond presenting information such as lab results. It's not easy to use it for communicating with his patients, which is what they want, he says

Wollschlaeger knows he has to educate his patients about the importance of using the portal, but doing so is difficult in light of the system's deficiencies. “Not every portal is beautiful or patient-friendly,” he points out.

However advanced a portal is, a prac-



“ I CAN'T GET MY PATIENTS TO COMMUNICATE WITH ME ONLINE. THAT'S THE FIRST CHALLENGE. THE SECOND IS ... WE'RE HARDLY ABLE TO COMMUNICATE WITH PHYSICIANS WHO HAVE DIFFERENT SYSTEMS.”

—BERND WOLLSCHLAEGER, MD, SOLO FAMILY PHYSICIAN IN NORTH MIAMI BEACH, FLORIDA

tic's physicians and staff must develop a strategy to enroll patients in it, notes Tennant. "It's going to continue to take a lot of work," he says. "When a patient walks in the door, they visibly need to see that the portal is available. The staff needs to be educated and patients have to be told the benefits of V/D/T."

Vernon Groeber, another consultant with Beacon Partners, adds, "You can count a V/D/T during an office visit [toward Meaningful Use]. So if you have a computer in the waiting room, and staff to help the patient, the patient can view their records in the office before they leave."

DIRECT MESSAGING

As part of MU 2, EPs are required to exchange care summaries electronically with other providers for at least 10% of referrals and other transitions of care. In addition, they must perform at least one exchange with a provider who uses a different EHR system.

This is the steepest hill for most doctors to climb, because the infrastructure to accomplish this goal is either not in place or not widely used. The two main choices are to use a health information exchange (HIE), which may not be available in a particular area, or to use Direct messaging, a protocol for sending messages and attachments securely from one provider to another.

The major problem with Direct messaging is that not enough providers are using it to enable many EPs to meet the Meaningful Use criteria. For example, Terry Hashey, DO, an experienced EHR user who is part of a two-doctor family practice in Jacksonville, Fla., says he has met every requirement of MU stage 2 except for the exchange of clinical summaries during referrals.

"That's a key requirement for stage 2, and there's nobody in Jacksonville—specialty or primary care—that we've been able to find that can receive an electronic referral," he says. "We've reached out to every hospital system and every group we deal with, and none of them can receive a Direct message."

Wollschlaeger, too, reports that few of his colleagues are accepting Direct. Moreover, because he hasn't yet received his 2014 edition EHR, he has to go to a website to send or receive a Direct message, instead of doing it within his EHR.

THE DIRECTTRUST NETWORK

The problem isn't with the Direct infrastructure, says David Kibbe, MD, president of DirectTrust, a nonprofit organization that accredits health information service providers (HISPs) that encrypt and convey Direct messages to their addressees. The DirectTrust network includes 27 fully accredited HISPs and 14 candidates for accreditation. Accredited HISPs can communicate with one another because they all meet stringent security requirements.

"HISP-to-HISP communication is at a very high level of reliability for the major carriers," Kibbe says. "Most of the traffic is being carried by about 12 to 15 HISPs, and among those the reliability of transport from HISP to HISP is better than 95%."

However, some EHR vendors don't make it easy for providers to exchange Direct messages, he says. For example, some suppliers have created a Direct module with an inbox that physicians can use to send and receive Direct messages.

In other EHRs, the Direct functionality is embedded in referral modules that may use one of several modalities to make electronic referrals, in-



MEANINGFUL USE 2 BASICS

Stage 2 of the meaningful use program focuses on:

- 1 More rigorous health information exchange
- 2 Increased requirements for e-prescribing and incorporating lab results
- 3 Electronic transmission of patient care summaries across multiple settings
- 4 More patient-controlled data

Source: ONC



HEART FAILURE SHATTERS MILLIONS OF LIVES

HEART FAILURE PATIENTS: “STABLE” OR SILENTLY PROGRESSING?

Heart failure is a progressive disease that is characterized by frequent hospital admissions and high mortality rates:

>1 MILLION
HEART FAILURE
HOSPITALIZATIONS
OCCUR EVERY YEAR¹
and rehospitalization
continues to be an issue²

≥24%
OF HEART FAILURE
PATIENTS DIE WITHIN
1 YEAR OF DIAGNOSIS³
this increases to ~50%
within 5 years^{3,4}

The neurohormonal imbalance associated with chronic heart failure is a major contributing factor to the progression of the disease. Sustained overactivation of the RAAS and SNS, with dysfunction of the normal counterregulatory effects of the NPS and other compensatory mediators,* lead to impairment in heart function and cardiac remodeling.⁵⁻⁷

LET'S WORK TOGETHER TO CHANGE THAT

*Additional counterregulatory mediators include adrenomedullin, prostaglandin E, bradykinin, etc.⁸

NPS=natriuretic peptide system; RAAS=renin-angiotensin-aldosterone system; SNS=sympathetic nervous system.

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“WE’VE REACHED OUT TO EVERY HOSPITAL SYSTEM AND EVERY GROUP WE DEAL WITH, AND NONE OF THEM CAN RECEIVE A DIRECT MESSAGE.”

— TERRY HASHEY, DO, FAMILY PHYSICIAN, JACKSONVILLE, FLORIDA

→ 21 cluding Direct, fax or e-fax. In the latter case, the physician doesn’t know how a message is being transmitted, and must depend on the vendor to document which referrals count toward the Meaningful Use requirement.

Another difficulty some physicians have found is that they have been assigned multiple Direct addresses by the hospitals that they use. When that occurs, it’s hard for them to know where to receive Direct messages.

When will enough providers use Direct to make it a way to meet the MU2 criteria? Kibbe believes that use of the technology will grow steadily over the next few years as people discover that it’s not just for Meaningful Use.

Holmes also predicts greater adoption of Direct in 2015, but mainly as a way of getting EHR incentives. EPs who are less focused on Meaningful Use, she says, are less likely to use it. Tennant believes that Direct will be more successful in areas where hospitals and health systems are pushing it.

But however you slice it, exchanging care summaries at transitions of care will continue to be difficult for doctors. Hashey, who got a reprieve on stage 2 when CMS introduced its flexibility rule last fall, bluntly says, “As soon as we find a specialist that can take the Direct messaging, [he or she] is going to get all of our business.”

WHY STICK WITH MEANINGFUL USE?

Hashey says that he and his partner are committed to achieving Meaningful Use however they can. The EHR incentives, which were front-loaded in the first few years, amount to only about \$4,000 this year for his practice,

he notes. However, he points out, “As a two-doctor practice, we can’t afford penalties.”

Wollschlaeger also isn’t focusing on the incentives as he pursues stage 2 attestation. He qualifies for a hardship exemption for 2015 because his upgraded EHR won’t be delivered until mid-year, but he intends to attest when he can.

His interest is related to his status as a patient-centered medical home, which garners health plan bonuses and makes it easier to deal with payers. The National Committee for Quality Assurance (NCQA) recognized his medical home under its 2011 standards, but he has to be recertified under the 2014 NCQA standards, some of which mirror the MU2 requirements, he says.

Wollschlaeger, who is active in the Florida Academy of Family Physicians (FAFP), says that in a recent conference call he and other FAFP members attributed the low attestation rate in stage 2 to “the very complex, cumbersome attestation process.

“There’s a difference between what we want to achieve and what we can achieve at this point in time” he says. “I don’t think physicians are resistant, we’re just overwhelmed to do that.” □

+ MORE COVERAGE ONLINE

The meaningful use 2 challenge
<http://bit.ly/13Bnb9C>

2014 EHR Scorecard
<http://bit.ly/1B2CYJw>

Physician outcry on EHR functionality, cost will shake the health IT sector
<http://bit.ly/1JPjnD>



Automated precertification lags behind, but new solutions emerging

New technology is poised to transform the precertification process, although the shift may depend on changes in how healthcare is reimbursed. **BY KEN TERRY** *Contributing editor*

HIGHLIGHTS

01 What makes the precertification process so difficult are the large variations in rules. These vary not only from one specialty to another and among different types of test and procedures, but also among the myriad plans that each insurer offers.

02 While new technology offers promising solutions, the real driver of prior authorization automation will be the industry's shift to value-based reimbursement.

While electronic prior authorization of prescription drugs is well on its way to becoming a reality (See

“Electronic prior authorization: The solution to physicians’ headache?” in the January 10, 2015 issue of *Medical Economics*), the precertification and advance notification of tests and procedures are still mired in the dark ages of phone and fax in most practices.

Still, experts say, new technology is poised to transform this area as well, although that shift may depend on changes in how healthcare is reimbursed.

Just how far we are from automated electronic precerts and notifications was shown in a recent report from the Coalition for Affordable Quality Healthcare (CAQH). In 2012, the report said, there were approximately 130 million authorization “events” unrelated to prescription drugs. Of those events, 110 million, or 84%, were handled manually. If healthcare providers had been able to submit these preauthorization requests electronically, the

researchers found, they could have saved \$13.33 per transaction.

Physicians confirm that prior auth places a significant burden on their practices. Medhavi Jogi, MD, an endocrinologist in Houston, Texas, says that a staff member spends an average of three hours per day filling out prior authorization forms and calling health plans on behalf of the four doctors in Jogi’s practice. The group recently had to add four fax lines simply to handle the increased volume of prior auth requests for their growing practice.

Edward Rippel, MD, a solo internist in Hamden, Connecticut, says, “We expend significant non-reimbursed resources in getting prior authorization for diagnostic testing and medications.” He estimates that a few years ago prior auth occupied between half and two-thirds of the time of one full-time employee.

Some specialists and surgeons have to cope with far more non-drug-related prior auths than do primary care physicians. And hospitals spend up to tens of millions of dollars annually on precert and notification, depending on their size, notes Jim Lazarus, managing director, strategy and innovation,



130 MILLION

Number of authorization "events" unrelated to prescription drugs in 2012.

