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SEPTEMBER 25, 2014
VOL. 91 NO. 18




# ICD-10

## Now is the time to prepare

### 9 keys to ensure your practice is ready

PAGE 14


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## IN DEPTH

### Operations



### Money



### Trends



### Policy



# ICD-10
## NOW IS THE TIME TO PREPARE


STARTS ON PAGE 14

COVER STORY | OPERATIONS

9 keys to ensure your practice is ready.

STARTS ON PAGE 14

+

- The costs of ICD-10
- A checklist of what you need to do to prepare
- Tips on training and testing

## COLUMNS

PAGE 26
LEGALLY SPEAKING

**Tracy D. Hubbell, JD**
*Translating for patients*

PAGE 34
FINANCIAL STRATEGIES

**Drew Haynes**
*Buying or leasing medical equipment*



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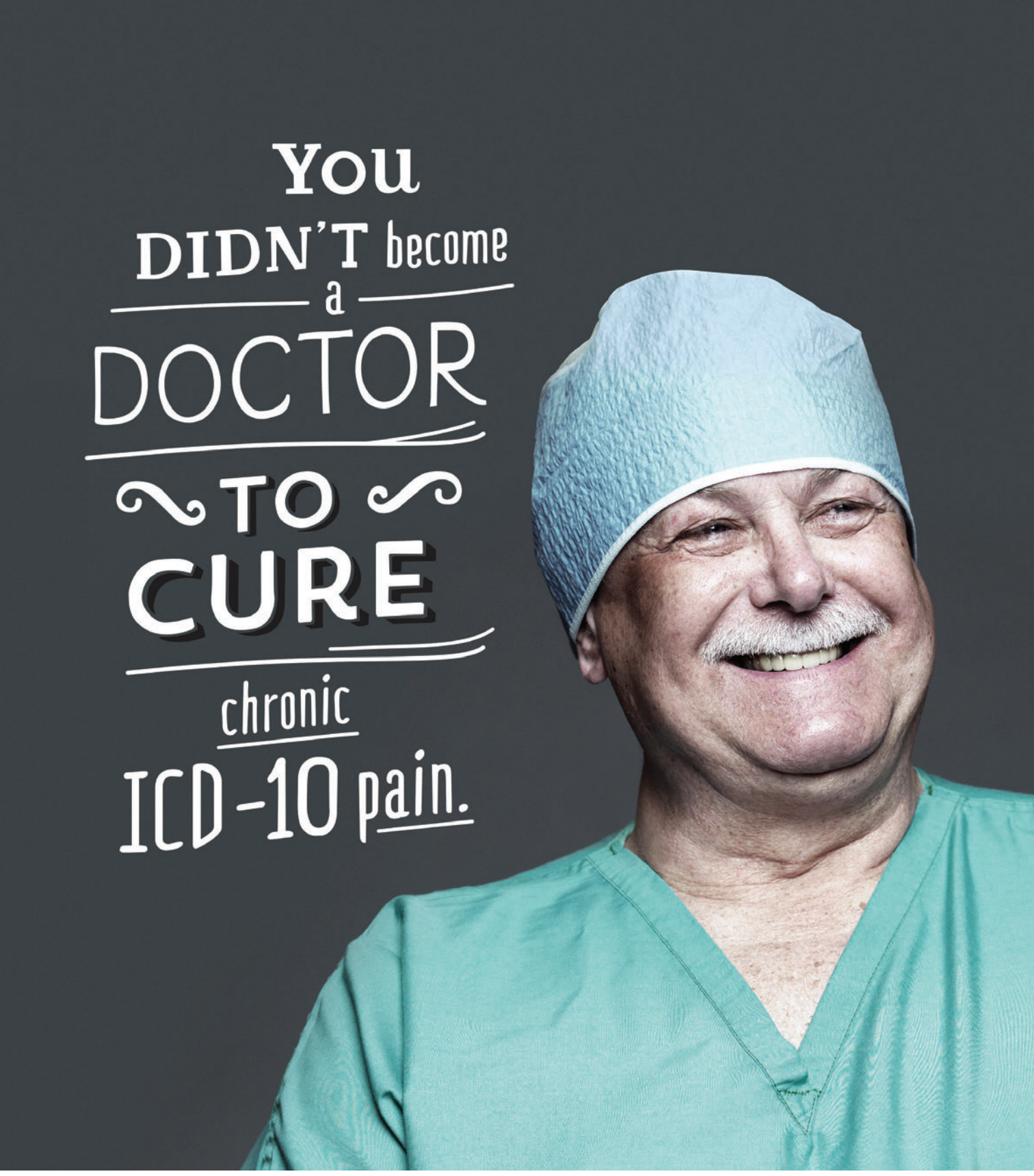


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# CONCERNS MOUNT OVER E-CIGARETTE USE

While a recent study has found that electronic cigarettes (e-cigarettes) pose less of a health risk than conventional cigarettes, the World Health Organization (WHO) has called for a ban on indoor use and stronger regulation, citing nicotine as a danger. Proposed regulations include restrictions on advertising, promotion and sponsorship, noting that teens are increasingly targeted and that teen use is on the rise. Read more at: **http://bit.ly/1BbmQpT**

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PAGE 29

If you've been struggling to find ways to remain autonomous and to grow your practice, now is the time for change." **—Thomas E. Bat, MD**

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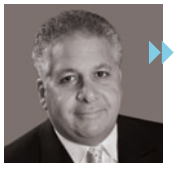

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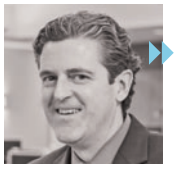

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# *from the* Trenches

> I have read reports on physician supply and none of them speak of the catastrophic shortage that a lot of organizations tend to push in the media. I see medical schools opening and the process of matriculating in these schools getting easier.
>
> **Carlos Hernandez, MD,** LAS CRUCES, NEW MEXICO

## 'PHYSICIAN SHORTAGE' A MYTH THAT BENEFITS MEDICAL SOCIETIES

This might seem like an odd question, but a lot of my colleagues and myself have been wondering: is there really a looming physician shortage, or is this shortage more of a financial interest from certain organizations?

I have read reports on physician supply and none of them speak of the catastrophic shortage that a lot of organizations tend to push on the media. I see medical schools opening and the process of matriculating in those schools getting easier, as well as some popularizing ideas such as three year medical schools programs so that "we can get primary care physicians working faster."

Is the real issue improving patient care? Or is it filling the pockets of physician organizations that benefit from having more doctors around? Or having more competition so that hospitals and large medical groups can reduce primary care physicians' already ridiculous salaries and benefits, while increasing their own revenue?

It seems to me that all these things point toward benefiting a lot of rich people instead of our patients. Which worries me a lot. Not to mention that it also worries me being unemployed a couple of years from now.

***Carlos Hernandez, MD***
LAS CRUCES, NEW MEXICO

## HEALTHCARE COST COMPARISONS ARE MISLEADING

Regarding the comparative information on health costs published in your May 10 issue ("ACP keynote: Physicians must engage on healthcare costs to strengthen relationships with patients," May 10, 2014): Almost all of this false information is derived from data from the OECD [Organization for Economic Cooperation and Development} which as you know involves 34 industrialized countries.

Their data do indeed show that the U.S. spends about 17% of its gross domestic product on healthcare, or about twice as much as most European countries and my native Canada. But the figures are deceptive and invalid for three reasons: accounting, legal and demographic.

First, the accounting: Every one of the other 33 countries has a single-payer universal system (SPUN) or close to a SPUN. A great expense of delivering medical care is the collecting of operating funds.

In this country this is chiefly done by insurers (premiums) and private offices (copays) like mine, and constitutes 25% of all expenses. In a SPUN, money is collected by tax authorities, given to the SPUN which does not record it as an expense, therefore the SPUN right away appears to operate 25% cheaper.


> The message that the U.S. spends 17% of GDP on healthcare is misleading and unfair. In fact, when adjusted for accounting, tort differences and demographics, the U.S. probably does better than most other OECD members...Such canards are slowly demonizing the best medical system in the world.
>
> **Calvin S. Ennis, MD, FAAP,** PASCAGOULA, MISSISSIPPI

Secondly, every OECD nation has some form of a loser pays tort system. The U.S. is the only country which does not. Because of this the U.S. endures an endemic of frivolous lawsuits driven by barratry and champerty.

Doctors, hospitals, etc. all try to protect ourselves by practicing defensive medicine which, depending on which study we believe, adds 10% to 25% to overall medical costs. Therefore other countries can operate more cheaply.

But by far the biggest difference between the 33 OECD countries and the U.S. is demographic in four chief areas all of which generate very expensive medical care for the U.S. and its citizens:

1) 8% of Americans are military veterans with expensive physical and psychiatric disease (Other OECD members have fewer than 1%.)

2) 30% of us are minorities, African-Americans and Hispanics who suffer up to 50% higher rates of cardiac and metabolic disease (diabetes). Many OECD nations are monocultural and minorities are 1 % or less of their populations. Diabetes and coronary care are very expensive diseases.

3) 10% of Americans are illegal immigrants who enter with unvetted illnesses such as cancer, diabetes, pregnancy, and tuberculosis. We treat them all anyway. On the other hand, the illegal populations of many OECD nations are 1 % or less.

4) No other OECD nation shares a porous border with a third world country across which flows drugs and violence into the inner city in the form of shootings, murders, etc.

These accounting, legal and demographic differences place on the U.S. a disease burden not borne by any other industrialized country.

It is possible to compare apples and oranges. But the comparison is invalid and incorrect. So the message that the U.S. spends 17% of GDP on healthcare is misleading and unfair. In fact when adjusted for accounting, tort differences and demographics, the U.S. probably does better than most other OECD members.

The technique of repeating false facts and false comparisons so often that they morph into the truth is not new. In modern times Goebbels and Mao Tse Tung perfected the technique and conquered countries.

Mr. Doherty, Dr. Patel, and others should stop doing this. Such canards are slowly demonizing the best medical system in the world- the U.S. system. I do my best over the years to counter such false claims. I hope I have convinced you to not reflexively repeated that canard.

***Calvin S. Ennis, MD, FAAP***
PASCAGOULA, MISSISSIPPI

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## HIGH DEMAND IN PRIMARY CARE AMONG PHYSICIAN RECRUITERS

**Primary care continues to be a hot job category for healthcare providers, judging by the latest survey from a physician recruiting organization.**

**Family medicine, internal medicine, general pediatrics and emergency medicine were among the specialties that saw the greatest number of job searches in 2013, according to the in-house physician recruitment benchmarking report published by the Association of Staff Physician Recruiters (ASPR).**

**About 70% of the approximately 5,000 member searches ASPR examined were for a family medicine provider, according to the report. 70% of nurse practitioner and 50% of physician assistant searches were for primary care, compared with 38% and 43%, respectively, in 2012. The typical organization participating in the survey conducted 26 searches in 2013 and employed two in-house physician recruiters. About 69% of searches were conducted for practices owned by hospitals or integrated delivery systems.**

# ACOs LAG IN HEALTH IT, INTEROPERABILITY

Accountable care organizations (ACOs) have made few strides in health information technology (IT) since early 2013, according to a recent survey from eHealth initiative.