110 MILLION

Of the 130 million authorization events in 2012, the number that were handled manually.

\$13.33 PER TRANSACTION

The amount that could have been saved if healthcare providers could have submitted the manual pre-authorization requests electronically.

Source: The Coalition for Affordable Quality Healthcare

for revenue cycle solutions, at The Advisory Board Company

While prior authorization continues to be largely a manual process, the barriers to automation are starting to come down. Read on to find out what those barriers are and how your practice can benefit from the latest technological innovations.

HIPAA TRANSACTIONS

The Health Insurance Privacy and Accountability Act (HIPAA) 278 transaction standard, enacted in the 1990s, was designed to let providers notify health insurers about scheduled admissions and referrals, request prior authorizations, and receive responses from payers through electronic clearinghouses. These are the same clearinghouses practices use to send claims, check claims status, check insurance eligibility, and receive remittance advice.

While the latter transactions are commonplace, the 278 transaction standard still is not widely used in the industry. A few years ago, UnitedHealthcare began accepting notifications of hospital admissions in the HIPAA format, but not many other payers have followed suit, says Lazarus.

The reluctance of most payers to take 278 transactions has discouraged electronic health record (EHR) vendors from incorporating it into their products. "The payers weren't interested in it and didn't implement these standards," says Ron Sterling, CPA, a health IT consultant in Silver Spring, Maryland. "That created a chicken or egg situation, because the EHR vendors weren't going to support it until the payers did."

Frank Ingari, president and chief executive officer of Navinet, a firm that facilitates web-based administrative transactions between providers and health plans, notes that the 278 transaction standard uses old specifications and can't convey some of the information required for prior authorizations.

Those EHR vendors that have built the 278 transaction into their products, he says, generally use a "bare bones" version that doesn't work in many cases. And unless something has a high success rate, he points out, clinicians won't use it.

HEALTH PLAN WEBSITES

The same problem is seen in health plan websites for prior authorization. When practice staffers fill out prior auth forms

on these portals, they may obtain approval if they're for simple, open-and-shut cases. But if anything more complex is involved, the forms may not include all the information required for auto-adjudication, and the request is turned down. Then the doctor or a staff member has to call the plan.

"Nowadays, they have these online methodologies you can use, and for the clearest cases, it usually works OK," says Rippel. "The problem is that in most of the cases, you don't have exactly the right buzzwords to choose from somebody's pick list or drop-down menu."

This kind of experience drives many practices to download the precert form, complete it and fax it to the plan or simply call the insurer, notes Ingari. "If I submit an electronic form, and three-quarters of the time I get pushed to the phone anyway, a lot of times the provider will say, 'I'm just going to call.'"

What makes this process so difficult are the large variations in authorization rules, Ingari points out. These vary not only from one specialty to another and among different types of test and procedures, but also among the myriad plans that each insurer (and sometimes, each employer) offers. So it's impossible to design online forms that will fit all situations.

Even if the success rate were higher on health plan portals, requesting authorizations through them would still be a largely manual process, Sterling notes. First the physician enters the data justifying the test or the procedure into the patient's treatment plan. Then a staff person goes to the portal of the patient's health plan and enters the same information again, along with the patient's demographic data. When a response comes back it doesn't go into the practice's EHR; it has to be printed out and reentered.

"Anytime we're talking about a system where the provider is doing all the work to save somebody else money, you're pushing costs from one place to another and not necessarily increasing the efficiency of the network," Sterling says.

WEB BOTS RULE

Automation would reduce the amount of work involved in requesting prior auths. Progress is starting to occur here, but not much of it has yet reached the practice level.



“We expend significant non-reimbursed resources in getting prior authorization for diagnostic testing and medications.”

— EDWARD RIPPEL, MD, SOLO INTERNIST, HAMDEN, CONNECTICUT

“Web bots,” or specialized programs that search the Internet, now are used to pull desired information off the websites of health plans. When a patient comes to a hospital, an imaging center, or an ambulatory surgery center, these web bots can determine whether the patient has an authorization or needs one so that the ordering physician can request it, Lazarus explains. But then the physician’s practice has to use the customary phone and fax process to obtain the authorization.

The main advantage of this “screen scraping” technology is that it spares the staff the time-consuming work of either combing the payer portal to find out what the patient’s benefits are and what requires authorization or waiting on hold to get that information from a health plan employee.

Unfortunately, the use of web bots requires the expertise of outside vendors that work mainly with healthcare systems. That’s fine for hospital-employed doctors, but independent practices are less likely to have this technology.

If they did have it, Lazarus points out, the same technology could be used to prepare a prior auth request. Web bots could prepopulate demographic and benefits information on precert forms and, as they become more integrated into EHRs, could pull required clinical information into the forms, as well.

This approach is in a nascent stage. Fewer than 5% of payers accept prepopulated forms, and few technology vendors are doing this today, Lazarus says.

Nevertheless, this is a rapidly-growing area, says Doug Hires, executive vice president of Santa Rosa Consulting. “It’s far from perfect, but there are vendors focused on it,” he says. “The big challenge is integrating it with EHR vendors, passing data and populating data elements.”

At present, he says, revenue cycle management firms that help providers optimize their financial systems are taking the lead in prior auth automation. He doubts that EHR vendors will build all of this functionality into their products. “It probably will end up being more of a collaborative effort, and it will be a foot race to see who can partner with whom to provide some of this.”

SUPPORTING DOCUMENTATION

Health plans frequently ask for documentation to justify precert requests—a sore point for physician practices. Payers generally ask for the last visit note and the last lab result, and they have to be faxed, notes Jogi. “It’s really annoying.”

At least in this area, automation is on the way or has already arrived, depending on whom you talk to. When a payer posts a request for more information on its portal, Lazarus says, a web bot can immediately pull that message off of the website and deliver it to the practice EHR. Then the practice can pull up the requested document, turn it into a PDF, and send it to the payer electronically, either through an encrypted channel or by uploading it to a secure website.

Navinet plans to offer an electronic document delivery service, Ingari says. The lack of secure networks for moving this data has hampered the automation of this process up to now, he adds. However, he’s sure that providers will be able to do this directly with health plans in the future.

INTERACTIVE FORMS

The biggest barrier to automating prior auths, as mentioned earlier, is the inability of static forms on a payer portal to convey all the information needed to obtain approval from a health plan or third party application. Part of the solution, Lazarus and Ingari agree, is to use interactive





By 2007, the HCV mortality rate surpassed that of HIV, and continued to rise.⁴⁻⁶

Of the approximately 3.5 million Americans with chronic hepatitis C virus (HCV) infection, half have been diagnosed, and about 9% have been successfully treated.¹

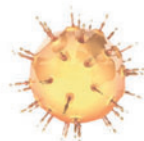
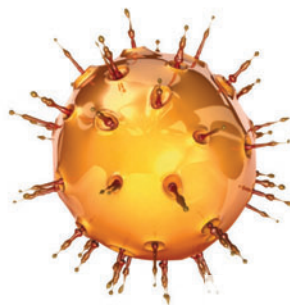
In the US, HCV is now the leading cause of liver transplantation² and liver cancer.³

References: 1. Yehia BR et al. *PLoS ONE*. 2014;9(7):1-7. 2. Kim WR et al. *Am J Transplant*. 2014;14(suppl 1):69-96. 3. El-Serag HB. *Gastroenterology*. 2012;142(6):1264-1273.e1. 4. Ly KN et al. *Ann Intern Med*. 2012;156(4):271-278. 5. Murphy SL et al. http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf. Accessed October 29, 2014. 6. CDC. <http://www.cdc.gov/hepatitis/statistics/2010surveillance>. Accessed October 29, 2014. 7. CDC. <http://www.cdc.gov/hepatitis/HCV/statisticsHCV.htm>. Accessed October 29, 2014. 8. Smith BD et al. *MMWR Recomm Rep*. 2012;61(RR-4):1-32. 9. USPSTF. <http://www.uspreventiveservicestaskforce.org/uspstf12/hepc/hepcfinalrs.htm>. Accessed October 29, 2014. 10. AASLD, IDSA, IAS-USA. Recommendations for testing, managing, and treating hepatitis C. <http://www.hcvguidelines.org>. Accessed September 18, 2014. 11. US Department of Health and Human Services, Center for Drug Evaluation and Research. Draft Guidance for Industry. Chronic Hepatitis C Virus Infection: Developing Direct-Acting Antiviral Drugs for Treatment. October 2013.

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RETHINK HCV



HCV CAN BE CURED



ADVANCES IN HCV MANAGEMENT HAVE MADE CURE MORE POSSIBLE FOR PATIENTS.

More than 75% of patients with HCV are baby boomers, persons born between 1945 and 1965.⁷ The CDC, USPSTF, and AASLD now recommend the one-time screening of all baby boomers, regardless of risk factors.⁸⁻¹⁰

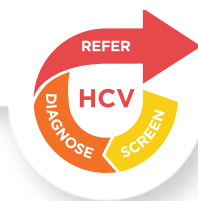
Additionally, scientific advances have made HCV treatment shorter and more effective.

Cure, also known as sustained virologic response (SVR), is defined as no detectable HCV in the blood at 12 or more weeks after therapy is complete.^{10,11}



Take action now: Screen. Diagnose. Refer.

Request the HCV Toolkit at HCVcanbecured.com/kit6





“In the next three to five years, we’re going to continue to see a rapid evolution, but it will be driven by what the payers are willing to do more than what the providers want.”

— JIM LAZARUS, MANAGING DIRECTOR, STRATEGY AND INNOVATION FOR REVENUE CYCLE SOLUTIONS, THE ADVISORY BOARD COMPANY

→ 27 questionnaires that can gather all of the requisite data.

“We need to move from a transaction to an interaction, where that interaction is supported by a richer software interaction than you have in a traditional transaction,” Ingari says.