Most ACOs have yet to incorporate data beyond immediate clinical or claims-based records, and few are offering more advanced capabilities such as population health, revenue, or customer relationship management systems, according to the survey.

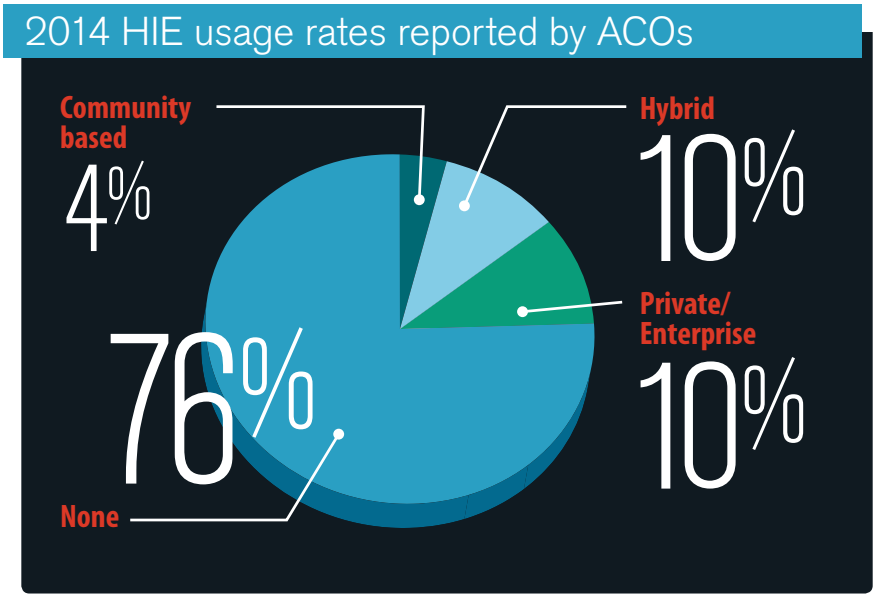
ACO patients can generally use basic Internet-based tools, but mobile and consumer trends are not yet widespread, the survey found. And although 100% of respondents said access to data from external organizations is a significant challenge, just 24% participate in health information exchanges (HIEs) at an enterprise, community, or state level.

The survey found that larger and more mature organizations pull data from more platforms and participate more actively in HIEs.

Provider satisfaction is falling, and cost and return-on-investment are crippling concerns, from 14% in 2013 to more than 90%, the survey found.

Interoperability and workflow integration have also grown as a significant challenge, from 50% in 2013 to more than 90% in 2014.

The survey notes that the limited improvements associated with health IT likely are due to reimbursement structure.




Source: eHealth Initative

*The Vitals continued on page 11*

# Preparing for ICD-10: The Basics

By Ken Terry

When Congress passed legislation on March 31, 2014, mandating that the Centers for Medicare and Medicaid Services (CMS) postpone the transition to the ICD-10 diagnostic code set for at least a year, many in the healthcare industry breathed a sigh of relief. Healthcare consultants strongly recommend that physician practices use the extra time to prepare for what is expected to be a very challenging transition, starting on October 1, 2015.

"Prepare now so you'll make it through the storm," advises Cindy Dunn, a consultant with the Medical Group Management Association (MGMA).

Whether or not you have received your ICD-10 upgrade, there are things you can do now to get ready for this transition so that you'll be ready to roll when the time comes. Here are some practical steps to take in the areas of impact assessment, vendor communications, training, testing, and revenue cycle management.

## Impact assessment

Diagnostic codes are used not only on claims but also on many other forms and documents in your practice, such as lab orders, authorization requests, and surgical scheduling forms. With that in mind, the first step in assessing the transition's impact is to identify everything in your practice that will require an ICD-10 code.

Second, draw up a list of your trading partners, including clearinghouses, payers, hospitals, and reference labs, and decide what the impact of ICD-10 will be in working with each of them.

Third, create an ICD-10 project team that includes an information technology (IT) specialist, a certified coder, and a physician champion who can help get doctors on board.

Because of the expected denials and delays in claims payments during the transition, experts recommend that you figure out how to cover your overhead during that initial period. CMS has advised practices to have enough cash on hand for five to six months of expenses, according to Dunn. But both she and David Zetter, a healthcare consultant in Mechanicsburg, Pennsylvania, say that few practices have the ability to set aside that much money.

Zetter recommends that practices take out or expand a line of credit to prepare for this potential financial emergency. Dunn agrees, but she points out that many physicians are reluctant to provide the personal guarantees that banks require for a line of credit. One alternative, she says, is to defer capital investments.

## Vendor communications

The top 50 electronic health record (EHR) vendors have all delivered ICD-10 upgrades to their clients, says Mark Anderson, a health IT consultant based in Montgomery, Texas. But many of these vendors have not rewritten their visit note templates, so their EHRs can't provide the documentation needed to support the ICD-10 codes. Some vendors are still fixing bugs in their software, and at least one major supplier with an ICD-10 version has advised its customers to wait for the next release, Zetter says. Meanwhile, many practice management system vendors and smaller EHR companies haven't provided any upgrades.

Anderson suggests talking to your software vendors now and finding out when their ICD-10 versions will be available, if they aren't already. Making your needs known will help put you at the head of the line when the upgrades are ready. Otherwise, says Anderson, it could be a few months before they're installed. With cloud-based EHRs, however, there's a difference: Since the software is online, rather than onsite, a cloud-based system can be upgraded and available to all users immediately.

An ICD-10 upgrade should include both ICD-9 and ICD-10 codes, and a crosswalk that transitions between them. This is not just for training purposes, as your practice may have to revise claims in ICD-9 for services provided before October 1, 2015, if these were not already submitted by then, Dunn notes. Moreover, workers' compensation insurers, which are not covered by HIPAA, may continue to use ICD-9 after the transition date, says Nancy Enos, President of Enos Medical Coding.

## Training

Now that practices have an extra year to train physicians and staff, they shouldn't waste a minute of it. If your practice has already started down the training path, "don't lose momentum, don't waste money on retraining next year because you put this on the back shelf," Enos urges. "Take advantage of the time now, so doctors have a full year to enhance their documentation."

Some practices with updated software are using it to stage a "soft launch" of ICD-10, Enos says. This means that doctors document visits as if they were already supporting ICD-10 and use that documentation to pick an ICD-10 code. Then, before the claim is submitted, a utility in the software automatically converts the code to ICD-9. With this kind of approach, doctors and staff can reach the shared goal of being wholly familiar with ICD-10 before the October 1, 2015, deadline.

Providers, nurses, billers, and front-office staffers who deal with authorizations and referrals will have to understand all aspects of ICD-10. Certified coders should attend ICD-10 seminars, Dunn says, and share their knowledge with the rest of the staff.

If your practice does not yet have an upgraded system, you can still begin training for ICD-10. Dunn recommends that you obtain crosswalk software from specialty societies or another source and apply it to the practice's top 20 diagnoses to show providers how they'll have to change documentation for ICD-10.

Similarly, Zetter suggests having coders sit down with physicians and go over five of their recent charts. "The coders should tell them what they're doing right and wrong with their coding, and also explain what needs to change for ICD-10."

"Don't lose momentum, don't waste money on retraining next year because you put this on the back shelf," Enos urges. "Take advantage of the time now, so doctors have a full year to enhance their documentation."

## Testing

Vendors should help with comprehensive internal testing to make sure that upgraded EHR and practice-management systems work properly. This includes the ability to generate a claims form compliant with ICD-10 and send it to a clearinghouse. Additionally, interface modifications must be tested and validated.

A bigger challenge is external testing with payers. Most payers are not yet ready to test ICD-10 and may not do so until next spring or summer. Dunn suggests that practices stay in touch with their clearinghouses, which interact with health plans, to get information on the insurers' intentions. Practices should also regularly check their top five payers' websites for information about their testing plans, she says.

Experts consider "end-to-end testing"—which includes claims adjudication by the health plan and an electronic response to the provider—to be a vital component of this process. But it's considered unlikely that payers will do end-to-end testing with all of their providers; instead, they might only acknowledge the receipt of test claims. In any case, you'll be testing with them through your clearinghouse (or possibly through your vendor, if they provide services along with software), unless you have a direct connection with a payer.

## Revenue cycle management

Regardless of what practices do to prepare, most are likely to have cash-flow problems during the ICD-10 transition. Besides putting aside money or getting lines of credit, practices should also strengthen their revenue cycle management to lessen the financial risk, Dunn recommends. That includes looking at ways to improve days in accounts receivable, collected charges, top charges and CPT codes by payer, and credit balances.

Dunn also notes that self-pay revenue now accounts for nearly 30% of revenues in the average practice, making the collection of copays and deductibles from patients more important than ever. That will be especially true during the ICD-10 transition, when third-party revenue will be at risk.

Delaying preparations for ICD-10 will cost you, not only in denied claims, but also in lost productivity. "If practices don't prepare, there's going to be a huge cost to the practice," Zetter says. "If they take their time and start now, they're going to be much better off." ■

# More veterans seek private care, but reimbursement rates remain low

**VETERANS CAN** now be referred to non-U.S. Department of Veterans Affairs (VA) primary care physicians (PCPs) to lessen wait times, but there might be pushback because reimbursement may be below Medicare rates.

The VA's Patient-Centered Community Care (PC3) program lets VA medical centers purchase non-VA care through contracted providers. The two providers currently in place, TriWest and Health Net, both note that paying below Medicare reimbursement rates is allowable. "TriWest pays against the VA Fee structure," said William Cahill, vice president of government relations for TriWest Healthcare Alliance. "Where the market allows, VA would like us to obtain discounts off of that fee structure."

Health Net has more than 235,000 providers in its TRICARE and VA programs, said spokesperson Brad Kieffer. The company, which uses the standard Medicare rates for provider contracts as a starting point, is "absolutely committed to negotiating mutually agreeable contracts best serving those in our military and veterans communities." Kieffer said.

Kieffer said that because both programs have reimbursement rates derived from the Medicare methodology, "most of our contracts are equal to or below Medicare rates."

Expansion of the PC3 program follows reports of backlogs and veterans who died while awaiting treatment, revelations that led to the resignation of VA Secretary Eric K. Shinseki and appointment last month of Robert A. McDonald, former Proctor or and Gamble chief executive officer.

The VA made 838,000 referrals to non-VA doctors in the last several months, up from 166,000 over the same time last year, noted McDonald in his August 13 address to Am Vets in Memphis, Tennessee.