Some plans are starting to offer these types of forms on their websites, he says. “Our payers are investing in making them easier to use and are particularly focused on enabling a more complex process to be handled entirely online. That means richer forms that are more interactive so that the requests can be refined during a work session.”

Rippel says that he has already encountered this kind of interactive form on the website of Availity, a service used by several major plans. “It’s basically a decision tree or an algorithm,” he says. “But that concept makes sense only if it works for all of your patients.”

VALUE-BASED REIMBURSEMENT

While new technology offers promising solutions, Ingari believes that the real driver of prior authorization automation will be the industry’s shift to value-based reimbursement.

As providers take more responsibility for quality and cost, he says, “The auths are morphing from a mainly administrative tool to ensure reimbursement to an instrument of evidence-based guidance. Future auth processes will add value through enhanced functionality such as defining preferred courses of treatment based on clinical evidence.”

This is already happening in the practice of Jeffrey Pearson, DO, a family physician and sports-medicine specialist in San Marcos, California. As a member of a large

primary care group that takes financial risk from HMOs, Pearson seeks approval for imaging tests directly from his group’s utilization reviewers. All he has to do is open a referral page in his EHR, put in the diagnosis, what he’s looking for, the study he wants, and whether it’s an emergency, and he sends the form to the UR staff. Normally they respond to his request the same day.

For PPO patients, however, he relies on a local radiology group that requests precertifications on behalf of its customers to make sure that its physicians get paid. When he was in solo practice a few years ago, he recalls, prior auth required the usual phone and fax rigmarole.

Automation of prior authorization is coming. It’s already on the horizon for pre-authorization of prescription drugs. While it will take longer to automate the precert/notification process, the elements of a viable solution are in sight.

“This is an area that can be automated as payers become more willing to cooperate,” Lazarus says. “In the next three to five years, we’re going to continue to see a rapid evolution, but it will be driven by what the payers are willing to do more than what the providers want.” ■

+ MORE ONLINE

The prior authorization predicament
<http://bit.ly/1wZG8R1>

Curing the prior authorization headache
<http://bit.ly/13yGUay>

Time is money: 4 ways to manage practice productivity
<http://bit.ly/1wZGjvu>



Tech Talk

EMBRACING EHRs: 8 WAYS THEY CAN IMPROVE YOUR PRACTICE

by **ANDREA L. HAYES, MD, FACE** *Contributing author*

A hot topic among many physicians is the “evils” of electronic health record (EHR) systems and how they represent a unique and vexing challenge to physician professional satisfaction. As a physician who has used an EHR in my practice since 2004, I truly believe this tool represents one of the best technologies that I have adopted in my practice.

INSTEAD OF dwelling on the challenges that physicians face in working with EHRs, which are well noted, let’s discuss some ways an EHR can actually improve our lives and practices.

Physicians must learn to roll with the times and adapt how we function with the new way of practicing medicine—and use it to our advantage.

No more lost charts

I will never forget my first few years in practice as an endocrinologist when we were still using paper charts.

Whenever another physician or other person would call about a patient, the chart was frequently missing in action! It could be in the medical assistant’s office, the billing office, the lab, or heaven forbid,

in a big stack waiting for dictation. Crucial lab values and imaging results would often be separated from the chart until it was finally discovered.

With an EHR, you will never have another lost chart. Simply go to your computer, type in the patient’s name or other identifying information and, *voila!* There is your chart.

One thing to keep in mind with an EHR system: Have someone back up your system continuously so the data is never lost in a computer graveyard.

Transcription is archaic

With a computer in every exam room, we document all our notes while in the room with the patient during the visit.

In my experience, most

patients do not mind the provider looking at the computer often because they realize that this is the most accurate way for the provider to access their data and document new data. Documentation while you are with the patient improves accuracy and saves time.

By doing this, there is no documentation required at the end of the day, when you might be trying to remember details about 20 or more patients. Not to mention the fact that when the note is done, it is immediately ready to be billed.

Code your own notes

No staff member knows what happens in the exam room better than the provider. Only the provider

truly understands the complexity of the visit, the decision-making involved, and the time that it takes to counsel the patient, provide prescriptions, order tests, etc.

An EHR helps with coding because it offers suggested codes based on what is entered into the templates.

However, providers should not be lazy and let the EHR do all the work. If the provider believes that the Current Procedural Terminology code should be billed “higher” than what was charged, then additional information might be needed to document the code properly.

Access charts from anywhere

Isn’t it frustrating to be stuck in an airport attempting to attend a meeting, and thinking about patient charting that needs to be done, including reviewing labs, imaging reports and more? Don’t you wish you could make use of this lost time to get your work done so that life is easier when you return?

With the help of your

→ 34



Tech Talk

→ 31 information technology consultants, you can access your EHR on your laptop, iPhone, iPad or other mobile gadget. We are a society “on the run” so we all need to be able to use those minutes from time to time to stay caught up.

Also, when a patient needs assistance while you are on call, it is very convenient to be able to access your charts so that you are not making decisions blindly.

Use those flow sheets

Those of us managing chronic disease states, such as diabetes, hypertension, hyperlipidemia, or providing primary care often need to review certain screening tests and previous lab values.

For example, you might want to document that your patient has had his/her annual eye exam. You could ask this question each visit, or you could access your handy flow-sheet that documents the date and result of the eye exam, including what follow-up is needed.

This is much easier than going back through many progress notes to find such results. Weight, blood pressure, lipid results, A1Cs, foot exams and more can be documented in these sheets, eliminating time

PHYSICIANS MUST LEARN TO ROLL WITH THE TIMES AND ADAPT HOW WE FUNCTION WITH THE NEW WAY OF PRACTICING MEDICINE—AND USE IT TO OUR ADVANTAGE.

wasted trying to access these results later on.

Reduce paper

In a busy office, your fax machines and printers could be continuously cranking out paper, using precious ink, toner, electricity, drums and more. Not to mention the fact that when all that paper is reviewed, it must be scanned by your employees into the chart.

There are ways to reduce the paper tornado by using some special features of your EHR. For example, you could establish an interface with your lab so that patient lab results are directly routed into your charts.

They can be reviewed and electronically signed, eliminating the need to print, write on the paper, and then re-scan the paper documents.

In addition, you could use a fax process directly from your EHR system, or better yet, communicate electronically with other providers and healthcare professionals. After all, isn't our ultimate goal to become virtually paperless?

Improve prescription accuracy and efficiency

Nearly gone are the days of handwritten prescriptions. Most providers have never acquired the talent of excellent penmanship. It is very frustrating to try and read other physicians' notes and I am sure my colleagues feel the same about me.

Using electronic prescriptions is possible through your EHR. You can also use the drug interaction feature that alerts you to any adverse events.

Still another handy feature is the “curbside consult” ability. This allows providers to obtain a

concise summary of a particular drug including indication, dosing, side effects, mechanism of action and more.

Get rewarded for excellent care

Most of us have simple goals in common. We want to provide excellent, efficient care to our patients and remain economically solvent so that we can pay our staff, our bills and our selves.

With reimbursements trending rapidly toward pay for performance, why not take advantage of any incentive money that might be available while we are taking good care of our patients? The fact is, in the not-too-distant future we may be penalized financially if we are not achieving certain health measures or standards of care with our patients.

So for both reasons including acquiring “bonus” money and avoiding “penalties”, an EHR will help you document and provide evidence to those concerned that you are indeed doing an excellent job. ■



Andrea L. Hayes, MD, FACE, is an endocrinologist in solo practice in Nashville, Tennessee. This article was an honorable mention in the 2014 Medical Economics physician writing contest. Send your technology questions to medec@advanstar.com.

> THIS YEAR'S TOPIC: "Connecting Care" <

We are seeking your real-life stories that can move, teach, and inspire other physicians.

YOUR STORY COULD WIN \$5,000...

Maybe in providing care you connected with a patient in a unique and meaningful way.

Maybe you actively engaged a patient in their own care and/or successfully involved their family.

Maybe you effectively coordinated care across settings or collaborated as a care team with powerful results.

Share your story of how you or others on your care team provided a more connected care experience for your patients.

First Prize **\$5,000 Gift Card**

Second Prize **\$2,500 Gift Card**

Third Prize **\$1,000 Gift Card**

Winning entries will also be published in the March 25th, 2015 issue of *Medical Economics* and featured on the *Modern Medicine Network*.

Here are some suggested story ideas to get the creative juices flowing (but don't let these limit your thinking). Consider a time when you:

- Connected with a patient as a provider in a unique and meaningful way
- Incorporated successful health team strategies for providing seamlessly coordinated care
- Effectively integrated your patient portal
- Used communication methods or skills
- Leveraged technology for a more connected care experience
- Involved a family in patient care

How to Enter

- Send us your story in 800 to 1,200 words
- Submissions must include name, contact email, address, and telephone number
- Submissions can be sent to **MedEc@Advanstar.com** or by mail to:

Medical Economics Writing Contest
24950 Country Club Blvd.
North Olmsted, OH 44070

Deadline for Submissions

All entries must be received by **January 31st, 2015** for consideration.

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Medical Economics Writing Contest Official Rules

(NO PURCHASE IS NECESSARY TO ENTER OR WIN)

The Medical Economics Writing Contest (the "Contest") starts on December 18, 2014 at 12:00 a.m. Eastern Time ("ET") and ends on January 31, 2015 at 11:59 p.m. ET ("Contest Period").

ELIGIBILITY: The Contest is open to licensed physicians who are legal residents of the fifty (50) United States or the District of Columbia, of legal age of majority in their jurisdictions of residence (and at least 18). Employees, temporary workers, freelancers and independent contractors, and their immediate families (spouse and parents, children, siblings and their respective spouses, regardless of where they reside) and those persons living in their same households, whether or not related, of Medical Economics ("Sponsor") and athenahealth ("Supporter") and their respective parents, affiliates, subsidiaries, participating vendors, promotion or advertising agencies are ineligible to enter or win the Contest. By participating, entrants agree to be bound by these Official Rules and the decisions of the judges and/or Sponsor, which are binding and final on matters relating to this Contest. Void where prohibited by law. Contest is subject to all applicable federal, state and local laws.

HOW TO ENTER: During the Contest Period, write an 800 to 1,200 word essay that shares your successful strategies, approaches, and/or experiences to providing a more connected health care experience for patients and/or actively involving patients in their own care and send to medec@advanstar.com or Medical Economics Writing Contest, 24950 Country Club Blvd., North Olmsted, OH 44070, along with your full name, contact email address, mailing address and telephone number (collectively, an "Entry"). All Entries must be received on or before January 31, 2015. Limit one (1) Entry per person. Entries received in excess of the stated limitation will be void. If handwritten, Entries must be legible. All Entries become the sole property of the Sponsor and will not be returned. Entry must (i) be your own original work, (ii) be in English, (iii) cannot be previously published or submitted in connection with any other contest, (iv) be in keeping with the Sponsor's and Supporter's image and (v) not be offensive or inappropriate, as determined by the Sponsor in its sole discretion, nor can it defame or invade publicity rights or privacy of any person, living or deceased, or otherwise infringe upon any person's personal or property rights or any other third party rights (including, without limitation, copyright). Without limiting the foregoing, Entries must not contain any confidential or personally-identifying patient information. Sponsor reserves the right to disqualify any Entry that it determines, in its sole discretion, does not comply with the above requirements or that is otherwise not in compliance with these Official Rules.

JUDGING: All eligible Entries received by the Sponsor will be judged by a panel of qualified judges based equally on the following criteria: practicality of solutions offered, clarity and quality of writing, and level of detail to enable other physicians to apply your solution to their practices. The three (3) Entries with the highest scores, as determined by the Sponsor in its sole discretion, will be deemed the first, second, and third place potential winners. In the event of a tie, an additional, "tie-breaking" judge will determine the winner(s) based on the criteria listed herein. Sponsor reserves the right not to award all prizes if, in its sole discretion, it does not receive a sufficient number of eligible and qualified Entries. Prize awards are subject to verification of eligibility and compliance with these Official Rules. Judges and Sponsor's decisions are final and binding on all matters relating to this Contest.

WINNER NOTIFICATION: Potential winners will be notified by telephone, mail and/or email on or about February 15, 2015 and may be required to complete an Affidavit of Eligibility, Liability and Publicity Release (unless prohibited by law), which must be returned within a time period specified by Sponsor. Return of prize or prize notification as undeliverable, failure to sign and return requested documentation within the specified time period, the inability of Sponsor to contact a potential winner within a reasonable time period or noncompliance with these Official Rules by any potential winner will result in disqualification and, at Sponsor's sole discretion, the prize may be awarded to a runner-up.

LICENSE/USE OF ENTRIES: By submitting an Entry, each entrant agrees that Sponsor and its designees shall have the worldwide perpetual right to exploit, edit, modify, and distribute such Entry, and all elements of such Entry, including entrant's name and likeness, in any and all media now known or not currently known, and for any legal reason, without compensation, permission or notification to entrant.

PRIZES: One (1) First prize of a \$5,000 VISA Gift Card (the "First Prize"), one (1) Second prize of a \$2,500 VISA Gift Card ("Second Prize"), and one (1) Third Prize of a \$1,000 VISA Gift Card ("Third Prize"). First Prize, Second Prize and Third Prize winners shall also receive publication of their respective Entry essays in a future edition of Medical Economics Magazine, MedicalEconomics.com, the Modern Medicine Network, and/or affiliated publications with attribution to winners. Approximate Retail Value ("ARV") of each prize is First Prize, \$5,000; Second Prize, \$2,500; Third Prize, \$1,000. Gift cards are subject to terms and conditions specified thereon. All prize details, including publication decisions, are at Sponsor's sole discretion. Sponsor may substitute a prize of comparable or greater value at Sponsor's sole discretion. Prizes are non-transferable with no substitutions or cash redemptions except at Sponsor's sole discretion. Additional restrictions may apply, subject to gift card terms and conditions available on the back of the gift card and in included literature. Winners are responsible for all applicable federal, state and local taxes, if any. Limit one (1) prize per person. In the event that Sponsor is unable to publish a winning essay, that part of prize will be forfeited and winner will receive a Visa Gift Card only. Sponsor makes no guarantee as to date of publication of each winning Essay.

GENERAL: By participating, each entrant agrees: (a) to abide by these rules and decisions of Sponsor and Judges, which shall be final in all respects relating to this Contest; (b) to release, discharge and hold harmless Sponsor, Supporter, their respective parents, affiliates, subsidiaries, and advertising and promotion agencies, and all of the officers, directors, shareholders, employees, agents and representatives of the foregoing (collectively, "Released Parties") from any and all injuries, liability, losses and damages of any kind to persons, including death, or property resulting, in whole or in part, directly or indirectly, from entrant's participation in the Contest or any Contest-related activity, or the acceptance, possession, use or misuse of the awarded prize or the use by Released Parties of any rights granted herein; and (c) to the use by Sponsor and its designees of his/her name, entry, biographical information, photograph, image and/or likeness for trade, advertising, publicity and promotional purposes in any and all media, now or hereafter known, worldwide and on the Internet, and in perpetuity, without compensation (unless prohibited by law), notification or permission, unless prohibited by law, and to execute specific consent to such use if asked to do so. Released Parties are not responsible for late, lost, damaged, delayed, inaccurate, misdirected, incomplete, illegible, undeliverable, destroyed, mutilated, stolen or postage-due entries, entry fees, or for errors or problems of any kind whether electronic, network, technical, typographical, printing, human or otherwise relating to or in connection with this Contest, including, without limitation, errors which may occur in connection with the administration of the Contest, the processing or judging of entries, or the announcement of the prizes or in any Contest-related materials. Persons who tamper with or abuse any aspect of the Contest, who act in an unsportsmanlike or disruptive manner or who are in violation of these Official Rules, as solely determined by Sponsor, will be disqualified and all associated Entries will be void. Should any portion of the Contest be, in Sponsor's sole opinion, compromised by non-authorized human intervention or other causes which, in the sole opinion of the Sponsor, corrupt or impair the administration, security, fairness or proper play, or submission of Entries, Sponsor reserves the right at its sole discretion to suspend, modify or terminate the Contest and, at its discretion, select the potential winners from all eligible, non-suspect Entries received prior to action taken using the judging procedure outlined above.

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REQUEST FOR WINNERS LIST: For the names of the Winners (available after March 2015), send a self-addressed, stamped, envelope to: Attn: David A. DePinho, Advanstar Communications, 24950 Country Club Blvd., North Olmsted, OH 44070.

Engaging patients to decrease costs and improve outcomes

Why the key to improving the healthcare system is for physicians to engage patients in their own care

by **ALEXANDRA B. KIMBALL, MD, MPH, KRISTEN C. COREY, MD,** and **JOSEPH C. KVEDAR, MD** *Contributing authors*

HIGHLIGHTS

01 Areas of opportunity for patient engagement include: scheduling appointments, managing correspondence, refills and prior authorizations, and facilitating communication with the medical team.

02 Physicians must focus on developing an infrastructure that supports and encourages active patient participation in healthcare management.

Increasingly, healthcare providers face insurmountable opposing pressures: To bring down costs, but accomplish more at every patient visit. »

» **TODAY'S PHYSICIAN** is responsible for a tremendous medical repertoire, evidenced by the increasing number of diagnoses in our codes. About 13,000 diagnostic codes will expand to 68,000 with adoption of the new ICD-10 system, originally set for 2011, but extended to 2015 out of concern for the administrative burden it presents.

Physicians also need to meet or consider 13 meaningful use objectives, 33 pay-for-performance measures, nine quality incentive measures, and 27 medical home elements. These include a daunting number of activities ranging from design of IT interfaces to medical assistant time, nursing interventions and physician effort.

To complicate the issue, these requirements have emerged in the context of a shortage of primary care physicians and certain types of specialists, generating further

discrepancies between supply and demand. The demands cannot be met, even with substantial help from ancillary staff. And even if they could be met, the cost to provide such care would be prohibitive.

So how do we manage the myriad of initiatives, the impending physician workforce shortage while also reducing cost and improving quality? In healthcare, we continue to insist on human resource-intensive solutions. However, the proportion of a provider organization's cost borne by human resources is 56%, and healthcare workers are generally less productive than those in other sectors. A staff-heavy plan of action is doomed to fail.

Other industries, when faced with the quandary of accomplishing more with less, have resorted to customer-empowerment initiatives. As → 37

→ 36 customers, we now do our own banking, pump our own gas, assemble our own furniture, check ourselves in at the airport and out at the grocery store. These examples allow those providing services to use human resources more efficiently, contributing to increased worker productivity.

In most cases, the advent of these strategies was viewed with concern, but now all are almost universally viewed as empowering consumers. Can we follow this model of customer empowerment and create an architecture that allows us to engage patients in their healthcare?

Patient self-management is not a new concept and represents an essential element of the chronic care model (CCM), a theoretical framework developed to guide higher-quality chronic illness management in primary care. Evidence has shown that incorporating CCM principles into practice results in favorable health outcomes.

Patient engagement initiatives have led to reductions in hospital visits, decreased morbidity and mortality, and improvements in treatment adherence and quality of life associated with chronic diseases such as heart failure, ulcerative colitis, and asthma. Although an overarching goal of patient engagement is to decrease cost, we do not have to sacrifice quality care.

Areas of opportunity for patient engagement include scheduling appointments, managing correspondence, refills and prior authorizations, and facilitating communication with the medical team. These tasks require more health literacy and familiarity with technology than we have asked of patients previously. Not all patients will be able or eager to handle this, but many will.

Most patients embrace responsibility for managing their health and view this approach as better quality care. A 2010 survey found that 79% of respondents were more likely to select a provider who allows them to conduct healthcare interactions online, on a mobile device, or at a self-service kiosk. One study found that many would even pay for such online services.