Each referral on average "results in seven visits or appointments. So, we're talking about more than 1.1 million additional appointments in the private sector just from increased referrals over the last two months," he said. "

The PC3 program was launched in January to provide non-VA services to vets for specialty, mental health care, emergency care, and limited newborn care. An additional $10 billion for referrals to private doctors was made available August 7 through the Veterans Access, Choice, and Accountability Act. Under the law, vets can be provided access to non-VA providers if they've waited at least a month for a medical appointment or live at least 40 miles from a VA hospital or clinic. The bill also sets aside $5 billion for hiring more VA doctors, nurses and other medical staff, and $1.3 billion to open 27 new VA clinics across the country.

The American Academy of Family Physicians (AAFP), which supports the new bill and the PC3 expansion to include primary care, noted in a release that "payment will be negotiated at rates not to exceed Medicare rates, except in highly rural areas to ensure access to care."

But the organization is also "a strong advocate for family and primary care physicians to be paid for the value" of their work," said Reid Blackwelder, MD, FAAFP, AAFP president.

Blackwelder noted that AAFP members see an average of nine patients a week who are under- or uninsured, and said an influx of VA patients receiving even Medicare reimbursement rates can help balance that. "The most important aspect is we have long advocated improved access to care for veterans, and we're ready to serve."

## STUDY: SMALL PRACTICES HAVE FEWER PREVENTABLE HOSPITAL ADMISSIONS

**While changes in healthcare push small, independent primary care practices toward consolidation and hospital ownership, a new study shows that those practices have fewer preventable hospital admissions.**

**The study, published in the August issue of *Health Affairs*, analyzed survey data from 1,045 practices and compared it to Medicare claims from 999,990 beneficiaries. It found that primary care practices with one to two physicians had 33% fewer preventable hospital admissions than practices with 10 to 19 physicians. Practices with three to nine physicians had 27% fewer admissions compared to larger group practices.**

**The authors called the results "unexpected."**

**"It is possible that small practices have characteristics that are not easily measured but result in important outcomes, such as fewer ambulatory care-sensitive admissions," the study says.**

**The authors encourage hospitals and large group practices to examine the benefits of small group practices.**

COMING NEXT ISSUE

OCTOBER 10, 2014

**Cover story:**

Medical Economics TOP 50 EHRs

***Medical Economics* will unveil the Top 50 EHRs, along with exclusive research on system usability**

**Other features include:**

**A conversation with ONC's Karen DeSalvo on interoperability**

**The future of EHRs**

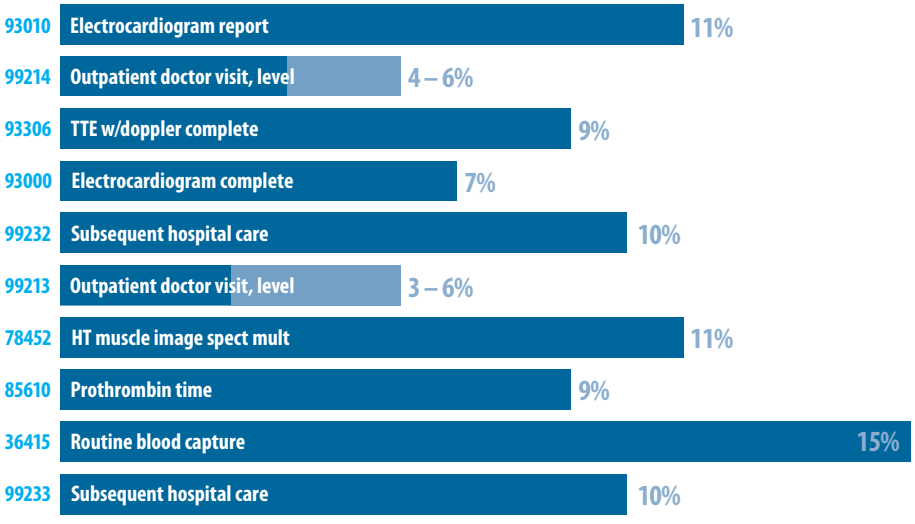
**The rise of mHealth**

**How technology is reshaping physician practices**

# Top 10 unexpected nationally denied CPT codes

FOR ALLOPATHIC AND OSTEOPATHIC PHYSICIANS / CARDIOLOGY SUB-SPECIALTIES

DATE RANGE: 4/21/2014 TO 7/21/2014




## Unexpected National Denial Rate: 9%

**Unexpected Denial Rate Explanation:** The unexpected denial rate removes expected denials that are typically a part of a "bill for denial" claim (on the claim the item isn't covered by the carrier, but you must receive a denial stating this so you can bill the secondary carrier). Remit DATA allows our users the option to remove expected denials from their view so they can obtain a "truer" denial rate, the Unexpected Denial Rate.

The top 10 are sorted by the denials with the highest counts (remittance service lines) and their related denial percentage.

Source: Remit DATA

# CMS' Open Payments site back online

**THE MEDICARE** payment website Open Payments is back online. The Centers for Medicare and Medicaid Services (CMS) shut down the website for nearly two weeks, after an error in the physician payment data was revealed. CMS said that the reporting error was the result of a of group purchasing organizations submitting data associated with the wrong state license numbers or national provider identifiers for physicians with the same first and last names.

CMS has not delayed the website's public launch date of September 30. The American Medical Association says the extension is not nearly long enough.

AMERICAN ACADEMY OF NEUROLOGY

# AAN updates guideline on preventing stroke in nonvalvular atrial fibrillation

by **CHERYL GUTTMAN KRADER** *Contributing author*

A new guideline released by the American Academy of Neurology (AAN) in February 2014, provides recommendations on identifying previously undetected nonvalvular atrial fibrillation (NVAF) and therapies for reducing the risk of stroke in patients with this cardiac condition.

The guideline states cardiac rhythm monitoring devices with continuous recording or automatic detection algorithms are preferred over those with patient-triggered recording as many NVAF episodes are clinically asymptomatic. Recognizing that the NVAF detection rate of cardiac rhythm monitoring is probably related to monitoring duration, the guideline recommends considering monitoring for prolonged periods (e.g., 1 or more weeks) instead of short periods (e.g., 24 hours).

The guideline emphasizes individualized, informed decisions on antithrombotic medication use, taking into account potential risks, benefits, and preferences. Use of a risk stratification scheme may help identify patients at higher risk of stroke and those without clinically significant risk. Individuals with NVAF and no additional stroke risk factors might not be offered anticoagulation or they may be offered aspirin.

Based on their review of clinical trial data for new anticoagulants, members of the guideline committee concluded dabigatran, rivaroxaban, and apixaban are at least as effective, if not superior, to warfarin for reducing stroke.

Use of warfarin may be continued in patients already well-controlled on that anticoagulant, but the new anticoagulants have the advantage of eliminating the need for international normalized ratio (INR) monitoring and so may be particularly considered when there is concern about poor patient compliance with INR monitoring.

Dabigatran, rivaroxaban, or apixaban are also specifically recommended for use in patients at increased risk of intracranial bleeding, and apixaban is recommended for patients at increased risk for GI bleeding.

Recommendations also addressed anticoagulant use in elderly patients (>75 years) and those with dementia or occasional falls, populations in whom there are reservations about anticoagulant treatment based on perceived high risk of bleeding. The guideline recommended routinely offering oral anticoagulant therapy to elderly patients if they have no history of recent unprovoked bleeding or intracranial hemorrhage. Oral anticoagulation might also be offered to patients with dementia or occasional falls but with counseling that the risk-benefit ratio of their use is uncertain in this population.

The review found insufficient evidence for making practice recommendations on oral anticoagulant use in patients with end-stage renal disease.

The guidelines were created based on a systematic literature review of papers published since 1998, the year of the previous AAN practice parameter on stroke prevention in NVAF, and using expert consensus. The full guidelines may be accessed at http://aan.com/guidelines.

## Based on a systematic review of published literature, the guideline recommends:

- **Clinicians might obtain outpatient cardiac rhythm studies in patients with cryptogenic stroke to identify patients with occult NVAF.**
- **Clinicians should routinely offer anticoagulation to patients with NVAF and a history of transient ischemic attack/stroke.**

DOWNLOAD

**Find this clinical guideline and others at:**
**MedicalEconomics.com/clinicalperspectives**

# ICD-10

## Now is the time to prepare


## 9 keys to ensure your practice is ready

**BY ELAINE POFELDT** *Contributing author*

A year away from the October 2015 deadline for transitioning to the International Classification of Diseases—10th revision (ICD-10), physicians cannot assume another delay will happen, experts say. Now is the time to prepare in earnest.

**KEVIN DE REGNIER, DO,** isn't wasting any time in getting his 27-year-old practice, Madison County Medical Associates, up to speed and ready for ICD-10.

He and his two physician assistants, who all do their own coding, have attended sessions to learn about the new coding system at national medical meetings and conferences. The practice in Winterset, Iowa, about a 40-minute drive from Des Moines, also has sent its three-person billing staff to classes.

de Regnier, who is president-elect of the American College of Osteopathic Family Physicians, does not mince words about all

Getty Images/iStock/360

# ICD-10: The costs to prepare

ICD-10 is not just a workflow disruption—the transition also means spending money on training and technology upgrades and lost revenue due to productivity disruptions. A study conducted by Nachimson Advisors on behalf of the American Medical Association in early 2014 found that the costs of the conversion are rising—in fact, the costs had reached a level three times higher than the previous analysis, conducted in 2008.

| Cost area | Typical small practice | Typical medium practice | Typical large practice |
|---|---|---|---|
| Training | $2,700—$3,000 | $4,800—$7,900 | $75,100 |
| Assessment | $4,300—$7,000 | $6,535—$9,600 | $19,320 |
| Vendor/Software upgrades | $0—$60,000 | $0—$200,000 | $0—$2,000,000 |
| Process remediation | $3,312—$6,701 | $6,211—$12,990 | $14,874—$31,821 |
| Testing | $15,248—$28,805 | $47,906—$93,098 | $428,740—$880,660 |
| Productivity loss | $8,500—$20,250 | $72,649—$166,649 | $726,487—$1,666,487 |
| Payment disruption | $22,579—$100,349 | $75,263—$334,498 | $752,630—$3,344,976 |
| **Total costs** | **$56,639—$226,105** | **$213,364—$824,735** | **$2,017,151—$8,018,364** |

SOURCE: American Medical Association

the time and money he and his team have invested.

"This is clearly about the insurance companies and the government wanting to have a better handle on fraud and abuse," he says. "It's another unfunded mandate that we have to absorb the cost of implementation. It's going to involve considerably more work."

In April, physicians got a reprieve from making the transition from the existing coding system, ICD-9, to ICD-10. President Obama signed a law that, for the second time, shifted the deadline for implementing ICD-10. On July 31, the U.S. Department of Health and Human Services issued a final rule that said that healthcare providers, health plans and healthcare clearinghouses must switch to ICD-10 by October 1, 2015. The change affects everyone who must comply with the Health Insurance Portability and Accountability Act.

ICD-10 was designed to update the existing system, which is 30 years old, and to provide more information regarding patients' medical conditions. But for that to happen, medical practices must master the complex new medical coding system, in which codes are three to seven digits, rather than the three to five digits used in ICD-9.

The consequences of failing to make the change on time are steep. Medical practices risk seeing improperly coded claims denied—and a resulting cash-flow crunch.

"Financial viability is really the issue," says Fletcher Lance, vice president and national healthcare leader at North Highland, a global consulting firm that is helping providers navigate the transition.

But getting ready for ICD-10 is a long and expensive road. A survey produced by the American Medical Association estimates that preparing a small practice for ICD-10 will cost between $56,639 and $226,105, including technology updates, training, testing and rev-

# ICD-10 preparation 101

- ☐ **Make sure ICD-9 still works**
  Practices must ensure that they are ready to continue with ICD-9. To do this, make sure all of your vendors are aware of the delay and that no forms or software for ICD-10 go active on October 1, 2014.
- ☐ **Continue training**
  Conduct high-level training in ICD-10 for providers and coders to prepare for eventual testing.
- ☐ **Take a financial snapshot**
  Begin analyzing the financial health of your practice. Evaluate your payer mix, determine your typical accounts receivable cycle and examine denied claims, both for coding and documentation reasons. Determine what you need to do to survive financially if you encounter a major problem with reimbursements after October 2015.
- ☐ **Gather coding data and identify diagnostic patterns**
  Analyze your practice's coding patterns to determine which codes you use most frequently, which ones make up the largest portion of your revenue, and which ones are denied most frequently. This should be done for each payer you work with, going back about one year.
- ☐ **Contact vendors and health plans**
  Ask all your payers and vendors—electronic health records, billing services, clearinghouses—about their ICD-10 readiness. Monitor the preparedness of your vendors and payers and work with them to identify and address gaps.
- ☐ **Beef up your documentation**
  No reason to wait on this. Providers should begin documenting patient encounters as if ICD-10 is already in place. The goal is to be ready, from a documentation standpoint, for testing and, eventually, going live with ICD-10.
- ☐ **Begin testing**
  Testing ICD-10 claims to ensure that your coding and documentation are working properly is vital, and should begin as soon as possible. CMS is holding testing weeks prior to the October 2015 transition, but waiting for those events is not necessary. Testing is important both within your practice and with the clearinghouses and payers you will be working with. One key: Test using records that reflect the patient encounters you will commonly deal with.

enue losses due to drops in productivity and payment delays and reductions.

Not sure how to start preparing in your own practice? To get an overview of what ICD-10 entails, start with the Road to 10 site (roadto10.org), run by the Centers for Medicare and Medicaid Services. It offers webcasts, frequently-asked questions and other information. Once you know the basics, here are other strategies to get your practice prepared.

## 1/ Beat inertia

Many medical practices got lucky when the ICD-10 implementation deadline was extended because they had procrastinated on learning it. While it is possible the deadline could be postponed again, Lance believes it's unlikely. "Hope was a strategy, but I don't think it will be this time," he says.

To make the transition manageable, experts recommend scheduling some time every month to work on it, starting now—rather than next July or August, when it is likely to become a mad rush. "I think there are a lot of physicians who have their head in the sand on this," says de Regnier. "It's going to come back to bite them."

Although de Regnier has started working on the transition, he is apprehensive. "I think we've frankly only scratched the surface," he says. "It's such a radically different coding system from what ICD-9 is. There's going to be a pretty steep learning curve. I think the result is we will see a significant decline in productivity initially."

## 2/ Budget for the blitz

Complying with ICD-10 requires a substantial investment, so make sure you plan for outlays to cover training, additional software or upgrades to your existing programs, and other costs.

Madison County Medical Associates has, for example, paid its electronic health records (EHR) vendor Allscripts more than $5,000 to update its system to manage ICD-10. If some members of your team have learned the system well, you may be able to offset some of the additional overhead by having them train others.

## 3/ Assess your internal capabilities

Large practices may have a large enough

business office to manage the change internally, but smaller ones may find it difficult to keep up.

Jeff Drasnin, MD, a general pediatrician based in Cincinnati, Ohio is among them. He is a partner in ESD Pediatric Group, which runs two practices that employ a total of five physicians and three nurses. After the practice's billing manager mentioned concerns about the scope of the change, ESD decided to rely on solutions such as athenaCollector, a practice management and billing service, to handle the requirements.

"If you have the wrong codes, it will grind your practice to a screeching halt," Drasnin says.

## 4/ Know who needs to learn

To avoid coding errors, include anyone who "touches" the system in your training, say experts.

For instance, if medical assistants fill out lab forms and need to list patients' diagnoses, they need to know the proper codes. de Regnier's practice employs three nurses and a health coach, but he says, "we haven't spent a lot of time with them, other than in our office meetings."

## 5/ Create a communication team

Designate one, or several individuals, on your team to tackle tasks like keeping in touch with software vendors, health plans and clearinghouses to find out their status in complying with ICD-10, and ask about changes in how you will work with them, experts recommend.

Your communication team should also keep your staff informed of any news on ICD-10 that affects how they do their jobs. Given the massive scale of the change, there will likely be snafus related to reimbursements.

"Plan for contingencies," advises Tim DeCou, a partner who directs the healthcare practice at Hardesty LLC, an executive services firm based in Irvine, California. He recently helped a medical group prepare for ICD-10.

## ICD-10 testing weeks

**The Centers for Medicare and Medicaid Services (CMS) has announced that it will conduct three weeks of ICD-10 testing.**

The testing weeks will be:

- November 17-21, 2014
- March 2-6, 2015
- June 1-5, 2015

**CMS says the testing is to reassure providers that the systems will be ready for the October 1, 2015 implementation deadline, which was officially confirmed by the Department of Health and Human Services earlier this month.**

**While submitters can acknowledge test ICD-10 claims at any time through implementation, the testing weeks were created by CMS to instill confidence in the provider community that CMS is ready.**

### 6/ Master the codes that matter

While many physicians have memorized the codes they use in ICD-9, that is harder to do in ICD-10, because the system is more elaborate. Instead, experts recommend focusing on learning the codes relevant to your specialty, rather than all 155,000 codes. "Make a short list of the codes you have to be good at," says Lance.

### 7/ Use the right lingo

To get the proper reimbursements, it is important for medical teams to understand how the terms "initial" and "subsequent" are being used in ICD-10, says David J. Freedman, DPM, CPC who, in partnership with Gary Chan, MD, CPC, operates a website called ICDtenhelp.com.

An initial visit is when a problem is first diagnosed, he explains. "It can be a patient you've seen on and off for years or a new patient," Freedman says. A subsequent visit follows the initial one.

Whether a visit is initial or subsequent affects how claims are coded. "The last of the seven characters changes on subsequent visits," says Freedman. "The documentation would have to match up with the coding."

Not understanding this difference can be costly. "If an insurer audits a record and it's really a subsequent encounter and not an initial encounter that's going to cause problems from a medical dollar reimbursement side," says Freedman. "The claim will be denied or held up."

### 8/ Keep an eye on operations

Be prepared for changes to your coding affecting other aspects of your practice's operations—and divert staffers from other tasks. "Look at where your work flow is going to have to change," advises DeCou.

How you create referrals and order services will likely change somewhat, notes Michael Palantoni, senior manager of product innovation at software provider athenahealth. Ask yourself: "If those are all created and generated in the ICD-10 world, how do you make sure those are handled well?" he says.

### 9/ Create a compliance team

Every practice should have a point person assigned to regularly check coding to make sure there are no errors that are costing the practice money—and identify staffers who need more training, say experts. The stakes are high for practices that don't get it right because errors may lead to delayed or denied claims.

"We've got to get it right. That's why planning is so critical," says DeCou. "No practice can afford to make big mistakes that affect cash flow today."

MORE ONLINE

**Read *Medical Economics'* series with Contexo Media on preparing to code for ICD-10:**
**www.medicaleconomics/ICD10ready**

# Meeting the needs of female patients

How physicians can reach out to women to help them deal with their unique health challenges, including pregnancy, heart disease, diabetes and breast cancer

*by* **DEBORAH OLSEN** *Contributing author*

## HIGHLIGHTS

**01** Many women have risk factors for heart disease, including diabetes, high blood pressure, high cholesterol and obesity.

**02** Talk to patients about plans to become pregnant—and ensure that they are doing everything they can to manage chronic illnesses.

In many ways, women are ideal patients. After all, they're more likely than men to have a primary care doctor and to comply with preventive care recommendations. But there's a catch: The stress of juggling work and family roles may cause some women to skip or delay annual physical exams, mammograms and other screening tests, according to a recent study of 9,000 women published in the *Archives of Internal Medicine*.

"Many women are motivated to make healthful changes, but they feel constrained by too many pressures—work, kids and aging parents," says Emily Oken, MD, MPH, a physician at the Fish Center for Women's Health at Brigham and Women's Hospital and an associate professor in the department of population medicine at Harvard Medical School and Harvard Pilgrim Health-Care Institute. "The challenge is to get them to say it's okay to put themselves first."

That's just one of several difficulties associated with caring for women. With ever-shifting screening guidelines for cancer and chronic illnesses and high rates of unintended pregnancies, diabetes and obesity, women face many health problems. As a result, it's becoming increasingly important to take a few extra minutes with patients. "I think women know more about their finances than their heath," says Jo Marie Munnich, MD, associate clinical professor of family medicine at the University of California-San Francisco (UCSF) Medical Center and a physician at the UCSF Women's Health Center.

## COPING WITH DEPRESSION AND STRESS

In the *Archives of Internal Medicine* study, more than 13% of women reported experiencing signs of psychological distress, such as feeling nervous, hopeless, restless, fidgety or depressed. And nearly one-third of those women were more likely to delay getting healthcare than their male counterparts. Clearly, stress is widespread.

"I see three women a day who cry," says Munnich. "They are so overwhelmed [by work and family obligations]." Many put their family's needs ahead of their own. So "doctors need to link the importance of a woman staying healthy to her ability to take good care of family members," says Molly Cooke, M.D. FACP, immediate past president of the American College of Physicians and a professor of medicine at UCSF.

That's why, for example, pregnancy is a great time to help women quit smoking. "When you make the point about the dan-

gers of secondhand smoke for the baby, it's powerfully motivating," says Cooke. To ensure that women don't miss check-ups and screenings, many doctors encourage patients to include their doctor's appointment in their calendar just as they would a business meeting.