The majority of patients prefer a shared decision-making approach with their healthcare provider, an attitude that will aid a patient engagement initiative. Although barriers will exist for individual patients to adopt this system and its associated tech-

TECHNOLOGY TO HELP PHYSICIANS IMPROVE PATIENT ENGAGEMENT

Online appointments.

Scheduling appointments represents a major effort by medical personnel. It is often undermined by the fact that 20% of patients cancel or do not arrive for visits within the same day. Many patients would prefer the convenience of scheduling their own appointments online, and studies have shown that advanced access and online scheduling reduce wait times and no-show rates.

Pre-visit check in. Several groups are using tablet computers and kiosks to give patients the opportunity to enter pre-visit updates, demographic information, etc., in order to expedite the process of information-gathering. Kiosk technology has even led to improved throughput efficiency in the busy emergency department.

Online visits. Online communication is not a new concept, but its adoption among physician practices remains low. Only 13% of physicians use email to communicate with their patients. As the burden of chronic illness increases, one of the consequences will be the need to use brick and mortar resources more thoughtfully. Visits to physicians for routine interactions or data collection can be moved into an asynchronous, online environment creating opportunities for increased efficiency. Patient portals allow certain functions traditionally

performed by office staff, such as viewing test results and communicating specific questions to a provider, to be performed by patients. The results are time-savings, patient satisfaction, and desirable patient outcomes. For example, patients with gestational diabetes receiving follow-up and monitoring care via a text message-based telemedicine system achieved similar HbA1c levels, blood pressure values, weight gain, and rates of normal vaginal delivery at greater convenience compared to patients attending conventional office visits.

Remote monitoring programs. Increasingly, devices that monitor the physiologic consequences of disease and treatment are able to share their data via wireless connectivity. Capturing this data and moving it to the electronic health record enables patients to realize how lifestyle and treatment choices affect their health, leading to improved compliance and disease management. In one recent study, patients with hypertension were given the opportunity to titrate their own medications based on home blood pressure readings and were able to do so with surprising ease. Patients with diabetes who upload their glucose readings to a centralized repository that allows them to view and contextualize these readings have achieved reliably lower HbA1c readings than their counterparts who do not participate.

nologies, we must focus on developing an infrastructure that supports and encourages active patient participation in their healthcare. ■

Alexandra B. Kimball, MD, MPH, is senior vice president of practice improvement at the Mass General Physicians Organization and a professor at Harvard Medical School. Kristen C. Corey, MD, is an internal medicine physician in Boston, Massachusetts. Joseph C. Kvedar, MD, is director of connected health at Partners HealthCare and a professor at Harvard Medical School. This essay was an honorable mention in the 2014 Medical Economics doctors writing contest.

Money

Creating and maintaining an employee benefits package

In our ongoing series, *Medical Economics* examines employee benefits, and discusses key elements and cost analyses of a benefits package for the practice's physicians and staff

by **ELIZABETH W. WOODCOCK, MBA, FACMPE, CPC** *Contributing author*

HIGHLIGHTS

01 Most items in an employee benefits package are optional. But consider that whatever you might save by eliminating or severely reducing benefits will come back eventually in the form of an expense to your practice if you can't retain employees or morale declines.

The cost of personnel is the highest single expense category in medical practices. And that should be no surprise, because a productive and motivated staff is critical to maintaining your productivity, as well as patient satisfaction—and a healthy bottom line for your practice. ►►

►► **DURING THE PAST** ten years, total support staff costs have fluctuated between 30% and 33% of medical revenue in multispecialty groups, according to the Medical Group Management Association (MGMA). The U.S. Bureau of Labor Statistics reports that wages and salaries totaled approximately 70% of private employers' staffing expenses in 2014 with benefits accounting for the remaining 30%.

The cost of your support staff includes salaries, and one option for retaining high-performing employees is simply to pay higher wages.

That's a costly proposition, however. Not

only does it mean shelling out more money, but it could also put "golden handcuffs" on employees who may become unmotivated and unproductive—and unwilling ever to leave your employ.

Paying a competitive wage is vital, but don't overlook the benefits package you offer to your employees. You may find ways to save money, not by cutting benefits, but by more appropriately targeting benefits to the needs of your staff.

Although it may be tempting to reduce staffing costs by cutting a staff position or two, research by the MGMA reveals the value of adequate staffing. The ratio of staff to

full-time-equivalent (FTE) physician tends to be higher in practices that performed better than comparable practices in profitability and cost management, according to the MGMA. The lesson? These practices make better use of their employees than other practices, significantly raising the level of the practice's productivity and bringing a positive return on their investment.

ARE BENEFITS OPTIONAL?

Most items in an employee benefits package are optional. But consider that whatever you might save by eliminating or severely reducing benefits will come back eventually in the form of an expense to your practice if you can't retain employees or morale declines, or you can't effectively compete for the best candidates when new openings occur.

Once your benefit plan is in place, consider framing it for employees. Brochures and forms are nice, but take the time to document all of your benefits on one page and put a dollar value to them. Divide the value by 2,080—the standard hours worked per year by a full-time hourly employee, and you'll have the per-hour rate of your benefits.

Present a benefits statement that delineates the benefits and the associated costs to potential candidates alongside the hourly rate you're offering. They'll see the proposed hourly wage (\$16.75, for example) but also the value of the benefits (let's say \$5.12.) Potential and existing employees will be pleasantly surprised by the investment you are making in them. An accounting of benefits can be very influential in attracting and retaining employees.

A comprehensive benefits plan is critical to attracting and keeping highly-qualified employees. Even in the largest urban markets, the healthcare community is like a small town. Word will get around quickly if you have built a reputation as a progressive organization. And you will need the flexibility that qualified and motivated employees provide in order to meet the many challenges of today's medical practices. The benefits package, in addition to salary, is a key tool to help retain those valued workers.

Take the time to review your benefits package to ensure that it complements, rather than sabotages, your staffing strategy. Below are a number of key benefit options to provide your employees.

1/ Vacations

Typically, paid vacation time increases with seniority. A common arrangement is to offer employees two weeks (10 days) of vacation during their first through fifth years of service, then bumping it up another week to 15 days after five years on the job. Start with five, and try gradually increasing the time-off-with-pay annually by offering, for example, an additional day of vacation each year.

The employee still reaches 15 days of paid time off in year five, but you avoid taking a sudden hit from that large jump in paid leave.

2/ Sick leave

Most practices provide sick leave because you don't want ailing workers to come in contact with patients and other employees, and you, with their illness.

Furthermore, there is a cost associated with "presenteeism"—the lost productivity that occurs when staff present for work, but execute their job duties below expectations because they are sick. Provide leave, while encouraging employees to avoid using sick leave inappropriately by allowing them to carry over unused leave days, or a portion of them, to the following year.

Other options would be to extend the opportunity to convert unused sick leave days into vacation time at a 50% ratio; that is, one day of unused sick leave becomes a half-day of vacation. Some practices offer a day or two of personal leave as well per year—just to enable employees to take a break.

3/ Attendance bonuses

In addition to purchasing unused sick leave, another route to discouraging inappropriate sick leave is to offer attendance bonuses.

Instead of cash, try offering an extra one or two days of leave to those with perfect attendance (no sick days taken) during the year. To reduce disruptions, require that attendance bonuses be used on slow days, such as Friday afternoons.

4/ Paid time off

Rather than hashing out what category of leave is appropriate, consider converting your program to paid time off (PTO), a step that a majority of companies now have taken, according to industry research.

Relatively simple to administer, PTO programs offer flexibility and privacy, allowing employees to

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→ 39 make their own choices about absences. Pay-outs for unused days work the same way as sick and vacation leave; you have to establish your policy and manage it appropriately.

Of course, regardless of your choice of leave packages, be sure that your practice has policies in place for handling family medical leave, jury duty, military leave, and any other types of leave that your state may require.

Finally, most practices provide paid holidays for New Year's, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas day.

5/ Health insurance

Health benefits are the crown jewel in the employee compensation package, particularly as you recognize its importance on a personal, daily basis.

Starting in 2015, the Patient Protection and Affordable Care Act and related legislation requires employers with 50 or more full-time employees (or a combination of full- and part-time employees equivalent to 50 full-time employees) to offer adequate health coverage or face an assessment for any employees who receive premium tax credits to buy their own insurance. Offering health

4 tips to hire the right employees for your practice

By **Judy Bee**

You can't run a successful practice without a trained and intelligent staff. But finding the right people is an ongoing challenge for most practices. Here is a process to follow to help you find top-notch candidates:

1

Start with a wish list

Build a wish list of the qualities that the perfect candidate would have. If you have a job description, start there. Without this 'shopping list' you might not recognize the best candidate. Ask yourself: Is this a job a good worker will want? Every job in a medical practice needs to include a reasonable mix of work.

2

Decide on a skill set

Decide what skills you are unable to teach a candidate. Those traits will require specific experience, and the good candidates will have it. Specific skills needed for your practice (scheduling, electronic health record entry, etc.) will be your responsibility to teach.

In general, look for some successful experience in customer service-related jobs, experience with a variety of software applications (medical and commercial), and the ability to communicate clearly.

For clinical positions, a certificate or training program is helpful. A full coding credential is probably overkill for a small single-specialty practice, but experience with coding and being able to read and understand the CPT and ICD books are important.

3

Cast a wide net

Let everyone know that you are looking, especially your own staff. List the job on Craig's List, and any other local digital job board. (Skip Monster.com. In our experience you spend hours kissing frogs on that site.) Make your job sound interesting and different from other positions. Newspaper ads are so expensive that the shorter, more affordable ones are ineffective.

Use your local chapter of the Medical Group Management Association and your county medical society. Often they have job boards that you can use to post opportunities to broadcast to their membership. Contact trade schools and community colleges with medical assistant programs. Ask for a candidate with experience if you don't have a good trainer in-house. While you are at it, volunteer to participate in an extern program. It is usually free and you might find someone you really like on this trial basis.

4

Phone screen first

Talk to the best candidates quickly and on the phone. When you get resumes, sort them by quality. Listen for communication skills and talents while discussing the job history. That is the most valid predictor of future behavior.

If the phone interview goes well, bring the candidate to the office. Set up role-play challenge scenarios, including collection calls, appointment scheduling and reception tasks. You are looking for grace and thinking under pressure.

Always check references and be sure to check them all. Make sure you have at least a confirmed history, if not the performance details. Perform a background check.

Don't be discouraged if a candidate doesn't work out. Just keep plugging away.

insurance to your employees also can provide you with an income tax deduction that effectively reduces your out-of-pocket cost for those benefits. If you employ fewer than 25 employees, your practice may be eligible for a tax credit in return for purchasing health insurance for employees.

Consider providing dental or vision plans as well, if funds allow. Hold down your expenses by providing the insurance but not financing the entire benefit. According to a survey of California companies by human resources consulting firm William M. Mercer, 91% of employers require employee contributions toward health insurance, while 92% require employees to contribute toward the cost of insuring dependents.

6/ Education and training

Your practice will benefit from extending training incentives to employees in good standing.

Higher education costs can be considerable, but you can keep a lid on this type of benefit by limiting its use to practice-specific training, such as coding recognition for business office staff, phlebotomy certification for medical assistants, technology training for administrative staff, continuing medical education for nurses, and so on. Typical packages include reimbursement for tuition and books.

If training opportunities come up, consider paying for the employee's travel and meals as well. In addition to professional organizations, there may be opportunities through state and county medical societies, or evening or online courses at a community college.

Make sure to budget for these costs and limit both overall spending and per-employee, so that one or two employees seeking specialized skills don't gobble up the entire allocation for training. Add a written clause for any assistance towards a certification or degree, so that the employee is required to reimburse you if, for example, he or she leaves within two years of the training's conclusion.

7/ Hours

Although you may not think of this a benefit, employees definitely believe the extent of their work week is a value-add.

Particularly if you are paying overtime, try migrating an employee (or two) to a four

10-hour day, or nine hours per day, followed by a workday with a half-day off. (If you are paying overtime, this may actually save you a great deal of money.)

These aren't your only choices. Be creative! If you stick with the traditional 8 to 5 workday, consider paying bonuses in the form of "hour-off" rewards, noting that it must be approved in advance.

Or, to save money, but keep your existing staff, migrate everyone to a 35 or 37-hour work week. Of course, set expectations that they'll get more time off, but their paychecks will be slightly reduced too.

8/ Additional benefits

In addition to the above mentioned benefits, practices can consider:

Retirement plan and insurance

Assist employees in saving for their future, as well as providing aid in the forms of life insurance and disability insurance. Alternatively, offer a cafeteria plan, allowing employees to choose what they value most.

Uniforms or uniform allowances

Providing uniforms to employees may be a welcome benefit because it will save them the cost of wear and tear on their own wardrobe, and you benefit because it eliminates at least a portion of potential dress code violations.

Health club memberships

Encourage your staff to be healthy; consider a walking club at lunch with small rewards or a "biggest loser" contest. Invite a nutritionist to host a cooking demonstration for your staff—with the resulting lunch or dinner on the house.

Special events

Try holding private luncheons off-site now and then for special occasions such as birthdays, employee anniversary dates, or other observances, such as Valentine's Day. Or support a charity and participate in an event as a team.

Make it fun

Perhaps the greatest benefit of all is coming to a happy workplace; thank your staff every chance you get, and make your practice a positive work environment. ■

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Coding Insights

CODING QUESTIONS ANSWERED: MIDDLELEVEL BILLING, WAIVING COPAYS AND MORE



Can a credentialed physician assistant or nurse practitioner see, and bill for, new patients without the physician being on site?

A: FIRST, always check and verify the licensing restrictions and scope-of-practice rules in your state. These rules can vary from state to state.

Keep in mind that billing incident-to isn't required by any payer, and is only recognized by Medicare and Aetna. If the NPP wishes to bill incident-to, the physician first must have seen the patient and established the plan of care for the problem being addressed by the NPP. We advise that the physician see the patient for the initial visit and establish the plan of care so that subsequent visits for that problem to be billed incident-to.

However, again, payers do not require incident-to billing, and the NPP has the option to treat a new patient.

If the NPP bills the payer directly, the claim should reflect the NPP as the "Servicing" and "Billing" provider.

Q: IS IT EVER APPROPRIATE TO WAIVE A PATIENT'S COPAYMENT OR DEDUCTIBLE?

A: PROVIDERS should not reduce the cost of care to a patient by waiving or forgiving a copayment, cost-share or deductible. To do so is a violation of the Anti-Kickback Statute and is considered fraud and abuse, which can result in fines and other legal action.

The Anti-Kickback Statute provides criminal penalties for individuals or

entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward the referral of business reimbursable under Federal health care programs as defined in section 1128B(f) of the statute.

The offense is classified as a felony and is punishable by fines of up to \$25,000 and imprisonment for up to five years. Violations may also result in program exclusions under section 1128(b)(7) of the Act (42 U.S.C. 1320a-7(b)(7)), and liability under the False Claims Act (31 U.S.C. 3729-33).

Q: DOES MEDICARE PAY FOR ULTRASOUND

SCREENING FOR ABDOMINAL AORTIC ANEURYSMS (AAA) OR SCREENING FECAL-OCCULT BLOOD TESTS (FOBT)?

A: A MLN MATTERS publication from the U.S. Centers for Medicare and Medicaid Services (CMS) dated October 17, 2014, made a retroactive effective date of January 27, 2014, for the updated requirements of ultrasound screening for AAA and screening FOBTs. The modifications of these requirements are detailed below.

Ultrasound for AAA

Coverage of AAA screening is modified by eliminating the one-year time limit with respect to the referral for this service.

This modification allows coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the Initial Preventive Physical

Examination (IPPE, also known as the “Welcome to Medicare Preventive Visit”). The beneficiary only needs to obtain a referral from his or her physician, physician assistant, nurse practitioner, or clinical nurse specialist. All other coverage requirements for this service remain unchanged, per 42 CFR 410.19.

Medicare beneficiaries must be at risk to be eligible for an abdominal aortic aneurysm screening. They are considered at risk if they meet one of these criteria:

- A family history of abdominal aortic aneurysms.
- A male age 65 to 75 who has smoked at least 100 cigarettes in his lifetime.

Screening FOBT

In addition to the beneficiary's attending physician, the beneficiary's attending physician assistant, nurse practitioner, or clinical nurse specialist may furnish written orders for screening FOBTs, per section 42 CFR 410.37(b). All other coverage requirements for this service remain unchanged, per 42 CFR 410.37.

Screening FOBT may be paid for beneficiaries who have attained age 50, and at a frequency of once every 12 months (i.e., at least 11 months

IF YOU STILL NEED TO ORDER YOUR ICD-10 BOOK, OR IF YOU'VE ALREADY ORDERED AND RECEIVED IT, YOU MAY NOT HAVE THE MOST CURRENT VERSION.

have passed following the month in which the last covered screening FOBT was performed).

Q: IS IT TOO LATE TO ORDER OUR 2015 ICD-10 CODEBOOK?

A: WITH THE ICD-10 (The International Classification of Diseases—10th revision) conversion scheduled for October 1, 2015, you still have time to order your ICD-10-CM book and schedule training for your practitioners and staff.

Please note: If you still need to order your ICD-10-CM book, or if you've already ordered and received it, you may not have the most current version with updates that were made to the official coding guidelines. The latest version was released only a few weeks ago, but not until after the 2015

books were published.

Whether you've received your codebook or have yet to order it, you can update it by going online to ICD-10 Guidelines Update and downloading a copy of the most recent official coding guidelines.

Changes to the guidelines are in bold, underlined items are those that have been moved, and revisions to headings are in italics. The latest version further explains initial vs. subsequent visit when it comes to coding fractures and information in Chapter 20 for external cause injury and much more.

Don't forget to print the update guidelines and keep it with your 2015 book. ■



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<http://bit.ly/1B867nl>

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Incident-to billing: Physician coding questions answered
<http://bit.ly/1qv0Q8a>



Answers to readers' questions were provided by **Renee Dowling**, a billing and coding consultant with VEI Consulting in Indianapolis, Indiana. Send your billing and coding questions to medec@advanstar.com.

Operations

Building a medical group in 12 steps

Joining with other physicians can improve your business efficiency, but requires hard work and tough decisions to create an organization that can benefit the bottom line of its members

by **DEBORAH WALKER KEEGAN, PHD, FACMPE** and **MARSHALL M. BAKER, MS, FACMPE** *Contributing authors*

HIGHLIGHTS

01 To facilitate decisions and assure ongoing day-to-day oversight, form an executive committee comprised of the organization's officers.

02 When considering practice site consolidation, determine if the site will give the practices an appropriate geographic reach, while achieving economies of scale.

Many physician practices are joining forces to better compete in today's healthcare market. But often these loose coalitions don't go far enough to gain the efficiency physicians seek. That requires the more challenging step of becoming an official medical group. ▶▶

▶▶ **A PHYSICIAN PRACTICE** often will identify itself as a medical group, yet may only vaguely resemble a true group practice. In the past few years, solo and small physician practices have come together to form common legal entities that often are no more

than a contracting confederation.

These "group-ups" involve physicians joining together to gain payer leverage in fee negotiations, along with cost savings for information technology, supply purchases, equipment main- ➔ 48

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→ 46 tenance agreements, professional liability insurance, and employee fringe benefits. The group-up also may benefit by centralizing business office functions, such as management of the accounts receivables.

Today, these loose collections of individual practices are increasingly finding themselves in difficult positions in the new world of healthcare reform. In this article we discuss the benefits and limitations of group-ups and the steps that can be taken to transition from a group-up to a true medical group practice.