Depression is also common among women; it affects about 12% of those age 40 to 59, according to the Centers for Disease Control and Prevention (CDC). Women are 70% more likely than men to experience depression during their lifetime, according to the National Institute of Mental Health.

Despite the condition's prevalence, patients are unlikely to tell you about their mood—and bringing up the subject can be tricky. To find out about a patient's emotional wellbeing, some practices routinely screen for depression in their new patient questionnaire, which incorporates the PHQ-4 screening tool (see box). If the result is positive, a medical assistant gives the patient a more detailed questionnaire. Other physicians ask their patients in person during the first visit. Questions such as, "How is your mood? Are you feeling depressed or down?" can be a good conversation starter. But keep in mind, some patients won't give you the answers right away.

"I try to make sure my patients feel comfortable talking with me," says Oken. "And I pay attention to symptoms like difficulty sleeping or pain, which can signal depression."

## PLANNING PREGNANCIES

About half of pregnancies aren't planned, according to a recent study published in the *American Journal of Public Health*. So it's crucial to ask patients if they're using birth control. If they're not, consider asking, "Would you be okay with getting pregnant?"

"Many 40-year-olds think they can't get pregnant, but I tell them I've seen so-called 'menopause babies,'" says Kisha Davis, MD, MPH, a family physician in Gaithersburg, Maryland and a board member of the American Academy of Family Physicians. Making matters worse, the risk of miscarriage is far higher among women in their 40s. The upshot? It's a good idea to recommend birth control for all women under 50 who have not reached menopause, says Munnich. Patients should know birth control doesn't have to be a pill; many older patients can benefit from the low-maintenance IUD or an etonogestrel implant like Nexplanon.

Some doctors are less concerned about unplanned pregnancies and more about whether a woman is healthy enough to become pregnant in the first place.

"I worry about patients who have health conditions that aren't well managed, like weight and diabetes," says Oken. "I tell them that a woman's health can have an impact

## A simple way to check for depression and anxiety

Use the Patient Health Questionnaire (PHQ-4) below to engage with patients about their risks for depression and coping with anxiety, then follow up with more detailed questions.

**Q: Over the last two weeks, have you been bothered by these problems?**

| | Not at all | Several days | More days than not | Every day |
|---|---|---|---|---|
| Feeling nervous, anxious or on-edge | ☐ | ☐ | ☐ | ☐ |
| Not being able to stop or control worrying | ☐ | ☐ | ☐ | ☐ |
| Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| Feeling down, depressed or hopeless | ☐ | ☐ | ☐ | ☐ |

The thought of harming myself has occurred to me (circle one) **Yes** **No**

on the baby. For instance, we know if someone has diabetes before pregnancy, the baby is more likely to be born with birth defects and may experience complications during delivery."

So it pays to talk to patients about their plans to become pregnant—and ensure that they are doing everything they can to manage any chronic illnesses.

## SETTING THE RECORD STRAIGHT ABOUT SCREENINGS

It's no wonder patients are confused about screenings, given the recent controversy about mammograms.

"During an office visit, I bring up the fact that the recommendations are confusing, so patients shouldn't feel badly," Cooke says. "I spend a few minutes explaining how screening tests work. That helps people understand why the recommendations change. If I say, 'Do this because I tell you to, the patient is likely to come back and say, What's the deal?'" Another approach is to use patient handouts, which can explain the tests.

Here's how to manage some of the most common screening challenges:

### Mammograms

Patients have many misconceptions surrounding breast cancer screening. For example, some women who have no family history of breast cancer assume they're at low risk and don't need to be screened. Others think a doctor can feel a lump—or they will feel ill if they have cancer—so they don't need a mammogram.

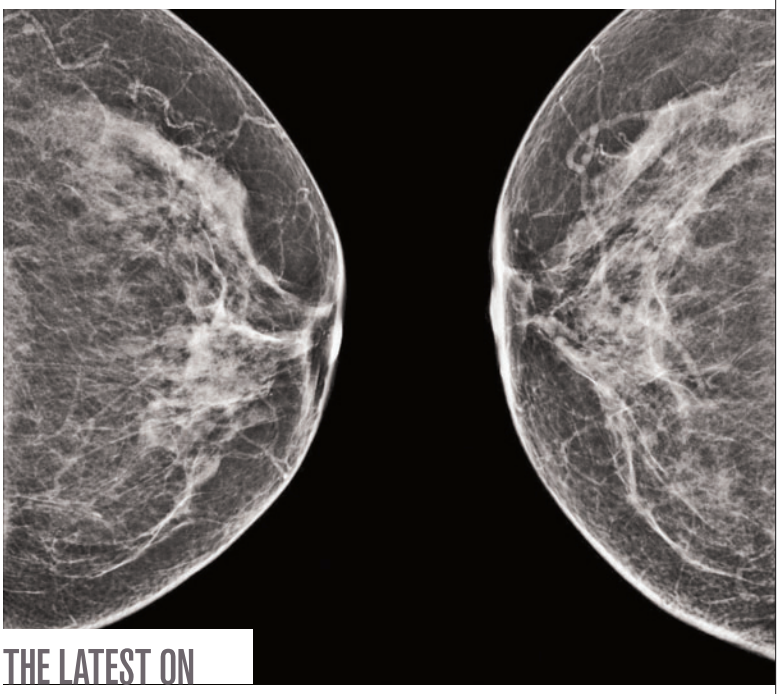
"It's important to take the time to figure out where a patient is coming from," says Munnich. "I can't assume someone is anxious about having a mammogram when they're actually skeptical."

Another observation Munnich has made: "I've noticed there's a drop-off in women getting mammograms between the ages of 50 and 70," she says. "Yet that's when they need it most. Some women are getting mammograms in their 40s and are 'burning out' by the time they hit 50."

She tells patients that although they may know someone who's had breast cancer in their 40s, the incidence is much higher in the 50s, 60s and 70s.

### Colonoscopy

Many women shy away from the test, but



Getty Images/iStock/360/flik47

## THE LATEST ON KEY SCREENING TESTS FOR WOMEN

### Mammogram

- **U.S. Preventive Services Task Force (USPSTF)**
  Routine screening should start at age 50 and be done every two years. Women in their 40s should discuss the benefits and risks with their doctors.
- **American Cancer Society (ACS)**
  Women should be screened annually starting in their 40s.

### Pap test

- **USPSTF**
  Screen women ages 21 to 65 every three years using the Pap smear, or screen with a combination of the Pap smear and HPV testing every five years.

### Colonoscopy

- **USPSTF**
  Screen using fecal occult blood testing, sigmoidoscopy or colonoscopy beginning at age 50 and continuing until age 75.

### Osteoporosis

- **USPSTF**
  Screen women age 65 or older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old woman.

> MANY WOMEN ARE MOTIVATED TO MAKE HEALTHFUL CHANGES, BUT THEY FEEL CONSTRAINED BY TOO MANY PRESSURES—WORK, KIDS AND AGING PARENTS."
>
> —EMILY OKEN, MD, THE FISH CENTER FOR WOMEN'S HEALTH AT BRIGHAM AND WOMEN'S HOSPITAL, AND ASSOCIATE PROFESSOR AT HARVARD MEDICAL SCHOOL

they will often agree to a fecal occult blood test (FOBT).

"I've noticed a huge difference in colorectal screening when patients are offered the FOBT," says Munnich. Over time, many people will tire of the FOBT and will go for the colonoscopy. One of the main reasons people want to avoid a colonoscopy is the prep. Fortunately, a patient handout can ease patients' fears. "My colonoscopy handout explains how to do the prep so patients aren't so miserable," says Munnich. "They can be finished by 8 p.m. the night before the test."

### Osteoporosis

Women can get the bone densitometry (DXA) scan before 65, but would have to pay for the procedure themselves. "Many women are very disappointed to learn that they can't get the DXA scan until age 65 years," says Munnich. "They may be worried because their mothers have osteoporosis." But getting plenty of weight-bearing exercise and taking calcium and vitamin D supplements can help protect against the condition.

### Pap smear

"Once women understand that we know what causes cervical cancer (the human papilloma virus)—and that it takes a certain amount of time to develop—it's easy to convince patients they don't need this every year," says Davis.

Still, patients often get confused about the difference between a Pap smear and a pelvic exam (they often assume they had the smear if they received a pelvic exam).

## PREVENTING HEART DISEASE

Women may be worried about breast cancer, but heart disease is what they really need to fear. Women's lifetime risk is nearly 40% by age 50, according to a recent study of cardiovascular disease in women published in *Epidemiology.* In addition, many have risk factors such as diabetes, high blood pressure, high cholesterol and obesity. About one-third of white women are obese; the numbers are even higher among African-American and women of Mexican descent. About 11% of women have Type 2 diabetes, and even more have prediabetes.

Although more women are exercising regularly and fewer women are smoking, there's plenty of room for improvement. But helping patients make lasting lifestyle changes is a challenge.

"There are women with prediabetes who aren't taking it seriously—either because they don't have any symptoms or are doing worse on the medication," says Oken.

Mentioning a relative who has the problem might help remind patients of the seriousness of the disease. As far as diet is concerned, some doctors recommend that women have their own shelf or cabinet at home stocked with healthy foods they like. They might also consider cooking meals on Sundays and putting them in containers for the week.

Exercise is also key. Even if time is scarce, patients might be able to set aside an hour for a walk or bike ride over the weekend.

"We ask patients what their goals are and how ready they are to make changes," says Davis. "We recommend that they start simple—cut back on soda and bread, for instance. Small changes tend to be more lasting." In some practices, nurses follow up with patients to check on their progress. Patient handouts can offer tips on healthful eating and exercise.

There are different ways to help patients make lifestyle changes, and some work better than others. "Exorting someone to do something they already know—like get more exercise—sets up an oppositional relationship," says Cooke.

"Using an approach called motivational interviewing gets the patient and doctor on the same side of the issue." This involves helping people identify ways their lives would be improved by altering their behavior. It involves assessing their readiness for change and giving people the confidence to take the necessary steps. For more information, go to http://www.motivationalinterview.org.

The key to helping women take charge of their health is, of course, to develop a good rapport with them.

"Women are worried about their health, and they often apologize for it," says Munnich. "I tell patients I know they're worried about their health and money. I say, I'm like your financial consultant. When I use that analogy, people really get it. It's a collaborative approach to health care, and it empowers women to open up to me about their fears."

FIGHTING BACK SERIES WINNER

# Surviving the chase for quality metrics

## How changing job descriptions and the roles of staff members can help physician practices meet quality care goals

*by* **LORI ROUSCHE, MD** *Contributing author*

Medical Economics FIGHTING BACK 2014 PHYSICIAN WRITING CONTEST

Physicians are operating their practices in midst of monumental change. And it signals the need for useful, practical and thoughtful solutions. The winners and honorable mentions in this year's writing contest delivered just that. *Medical Economics* unveiled the first winner in the Aug. 25 issue, and will unveil three other winning entries in the Oct. 25, Nov. 25 and Dec. 25 issues. As a finale in late December, many of the entries in this year's contest will be featured on medicaleconomics.com to offer even more great ideas from your colleagues in practice and academia.