The most notable failings of the medical group-up is in governance, and sometimes, management, and many fail to generate substantial savings for a variety of reasons. Many group-ups allow the physicians to remain in their small practice sites, duplicating administrative and clinical support staff that would have been consolidated in a true group practice. Contributing factors allowing physicians to remain in their historic small-practice environments are the terms of current lease agreements and/or ownership of the practice facilities by the physicians.

If you recognize some of these characteristics in your own practice and group, there are steps to take to transition from a loose group-up into a true group practice, with all the benefits that go along with it.

Revise the governing body structure and composition

Many group-ups form a governing body with equal representation from each practice site. As the group grows in size, however, usually it is not possible to sustain this governance model.

Instead, transition to a structure appropriate for your legal form, with a board of directors for a corporation or a board of managers for a limited liability company. The shareholders/members that are elected to the board should have staggered terms to assure ongoing continuation of the medical group practice's governance.

We suggest two- or three-year terms for each director/manager. The board should be comprised of no more than seven physician-owners.

To facilitate decisions and daily oversight, form an executive committee comprised of the organization's officers.

Revise the chair/president term and conditions

Require the chair/president term to be a two- or three-year paid position. Base the election of the chair/president on leadership and administrative capability, with successive terms permitted, rather than rotating or assigning this role. Encourage physicians interested in being chair/president to take courses or attend meetings to gain business and leadership skills.

Institute formal physician compensation plan and assessment

Implement a formal physician compensation methodology and couple this with a physician assessment process to include an evaluation of each physician's:

- clinical performance,
- contribution to group mission and values,
- commitment to quality,
- resource utilization and cost management,
- group citizenship,
- professional and personal behavior,
- work ethic, and
- community/hospital involvement.

By focusing physician attention on these specific areas, discussions can take place on methods to enhance and develop a more unified group culture.

Clarify decision-making powers

Reach consensus of the shareholders/members on a decision matrix that identifies who has authority for any particular decision within the medical group.

It is important to create an appropriate decision-making process without the need for a meeting of the owners for particular (authorized) decisions. The group needs to demonstrate the ability to meet the needs of patients, payers, community, and other key constituents, requiring it to move quickly and act with one voice.

Formalize the use of data and analysis

Data should drive decision-making, thereby reducing the reliance on emotion and persuasion to guide decisions.

For example, new projects, new equipment, new staffing models, and/or new provider recruitment should be supported by data and return-on-investment analyses. After new projects or → 51



→ 48 programs are implemented or new providers are recruited, data should again be analyzed to determine if the expectations for financials, market share growth, etc., have been met or if a decision needs to be modified.

Develop a strategic plan

Obtain agreement on a two- to three-year strategic plan. The plan should define the image the group wants to project to the community,

as well as the key initiatives and timeline the group is committed to achieving. This is invaluable in today's environment, given the increasing concentration of providers into narrow networks. The group needs to be viewed as a strong, viable practice to ensure that it remains in the "tier 1" networks of its key payers.

Evaluate practice site consolidation

Determine if site consolidation will give the practice an appropriate geographic reach,

CHALLENGES

- **Identity.** The group has an identity problem since there is a lack of strategic plan and direction. As a consequence, the group is also late to innovate.
- **Branding.** The group may miss the opportunities for shared practice promotion strategies.
- **Communication.** Informal communication takes precedence over more formal methods, creating a culture of informality and contentious debate.
- **Physician Preferences.** Physicians seek to run their practice in their own style, with impacts on physical, fiscal, and human resources.
- **Climate.** There is a strong climate of internal competition, with accompanying trust deficits.
- **Patient access.** Patient access is highly variable among physicians, each with their own scheduling templates, scheduling methods, and time availability to see patients.
- **Decision-making.** Decisions are made based on the immediate, bottom line impact to a physician or his/her practice site; or a physician voting block develops, rather than assuming a long-term view of what is best for the group as a whole.
- **Execution.** There is an inability to execute or implement decisions in a timely fashion.
- **Deal-making.** Some physicians work their own deals with local hospitals or other organizations for personal benefit, without regard to the impact on the group.
- **Cost of practice.** Overhead costs are higher than other practices, due to the independence of each practice site and its own staffing model and expenditure decisions. Physician-specific processes prevail leading to high cost and redundancies.

STRENGTHS

- **Size.** Expanded group size, thereby gaining significant market exposure.
- **Contracting.** Payer contract negotiation clout.
- **Autonomy.** Physician autonomy in clinical practice and decision-making.
- **Governance.** Physician governance, often with equal representation on the governing body.
- **Ownership.** Physician ownership and continuation of private practice.
- **Shared Costs.** Shared cost of practice (overhead) expenditures, such as accounts receivable management, legal/accounting, group purchasing, information technology, and management services—operational, financial, human resources, and facility.
- **Shared Facilities.** Consolidated practice site cost vs. numerous small office rents.
- **On-call.** Shared on-call coverage leading to improved work/life balance.



while achieving economies of scale.

If the brick and mortar of the practice sites are owned by individual physicians or practices, evaluate market conditions and determine if the existing facilities can be sold or sub-let so that the group can consolidate in more efficient and cost-effective practice space.

Standardize patient access

Payers, employers, and patients are equating “quality” with “access,” so a group-up will need to adopt open, rather than restricted access. In many such practice arrangements, each physician retains his/her own scheduling templates and scheduling rules and methods.

Consider the following methods to standardize patient access for the group:

- standardize templates and employ unassigned templates with guidelines, thereby permitting schedulers to take two or three slots for a new patient or a complicated patient rather than set specific rules for appointment times for specific patient appointment types;
- adopt sophisticated scheduling methods, such as modified wave scheduling;
- agree on wait time to appointment time – and if the physician cannot accommodate the patient, always offer the patient an appointment with a colleague in the same practice site or within the group; and
- agree on wait times in the reception area, minimizing the amount of time from patient arrival at the practice until the patient is seen by the physician—ensuring high patient satisfaction and experience scores

Administrative infrastructure

The administrative infrastructure of a group-up often has a physician serving as both the president and chief executive officer (CEO). This is a difficult model to sustain if the physician continues to maintain an active clinical practice.

In more mature medical groups, there will be a separate administrative arm of the organization consisting of a CEO and, depending on size, a chief operating officer and chief financial officer, each with well-defined roles and performance expectations.

Practice managers

In a group-up, each the practice site typically will retain its own office manager or practice manager. This is a high-cost staffing model,

given the size of many of the practice sites.

Instead, as a group matures, regional practice managers overseeing working leads in the practice sites is a model that is cost effective and facilitates the standardization of policies, procedures, forms, and processes, as well as knowledge transfer from each site regarding performance best practices.

Clinical support staff

The clinical staff of a group-up typically involves a one-to-one assignment between the physician and a nurse or medical assistant. The physician's clinical staff member usually performs all of the work associated with that physician's clinical practice, including visit preparation, patient flow, visit support, visit discharge, follow-up, inbound telephone management, and secure messaging.

In true medical groups, this model typically changes to recognize nurses or medical assistants who support patient flow for the face-to-face visit and separate staffing unit to manage inbound clinical calls and secure messaging, in a shared staffing model. This clinical support team model has been very successful not only as a “patient satisfier,” but because it allows the physician to stay on time throughout the day, with a member of the team available to support the physician rather than the physician having to wait for the nurse.

Transition timeline

The transition from a group-up to a true group practice will not occur overnight. In our experience, it may take three to five years after the consolidation or formation of a group-up before it attains corporate culture.

Significant work needs to be done, including developing a single compensation plan, transitioning to an elected governing body, consolidating practice sites, creating common forms, policies and procedures.

Although the transition from a group-up to a true medical group is difficult, it will likely be necessary to achieve competitive advantage in the new world of value-based care. ■

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Legally Speaking

HIPAA LIABILITY PROTECTIONS: BUSINESS ASSOCIATE AGREEMENTS

by **ZACHARY B. COHEN, JD** *Contributing author*

The Health Insurance Portability and Accountability Act (HIPAA) requires providers to protect patient information. However, many physicians do not know HIPAA's specific requirements for business associate agreements (BAAs) when dealing with certain vendors or external agents who may handle patient information.

THE FIRST STEP for a physician, known under the language of HIPAA as a "covered entity," is to determine the need for a BAA with a vendor. A vendor is considered a "business associate" under HIPAA if the vendor creates, receives, maintains, or transmits patient health information (PHI) on the provider's behalf.

Common services performed by a business associate (BA) include claims processing, data analysis, quality assurance, billing and collection, practice management, legal, accounting, and consulting.

Entities that only serve as conduits, such as the post office or Internet service providers, are not considered BAs even

though they handle patient information.

What BAs must include

If a business associate is providing services to a covered entity, the parties must enter into a written BAA that:

- establishes the permitted uses/disclosures of PHI,
- stipulates that the BA must use appropriate safeguards to prevent unauthorized PHI uses and disclosures,
- spells out that the BA reports to the covered entity any unauthorized uses and disclosures,
- extends the terms of the BAA to its subcontracts, and

- establishes that upon termination of the BAA, the vendor must either return or destroy all PHI.

The consequences of not having a written BAA can be severe. The Office of Civil Rights (OCR) could request a copy of a covered entity's BAA if there is a complaint registered over a covered entity or if a breach occurs.

Violations under HIPAA can be penalized at anywhere between \$100 to \$50,000 per violation, up to a calendar year maximum penalty of \$1,500,000 for a single violation. The OCR could take the position that every day that the BA and covered entity did not have a business associate agreement is a violation, and multiply the fine by

the number of days no BAA penalty was in place, so the penalties can be steep.

Liability of agents

Under HIPAA, a covered entity is liable for the acts of its agents, which can include a BA.

Whether an agency relationship exists is determined case by case, with the essential factor being whether the provider has the right or authority to control the BA's conduct. The authority of a provider to give instructions or directions is the control that can result in an agency relationship.

The language in the BAA will be considered in determining whether an agency relationship is present. If a covered entity is controlling the performance of its BA, the covered entity should closely monitor the BA's performance since the covered entity will be held accountable for its performance. ■

Zachary B. Cohen, JD, is an associate at Garfunkel Wild, P.C., in Great Neck, New York. Send your medical legal questions to medec@advanstar.com.



How motivational interviewing can help reach noncompliant patients

Connecting with patients may require a shift in how physicians discuss health issues and negative behaviors

by **DEBRA BEAULIEU-VOLK** *Contributing author*

HIGHLIGHTS

01 When working with patients on setting their personal goals, it may require a bit more discussion time at the start, but the investment pays through improved outcomes in the long run.

02 The best way for clinicians to learn their way around the stumbling blocks of addressing bad health habits with patients is through practice.

For as long as primary care has existed, there have been patients who did not, would not, or (so they thought) could not follow doctors' advice. Despite hearing physicians' warnings or even experiencing health consequences, these patients might continue to smoke, eat a poor diet, avoid exercise, skip medications, or otherwise sabotage their own well-being.

But innovative physicians have been honing techniques to reach these most difficult patients.

A catch-all term used to describe patients who don't follow the recommendations of a physicians is nonadherent. Historically, physicians might lecture such patients repeatedly, but at some point concede that it's not always possible to make another individual change. But in the era of health reform—in which physicians are increasingly held accountable for measures linked to patient behavior—giving up is not an option.

Enter motivational interviewing. It's a concept that predates the Affordable Care Act and even the patient-

centered medical home (PCMH), but this collaborative communication style offers results that help satisfy both, according to Barbara Clure, MD, a family physician at Interfaith Community Health Center in Bellingham, Washington.

Since adopting the technique about 10 years ago, Clure says she has seen countless patients transform their lives and health in ways she didn't previously think possible.

BEFORE AND AFTER

"I used to be the kind of doctor who would tell people, 'Hey, you need to quit smoking...blah, blah, blah.' But they didn't like to get lectured or hear that, and it wasn't very fun for me either. It doesn't generally create any space for change," Clure says.

But after participating in a research study that included hands-on training in motivational interviewing, Clure began a new path toward empowering patients to set goals they'd actually attain. To illustrate how it works, Clure uses the example of working with a patient struggling with multiple health problems, including diabetes, high blood pressure, and severe arthritis requiring opiate → 56

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Motivational interviewing: an example

Imagine you are about to sit down with a patient who smokes and suffers from chronic conditions such as hypertension or diabetes. How would you approach the conversation?

1 Express empathy

“So what I hear you saying is that you are tired of being lectured about smoking. Tell me more about why you feel this way.”

2 Develop discrepancy

“What are your goals for the future? How do you see smoking fitting in with your aspirations?”

3 Avoid arguments

“The single best thing you can do for your health is to quit smoking, and I’m here to help you when you’re ready.”

4 Roll along when resistance comes

“It sounds like you have thought of a lot of possible stumbling blocks to cutting back your smoking. What could be some of the possible solutions?”

5 Support self-reliance

“I’m really impressed that you are thinking about cutting back on smoking. I want you to know that I believe you can do it. Let’s plan to meet in a month to see how things are going.”

Source: Miller WR, Rollnick S. “Motivational Interviewing: Preparing People to Change Addictive Behavior.”

→ 54 pain medication. He had also undergone heart-valve surgery and remained morbidly obese.

But rather than simply instructing the patient to lose weight, Clure began the conversation in a more open-ended way. It went along the lines of: “You know, your BMI [body mass index] is at a level that’s really dangerous for your health. How do you feel about that?” Clure says.

His response was something like the following: “I know. I’ve been trying to lose weight forever, but I stay a couch potato because my knees hurt, I have a bad heart valve, and I’m afraid to do anything.”

Next, Clure asked her patient if there was any level of activity he’d be comfortable trying on a regular basis, and they agreed he’d take the short walk to get his mail daily, and check back with her in a few weeks. At his follow-up appointment, they set a new goal that he would walk one block a day.

“We kind of did that dance for a year. And after a year, he was able to walk four miles per day—which was huge for him—and lose 60 pounds,” Clure says.

Meanwhile, Clure’s patient also was able to get off his diabetes medications and reduce his pain medications significantly. As the results continued to snowball, he improved his eating habits and ultimately turned his whole life around, Clure says. “He just gained tremendous confidence in realizing he could do this,” she says.

According to Clure, this is just one success story of many that have made her a believer in motivational interviewing. But despite the mounting evidence confirming that the technique works, physicians face barriers of their own in incorporating motivational interviewing into their daily practice.

THE TIME CONUNDRUM

A reality of medical practice today, of



IF WE CAN MOTIVATE PATIENTS TO DO THEIR OWN PROBLEM-SOLVING TO FIGURE OUT WHAT'S GOING TO WORK BEST FOR THEM, THEY ARE BETTER ABLE TO ACHIEVE THEIR EATING AND EXERCISE GOALS IN THE CONTEXT OF WHERE THEY LIVE AND WORK."

— BARBARA CLURE, MD, FAMILY PHYSICIAN, INTERFAITH COMMUNITY HEALTH CENTER, BELLINGHAM, WASHINGTON

course, is that physicians' face-to-face time with patients is limited, notes Craig M. Wax, DO, a family physician in New Jersey and member of the *Medical Economics* advisory board.

As a result, physicians may assume they don't have time to really engage their patients through motivational interviewing. "I think the biggest misconception is that you can't make a positive impact on a patient in a relatively short time," Wax says.

One of the ways Wax seeks to help his patients, he says, is by being a good role model: exercising vigorously every day, following a plant-based diet, and not smoking or drinking.

"So when I encourage someone to lose weight, I can tell them that I was a fat kid," he says. "Or if somebody comes to me in pain, I can say, 'Well, I've fractured my spine in the past and have pain every day. But I manage it with exercise, healthy lifestyle, and a positive outlook, and I am here to help you.'"

When it comes to working with patients on setting their personal goals, it may take a bit more discussion time at the start, Clure says, but the investment pays off through improved outcomes in the long run. "When you really try to engage people, they come up with really creative solutions," she says. "And they are a lot more effective because they know what works for them and what doesn't, and they know what they'd be interested in trying or not. It's more efficient to ask people what's going to work for them rather than put your own spin on what you think will work for them."

HOW TO HANDLE MISMATCHED PRIORITIES

But before many patients will be open to

change, physicians must first address their top priorities, even if they're not the most important issues medically, says Wax.

"The first thing is you have to listen to the patient," he says. "You have to understand what the patient's goals are, what your goals are as a physician, and try to get something for everybody."

Wax cites a recent visit with a patient who had hypertension, high cholesterol, and smoked two packs a day, but arrived at the office because he had an ingrown toenail. "Of course I wanted to address his hypertension, hyperlipidemia, smoking habits, and lack of preventive care over the last five years; but he just wanted to deal with his toenail," Wax says. "And if I didn't deal with his toenail first, none of the other stuff would be on the table."

PRACTICE MAKES PERFECT

The best way for clinicians to learn their way around these stumbling blocks, according to Wax, is through practice.

"You can consult with other speakers on positive thinking and interviewing techniques, but no one holds all the truth. Practicing with patients and their families and learning what works with each individual patient is ultimately the answer," he says.

For Clure, attending training sessions that included role playing made all the difference. While reading about the techniques and watching presentations about them gave her a good start, she explains, it was trying it out with educators that really led her to understand the concepts and use them well.

"Now these skills are pretty much just part of my practice," Clure says. "I don't really think about it any more." ■

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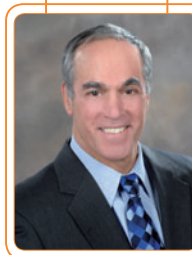
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The Last Word

MEDICAID PROVIDER FIGURES DON'T REFLECT REALITY OF PATIENT CARE

by **JEFFREY BENDIX, MA** Senior Editor

More than half of the physicians across the country who supposedly treat Medicaid patients don't actually do so, a new government report finds. Approximately 49 million Americans obtain healthcare services under the Medicaid program, and most of those services are provided through Medicaid managed care organizations (MCOs).

BUT ACCORDING to a report prepared by the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, 43% of providers listed by MCOs as accepting Medicaid patients either were not practicing at the location where they were listed or were not participating in the MCO, and another 8% were not accepting new patients enrolled in the plan.

"When providers listed as participating in a plan cannot offer appointments, it may create a significant obstacle for an enrollee seeking care," the report notes. "Moreover, it suggests that the actual size of provider networks may be considerably smaller than what is presented by Medicaid managed care plans. It

also raises questions about whether these plans are complying with their states' standards for access to care."

Under the Affordable Care Act, states have the option of expanding Medicaid eligibility to include families earning

up to 138% of the federal poverty level, with the additional costs covered entirely by the federal government for the first four years and at 90% thereafter.

To-date 27 states and the District of Columbia have expanded Medicaid

eligibility, and the Congressional Budget Office estimates that the number of people covered by Medicaid will increase to 87 million by 2018. The OIG report thus may raise doubts as to Medicaid's ability to deliver healthcare services to new enrollees in a meaningful way.

Other findings from the report:

- among the 49% of providers who did offer appointments, the median wait time was two weeks, but more than 25% had wait times of more than one month,
- specialists were more likely to provide appointments than primary care providers (57% versus 44%),
- the median wait time for a specialist appointment was 20 days, versus 10 days for a primary care provider.

Results of the study were based on telephone calls to a random sample of primary care providers and specialists from July through October, 2013. ■

The report recommends that the Centers for Medicare and Medicaid Services work with states to:

1/ assess the number of network providers and improve the accuracy of plan information,

2/ ensure that MCO networks meet the needs of their enrollees, and

3/ ensure that plans are complying with existing state standards and assess whether additional standards are needed.