In the current world of medical reimbursement, a doctor's revenue is often tied to quality. Insurance companies will pay bonuses to doctors for better care. To obtain these extra monies, however, practices need to meet certain metrics that are designed to provide a higher quality of patient care and decrease costs. Meeting these quality metrics requires the help of the entire office staff, not just the physicians. Our office is currently revising our job descriptions, because everyone's job is changing.

So what are some of these quality metrics that an office might chase? Currently, our office can receive bonus dollars if we can convince a percentage of our age-appropriate patients to get their colonoscopies and mammograms. There is also money available if we can convince patients with diabetes to undergo yearly urine tests for microalbumin.

Another quality metric involves getting our patients with diabetes to have hemoglobin A1C levels under 8.0%, blood pressures less than 130/80 and LDL cholesterols of under 100. If we can get all three of these reports on a percentage of diabetic patients to meet our goals, then we earn substantial bonuses.

An additional quality issue, albeit one much easier for our office to obtain, is screening every patient over 65 for falls. If we can document that we have asked a certain percentage of our patients this question, we can make more money.

There are many barriers to fulfilling our quality requirements, including lack of time in an office visit, noncompliant patients, and medication costs. But the availability of trained staff to help pursue quality should not be one of them.

Our office has been slowly evolving staff responsibilities to handle the onslaught of data entry, phone calls, letter mailings and information tracking we are required to handle.

Our receptionist doesn't just answer phones and schedule appointments, for example. With the advent of electronic health records (EHR), the changes to front staff duties has been substantial. With no paper charts to file and search for, the front staff seems to have more downtime than

the nursing staff. We decided, therefore, to assign much of the audit/quality improvement work to the front staff. We now have an audit specialist working 'upfront.' She is in charge of pursuing quality by tracking patients on the audit list to be sure they meet the required goals.

If a patient hasn't had her mammogram, she sends a letter or an email via the electronic portal. If a patient isn't at goal with his A1C, she generates a new telephone message and sends it to the patient's physician. The physician then has the option of reviewing the medications and deciding if pushing the dose or adding medications would be appropriate for the patient.

Often in a given office encounter, the physician does not have adequate time to address every issue. If a patient presents with acute depression because his or her spouse just died, it is not necessarily the right time to say, "I see your diabetes isn't to goal, let's increase your medication."

When, as a team, we meet the quality guidelines and receive a bonus, we award the audit specialist a bonus as well. She has a vested interest in performing well.

Not all of the audits and quality goals are appropriate for front office staff to handle. Some of the metrics are better pursued by a member of the nursing staff with a clinical background. We are participating in a program that rewards us financially for improving our coding by adding the high-risk codes that doctors sometimes neglect to enter during the office visit. For example, many of our patients have chronic kidney disease stages I to IV, but our doctors were not remembering to include that information at least once a year during a visit. Certainly, the physicians were considering it, because with any medication prescribed the glomular filtration rate needs to be taken into account.

If the patient presents with a urinary tract infection, and an antibiotic was recommended, you can be sure that the doctor was adjusting the antibiotic if the kidney function was down. By including these codes, the patient's risk assessment factor (RAF) will be higher, because he or she is a more complex patient. The RAF is important, because more money is allocated for more-complex patients, so insurance companies need to know who requires a more intricate level of care. The nurse assigned to this audit needs to go through past office visits and document for the insurer whether the coding is still pertinent.

Again, if we receive a bonus for this work, we make sure to give our nurse a portion of it. This lets her know we appreciate her hard work and motivates her to keep it up. It also makes more sense for the nursing staff to ask the question regarding falls in the over-65 group. because it is asked as part of obtaining patient vital signs. When the clinical staff brings back a patient, staff members enter information regarding fall risk into the computer at the same time they are entering blood pressure data. This allows for an easy capture of a quality measure.

Gone are the days of the vital signs being just blood pressure, pulse and temperature. Our vitals now include fall risk and smoking behaviors which a clinical staff member obtains before the doctor even enters the room. So the job description of the nurse is also expanding to include data entry.

Acquiring much of the quality metrics and audit information requires a team effort. Job descriptions have changed and the entire staff needs to work together to earn the bonus money. By assigning our detail-oriented existing staff to work the audits, we have been moderately successful in maintaining a reasonable income. All of this work is not just for the money. It would only be worth it if it improved our patient care.

> "Meeting the quality metrics requires the help of the entire office staff, not just the physicians."

The bottom line is that this effort does advance the health of our patients. The entire office can be proud and satisfied at the end of the work day, if we know our patients are getting the best possible care.

*Lori Rousche, MD, is a physician owner in TriValley Primary Care, a seven-office primary care group in southeastern Pennsylvania. She has been practicing family medicine for 22 years.*

# Legally Speaking

# Non-english speaking patients: Are you required to hire an interpreter?

*by* **TRACY D. HUBBELL, JD** *Contributing author*

Physicians are subject to a wide range of federal and state mandates impacting their practice. Many of these laws require physicians to implement policies and procedures in their offices to remain compliant. Some of these requirements are murky, such as laws addressing discrimination against patients who speak limited or no English.

**TITLE VI OF THE** U.S. Civil Rights Law of 1964 has been interpreted to prohibit hospitals, physicians, and other healthcare providers receiving "federal financial assistance" from discriminating against patients who do not speak English. The U.S. Department of Health and Human Services (HHS) published a list of the types of federal financial assistance to which Title VI applies, which includes services reimbursed under Medicare Part A.

However, Medicare Part B payments were not included, because those payments were deemed to be made pursuant to "insurance contracts," and they were expressly excluded from the definition of federal financial assistance. Thus, under prior law, physicians who received Medicare Part B payments, and no other "federal financial assistance," were not required to comply with Title VI and its regulations.

However, a subsequent change in federal law that became effective in 2010 modified the definition of federal financial assistance to include payments under insurance contracts. Although clarifying regulations have not yet been adopted, it appears that this change would re-characterize Medicare Part B payments as federal financial assistance, and on that basis, physicians receiving Medicare Part B payments would now be subject to Title VI.

The HHS Office of Civil Rights (OCR) has provided guidance for use on a case-by-case basis to determine what language services must be provided to patients with no, or limited, English proficiency (LEP) pursuant to Title VI.

## Government guidance

OCR's most recent guidance provides a four-part test for physicians to use in evaluating how to fulfill their responsibilities to LEP patients. It requires a determination of:

- **the number or proportion of LEP persons eligible to be served or likely to be encountered by the physician's services;**
- **the frequency with which LEP patients come into contact with the services;**
- **the nature and importance of the services being provided; and**
- **the resources available to the physician and the costs for providing access to LEP patients.**

To apply OCR's test, physicians should look first at their prior experience with LEP encounters and demographic data for their eligible service population, including census data, to determine what languages are spoken by LEP persons in their service area.

Second, physicians should assess the frequency with which they will or should have contact with an LEP patient. The more frequent the contact with a particular language group, the more likely language services in that language will be needed.

Physicians who encounter LEP patients on a daily basis have greater duties than physicians who serve LEP patients on an unpredictable or infrequent basis. Physicians who encounter ➔28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Our mobile app for iPad® brings you expanded content for a tablet-optimized reading experience. Enhanced video viewing, interactive data, easy navigation—this app is its own thing. And you're going to love it.
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# Legally Speaking

➔26 LEP patients on an infrequent or unpredictable basis might use one of the commercially available telephonic interpretation services to obtain real-time interpreter services to ensure that LEP patients have access to their services.

Third, physicians need to consider whether denial or delay of access to their services or information could have serious or life-threatening implications for a LEP patient.

Physicians must take into account whether the services or information are important and urgent, to determine if immediate language services are necessary. Physician services are important, but not always urgent; therefore, providing language services may be delayed for a reasonable period of time.

Last, a physician's level of resources and the costs imposed on the physician to provide language services should be considered when determining what steps the physician should take to comply.

Even though costs may not be considered reasonable when the costs exceed the benefits of providing the language services (e.g. providing on-site interpreter services), physicians should remember that costs may be reduced by technological advances, sharing language assistance materials, use of bilingual staff, pooling resources, standardizing documents, or the use of qualified community volunteers.

**PHYSICIANS WHO RECEIVE FEDERAL FINANCIAL ASSISTANCE AND SERVE NON-ENGLISH SPEAKING PATIENTS ARE REQUIRED TO PROVIDE SOME LEVEL OF LANGUAGE SERVICES.**

## Small practice considerations

OCR recognizes that small practices with tighter budgets can not be expected to provide the same level of language services as larger recipients with larger budgets.

Importantly, HHS uses this same four-part test when evaluating whether physicians are in compliance with Title VI. Services required may include translating certain forms and documents into foreign languages and providing oral interpreter services for patients, either in person or via telephone.

Physicians should inform their LEP patients that they have the option of having an interpreter without charge or of using their own interpreter (e.g. a family member or friend). However, physicians cannot force patients to use their family member or friend as an interpreter.

## Patient-family concerns

Additionally, physicians should remember that family members, especially children, may not be appropriate interpreters because they may not provide quality and accurate interpretations, and privacy and conflict of interest issues may arise.

Importantly, OCR recognizes the possibility of referring a LEP patient to another physician for language assistance, only when there is no discriminatory intent, and it will result in better access for the LEP persons.

For example, it would not be reasonable for a physician to refer a LEP Spanish-speaking patient to another physician without first ensuring that the other physician provides language services for Spanish-speaking patients, has availability, and is in the patient's geographic area.

Physicians in private practice who receive federal financial assistance and serve LEP patients on a regular basis are required to provide some level of language services under Title VI to ensure that they are not discriminating against LEP patients. Keep in mind, there may also be state laws that bear on this situation. As always, it would be wise to consult with your attorney. ◘

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# Practical Matters

# HOW PHYSICIAN ASSISTANTS ENABLE IMPROVED WORKFLOW, PATIENT CARE

*by* **THOMAS E. BAT, MD** *Contributing author*

My 25 years in practice have taught me that primary care profit margins are 3% to 5%, which means that a practice has to both grow and contain costs to remain independent and financially viable. Integrating physician assistants (PAs) into the practice can be key to containing costs, sustaining practice growth, and meeting the demands of a changing healthcare marketplace.

**I HIRED OUR** first PA in 1997, and today employ 12 certified PAs who team up with 18 physicians across five locations, soon expanding to six.

We didn't develop our team-based approach to care overnight, but through collaboration, we developed strategies that have helped us maximize integration of PAs, ensure optimal patient-centered medicine, and become a successful, independent group of physicians.

Our approach has allowed us to grow even in a highly competitive suburban marketplace, where hospitals have been on a physician acquisition spree and where specialists heavily recruit PAs. (According to the National Commission on Certified Physician Assistants [NCCPA], there are currently 96,000 certified PAs, and two-thirds of them are working in specialties outside primary care.)

Nevertheless, we have created a practice environment that both PAs and patients appreciate. This improves employee retention, because being appreciated is the greatest reward we get in primary care. The stability and camaraderie help me and the other MDs in our practice do what we want to do–deliver concierge care without the concierge cost.

PAs help us do that by providing urgent care access six days a week, answering patients' questions daily via our online portal and providing additional access to care and on-site tests.

Patients are more than ready for greater use of PAs. According to a recent NCCPA survey, prompt access to quality healthcare now trumps almost every other major concern among insured Americans– even the economy. As a result, more than 94% of patients are happy to see a PA, according to the survey.

If you haven't yet hired a PA in your practice, I would encourage you to consider precepting a PA student. It's a great way to learn to work with PAs, assess their capabilities, and gauge their fit with your team.

If you've been struggling to find ways to remain autonomous or to grow your practice, now is the time for change. PAs can help make sure that change is the kind you want and need.

## INTEGRATING PAs INTO YOUR PRACTICE

### Flexible scheduling

**The PAs in our practice are not scheduled the first hour, so they can provide acute care for our walk-in appointments.**

### Entrust PAs

**After the opening hour for walk-ins, the PAs have their own daily schedule of patients. They don't do just coughs and colds. They co-manage complex patients with multiple comorbidities with outstanding results.**

### Keep PAs and MDs close

**Our offices are designed to keep the physician/PA team in close proximity. Each hallway functions as a separate office or "pod," with six exam rooms, shared by the physician and PA.**

**This proximity enhances shared decision making. Centralized nurses' stations support multiple pods.**

### Maximize technology

**We have used electronic health records (EHRs) for more than 20 years and an interactive, patient portal for 15 years. Through the EHR, a PA can send an instant message to the physician, ensuring any questions are answered while the patient is still in the office.**

***Thomas E. Bat, MD,*** *is the founder and chief executive officer of North Atlanta Primary Care, P.C. Send your practice management questions to* ***medec@advanstar.com****.*

**BUY OR LEASE?**
Making the decision about medical equipment [34]

Money

# TIME'S UP! Financial incentives are turning into penalties

## Physicians not participating in meaningful use, PQRS should prepare for financial hits

by **JEFFREY BENDIX, MA** *Senior Editor*

### HIGHLIGHTS

**01** Eligible providers not participating in Medicare's electronic prescribing program, the penalties start at 2% in 2015, also plateauing at 5% in 2019.

**02** 2015 will be the first year in which Medicare will begin paying PCPs for the time they spend coordinating the care of patients with multiple complex conditions

Primary care physicians (PCPs), already squeezed by years of stagnant reimbursements and rising overhead costs, will face a new challenge to their bottom lines starting next year. That's when government financial incentives aimed at encouraging physicians to use electronic health records and report quality metrics will turn into penalties.

**IN ADDITION,** two government programs targeted specifically at primary care—the Medicare Primary Care incentive program and the Medicare/Medicaid parity program, are scheduled to expire in the near future. Taken all together, they could add up to a significant drain on practice finances, especially for practices that have chosen not to participate in the Medicare meaningful use (MU) or physician quality reporting system (PQRS.)

On the bright side, however, 2015 will be the first year in which Medicare will begin paying PCPs for the time they spend coordinating the care of patients with multiple complex conditions. (See sidebar, "Paying for

chronic care management.")

The "carrot and stick" policy reflects CMS' long-term goals of encouraging physicians to make greater use of health information technology, and of moving the healthcare system away from rewarding physicians based on the volume of services they perform and towards an emphasis on quality and outcomes.

"If you want to see something happen, you make sure that what you pay for reflects what you'd like to see happen," says Stuart Guterman, vice president, Medicare and cost control at The Commonwealth Fund. "All these efforts are attempts to kind of shift payments at the margins, to send the message that we want to start paying for the things that should be happening in the healthcare system, rather than just continuing to reward providers for doing more complicated stuff."

The payments available to doctors under the meaningful use program, Guterman adds, are designed to create a business case for using health information technology. "And that means, especially at the beginning, overcoming the initial cost of buying the equipment, and the psychic cost of having to change the way you organize your office and practice medicine."

While the actual dollar figures may seem small—especially to a multi-provider practice—sometimes money is only part of the incentive, notes David Harlow, JD, MPH, principal of the Harlow Group consulting firm in Newton, Massachusetts.

"Physicians seem to be motivated by seeing that they're in better compliance than other groups or others within their group," Harlow says. "Even seeing that information without a financial kicker seems to have moved some behavior, so the idea of adding an incentive, or increasing the penalties, does make sense in general terms."

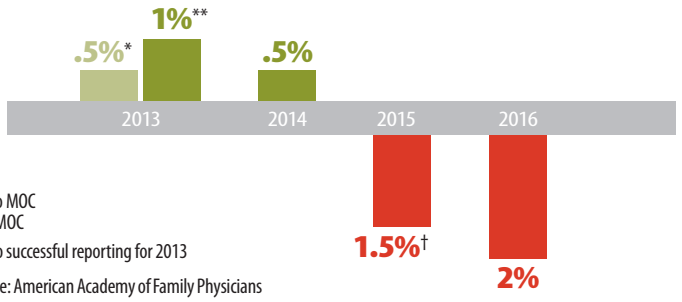
The real question, Harlow says, is whether the actions and behaviors the programs are meant to incentivize are the right ones to actually improve the nation's healthcare systems.

"It does make sense on some basic level that humans are motivated by financial incentives, and the $2.8 trillion question

# Incentives to penalties

## PQRS

Bonuses are available now, but you must start reporting in 2013 to avoid a penalty in 2015.

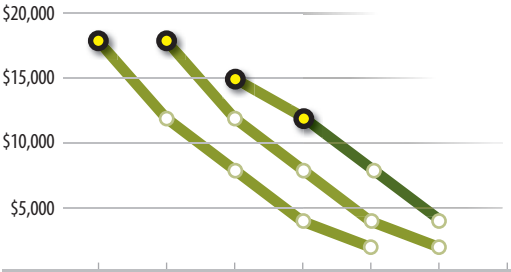



* if no MOC
** if MOC
† if no successful reporting for 2013

Source: American Academy of Family Physicians

## MEANINGFUL USE

### MEDICARE INCENTIVE PAYMENTS

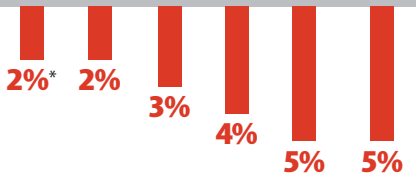



**Maximum totals**

| | |
|---|---|
| 2011 | $44,000 |
| 2012 | $44,000 |
| 2013 | $39,000 |
| 2014 | $24,000 |
| 2015 | $0 |
| 2016 | $0 |

Based on the first calendar year the eligible professional receives payment.

### MEDICARE PENALTIES




% Penalties assume less than 75% of eligible professionals are meaningful users.
*Eligible professional is subject to the penalty for the e-Rx in 2014

**START DATE:** Penalties will begin January 1, 2015

**ANNUAL PENALTY:** 1% per year, cumulative for every year eligible professional is not a meaningful user.

**MAXIMUM CUMULATIVE PENALTY:** 5% per year

Source: Centers for Medicare and Medicaid Services

# PAYING FOR CHRONIC CARE MANAGEMENT

Not all the payment news is bad for PCPs, however.

Beginning next year, the Medicare PFS will include payment for non-face-to-face chronic care management services for patients with two or more significant, chronic conditions. CMS defines chronic care management (CCM) services as including "regular development and revision of a plan of care, communication with other treating health professionals, and medication management." The proposed payment rate is $43.67 for the code, which can be billed no more than once per month per qualified patient.

In addition, CMS is proposing greater flexibility in some of the accompanying requirements to bill for CCM services. That comes as welcome news to the medical societies representing PCPs. For example, the initial proposal essentially required practices to designate a member of the care team to oversee all CCM services and be available for routine appointments, says Shari Erickson, vice president of government and regulatory affairs for the American College of Physicians (ACP).

"We expressed concern, given that there's a variety of approaches practices could take to perform these services, because every practice is unique and has its own patient population," Erickson said. "Now [under the updated proposal] clinical staff time can be shared across any of the staff members in the practice."

While the ACP is encouraged by CMS' moves towards paying separately for non face-to-face care, Erickson says, the college is concerned that the proposed payment amount doesn't reflect all the work needed to prepare a care management plan for patients with multiple, chronic conditions. Based on the guidance CMS provided last year, the amount of time needed would translate into about one relative value unit, or between $75 and $80. "We believe that value and the work associated with it is reasonable and appropriate," she says.

The American Academy of Family Physicians, in an August 26 letter to CMS Administrator Marilyn Tavenner, also endorses the concept of a separate code for billing CCM services, but proposes creating a "risk-adjusted, per-patient per-month care management (PPPM) fee approach" rather than fee-for-service. It proposes having the PPMM fee cover:

- nonphysician staff time dedicated to care management,
- patient education,
- use of advanced technology to support care management,
- physician time dedicated to care management,
- medication management,
- population risk stratification and management, and
- integrated, coordinated care across the healthcare system

is, what are the right incentives? How do we define better care? And that's still a work in progress."

## 1/ Meaningful use

The "stick" that will probably have the biggest impact for most practices comes from not participating in the meaningful use program.

Eligible professionals (EPs) who have not demonstrated meaningful use of electronic health records (EHRs) will face a 1% penalty (or "payment adjustment," in government-speak) in their Medicare reimbursements in 2015. Penalties are due to increase by 1% each year until 2019, when they will plateau at 5%.

For EPs also not participating in Medicare's electronic prescribing program, the penalties start at 2% in 2015, also plateauing at 5% in 2019. In addition, all EPs must continue to demonstrate meaningful use every year through 2019 to avoid penalties. A one-time demonstration is not sufficient.

According to the Centers for Disease Control and Prevention, 78% of office-based physicians were using some form of EHR by the end of 2013, and 69% had applied or planned to apply for meaningful use incentives. Data from the Medical Economics Continuing Survey, meanwhile, show that physicians not using EHRs tend to be in smaller practices with lower income and to be older than age 50.

## 2/ PQRS

The second program due to switch from paying incentives to imposing penalties is the PQRS.

First adopted in 2006, and made permanent in 2008, it has paid doctors bonuses of between 0.5% and 2% of their annual reimbursements for reporting data from their practice on a broad array of quality measures. (Physicians have been eligible for an additional 0.5% incentive payment for participating in a maintenance of certification program.)

Starting next year, however, physicians and practices that had not reported PQRS data by 2013 will be subject to a 1.5% adjustment to their Medicare reimbursements, rising to 2% in 2016. Also beginning in 2015, under the Centers for

> "ALL THESE EFFORTS ARE ... TO SEND THE MESSAGE THAT WE WANT TO START PAYING FOR THE THINGS THAT SHOULD BE HAPPENING IN THE HEALTHCARE SYSTEM."
>
> –STUART GUTERMAN, VICE PRESIDENT OF MEDICARE AND COST CONTROL, THE COMMONWEALTH FUND

Medicare and Medicaid Services' (CMS) Value-based Modifier Program, Medicare reimbursements for group practices consisting of 100 or more EPs that have not reported PQRS data by 2013 will be reduced by an additional 1%.

Groups that have reported PQRS data will either receive a bonus or penalty, or see no change, depending on how they chose to report their data and how they performed under the quality metrics they reported on. Bonuses can range as high as 2%, while penalties can be up to 1% of Medicare reimbursements as specified in Medicare's Physician Fee Schedule (PFS.) Although it's too late for non-participants to avoid the 2015 or 2016 penalties, they can avoid penalties in 2017 by beginning participation next year.

## 3/ Medicaid parity and primary care incentive program

While these financial carrots and sticks will affect physicians across all specialties next year, two other developments—one taking place next year, and the other scheduled for 2016—are of particular concern to PCPs. On January 1, 2015, the two-year program under which Medicaid reimbursements for PCPs were equalized with those of Medicare is scheduled to expire.

Numerous medical societies, including the American Academy of Family Physicians (AAFP), American College of Physicians, and American Osteopathic Association have been lobbying Congress to have the program extended or made permanent. Robert Wergin, MD, FAAFP, incoming AAFP president, says he is optimistic that Congress will act on the societies' request, although it probably won't do so until after the November elections. "I think they understand that improving access to primary care saves money in the long run," he says.

A year later, the Primary Care Incentive Program, under which PCPs are eligible for a bonus equal to 10% of their Medicare reimbursements, is due to expire. Earlier this year the Medicare Payment Advisory Commission recommended replacing it with a per-patient stipend to PCPs for primary care services.

## How your EHR can help you attest to Meaningful Use

**Use the quality metrics dashboard provided by your EHR vendor** Many vendors have a dashboard that tracks quality measures. Follow the instructions provided by the vendor to ensure proper documentation.

**Consider joining a health information exchange** Of the 17 core objectives in Meaningful Use Stage 2, three involve the exchange of electronic health information. This has been a concern for providers because many EHR systems lack interoperability. Health information exchanges (HIE) give members access to a centralized electronic repository where they can send and receive patient continuity of care documents.

**Connect with local hospitals and providers to exchange information** Many physicians site exchanging electronic health information as their biggest concern when attesting to Meaningful Use Stage 2. One solution is to contact your local hospitals and other healthcare providers in your area. Start building a small network with them and discuss other data exchange opportunities.

**Documentation is key** If you accept Meaningful Use money, then you may be audited. A failed audit means giving back incentive money. A primary reason practices fail these audits is because they do not have the documentation to support their attestation numbers.

# Financial Strategies

## MEDICAL EQUIPMENT: SHOULD YOU BUY OR LEASE?

*by* **DREW HAYNES, EA, CHBC** *Contributing author*

One decision often facing medical practice owners is whether to buy or lease equipment. Here are a few points to consider before making your decision.

**THE CLEAR ADVANTAGE** of purchasing your office equipment is that you become the owner of that machine.

This makes the most sense for equipment that you know will last a considerable amount of time and doesn't run the risk of becoming obsolete in the near future. Use your past experience to evaluate how long certain equipment should last.

If you are purchasing a piece of equipment that you don't know much about, ask around to see what other physicians using the same or similar equipment have experienced. As you can imagine, you tend to get a better idea of the quality of a machine from someone that is actually using the device everyday as opposed to someone trying to sell it.

### Short-term costs

Depending on your practice's financial situation, obtaining enough cash to purchase an expensive piece of equipment may be difficult.

Even if you are considering borrowing the money, it can still be tough to come up with enough money for the down payment. I know this is the case with many of the small and mid-sized medical practices that we work with.

This is where working with your accountant or business consultant can help to determine a plan. Maybe you can afford it now or possibly save up over a certain amount of time to purchase it later. However, if it just doesn't make financial sense to purchase the machine, leasing could be a viable option.

There is usually very little initial cash investment, which can be valuable to practices that either lack cash or prefer to reinvest their cash into other areas of the practice.

### Long-term costs

If the equipment is going to last a long time and will require only inexpensive routine maintenance, purchasing the equipment will most likely be better in the long run.

If you just add up the monthly lease payments over the lease term and compare that to the purchase price, you might think it would never make sense to lease. However, what you must consider is that repair and maintenance costs come out of your practice's cash flow when you purchase. I know it is impossible to predict every expense that will be associated with a machine, but this is where asking around can help give you an idea of what kind of upkeep will be necessary.

If you anticipate that there could be some costly repairs in the future, leasing may be the right choice. Make sure you are aware ahead of time what kind of repairs and maintenance costs are included in the lease terms.

It boils down to analyzing your financial situation and weighing the pros and cons of both leasing and purchasing. Take some time at the outset to learn how each scenario could play out. The best decision you can make is an educated one.

### Calculating return on investment

| Equipment purchases or leases | |
|---|---|
| | Determine gross revenues collected |
| | Subtract financing costs |
| | Subtract direct costs to operate equipment |
| | Subtract indirect costs to operate equipment |
| | **Net profit** (or loss) |

***Drew Haynes, EA, CHBC,*** *is an accountant and certified healthcare business consultant with Medical Resources Group, Inc., in Louisville, Kentucky. Send your financial questions to* ***medec@advanstar.com****.*

Trends

# The future of family medicine

## Successful care coordination, business models will hinge on physician collaboration and community-based medicine

by **ALISON RITCHIE** *Content Associate*

### HIGHLIGHTS

**01** For family medicine truly to begin transforming healthcare, family physicians say the patient-centered medical home model must be fully implemented.

**02** Ten years from now, more family physicians likely will look toward practice models that will free them from the administrative headaches tied to traditional fee-for-service payments.

The healthcare landscape is shifting rapidly, and for family physicians, that change is placing increased importance on their role within the system. Family physicians can thrive by embracing high-value, patient-centered care, coordinated among providers with the aid of technology and data exchange.

**REWORKING FAMILY** medicine with this future in mind is a challenge that many physicians are taking on.

"I really believe that all of the things that family physicians have been doing over the years are poised to really be valued and to be core part of a true transformation," says American Academy of Family Physicians (AAFP) President Reid Blackwelder, MD, FAAFP.

That transformation won't occur without growing pains. Right now, health information technology developments have left many providers with enormous amounts of patient data, but lacking an effective way to share it. And in an era of increased consolidation, private-practice physicians are struggling to stay independent and financially viable.

But through increased collaboration and community involvement, physicians are finding innovative solutions to family medi-

cine's biggest challenges and leading the way toward its brighter future.

## COLLABORATION AND COMMUNITY-BASED HEALTHCARE

Wanda Filer, MD, MBA, an AAFP board member, is a family physician at Family First Health, a federally qualified health center with five locations throughout Pennsylvania. She practices alongside nurse practitioners, physician assistants, pediatricians, dentists and behavioral health specialists.

"When I think about team-based care, what it means is the patient can get the care they need, when they need it, by the right person," Filer says.

Recently, a patient came into Filer's practice having been diagnosed with a urinary tract infection (UTI) the night before at a retail clinic. She was first seen by one of the practice's nurses. But when the urinalysis revealed unusual results, Filer was called in to make the diagnosis of an acute gall bladder, rather than a UTI.

It's occurrences like these that make physician-led teams critical to the future of patient care. "Primary care has never been more complex," Filer says. "Between multiple medical conditions and multiple medications, you need that expertise and that level of training to help sort out some of the harder and riskier aspects of care."

Blackwelder says that for family medicine truly to begin transforming healthcare, the patient-centered medical home model (PCMH) must be fully implemented. Under the PCMH model, family physicians will provide care coordination for their patients in a multidisciplinary healthcare system, with ultimate goal of improving patient outcomes and reducing healthcare costs.

But getting there might not be easy, especially at a time when the industry is facing a shortage of family physicians and the financial incentives have yet to align.

Some payers have created bonus payments for PCMH participants, but family physicians are still largely uncompensated for the time they spend developing and coordinating care plans. A report from the Agency for Healthcare Research and Quality concluded that the current fee-for-service payments are not enough for physicians to pay for the additional resources and activities needed in care coordination.

Blackwelder agrees that over the next 10 years, the industry needs to move away from what he calls bullets-for-billing, "where you check a box on a patient form to support billing as opposed to impacting patient care," and move toward value-based payment models.

> "IF WE CAN WORK THROUGH THE ATTRIBUTION ISSUES, PAYMENT AND IT, WE WILL HAVE A SYSTEM THAT'S FAR MORE PATIENT-FOCUSED."
>
> — WANDA FILER, MD, MBA, AAFP BOARD MEMBER AND FAMILY PHYSICIAN, FAMILY FIRST HEALTH, PENNSYLVANIA

But it also remains unclear if the PCMH model will lead to the healthcare costs reductions that it promised. Established medical homes across the country have touted their success. According to the Patient-Centered Primary Care Collaborative, Capital Health Plan in Tallahassee, Florida, had 40% fewer inpatient stays and 37% fewer emergency department (ED) visits under the model.

Other research has called the cost savings into question, however. A 2014 study published in the *Journal of the American Medical Association* found that a PCMH pilot in southeastern Pennsylvania was unable to lower costs over the course of three years.

But regardless of the model used, Blackwelder says the industry's future success will depend largely upon provider collaboration.

"That will be the wave of the future," Blackwelder says. "Nobody is alone. No one is isolated. No one is siloed. We can't afford that. We have to get comfortable sharing information, recognizing that many different parts of the patient-centered home can provide care, and how we coordinate those so we don't duplicate efforts."

While the PCMH model can provide care coordination within a defined practice setting, for large-scale collaborative care to occur, a significant hurdle remains: electronic health record (EHR) interoperability.

## OVERCOMING INTEROPERABILITY CHALLENGES

For many physicians, the implementation of EHRs and other office-based technology has been more hindrance than help. But one city in Indiana has successfully broken the interoperability barrier.

"South Bend has been this quiet, little college town that is at least a decade ahead of everybody else," says Chris Zaenger, CHBC, president of Z Management Group and a *Medical Economics* editorial consultant. "The reason they are is largely because there is a spirit of cooperation among the physicians, the three hospitals in town and [one of] the largest laboratories in town."

What sets this region apart is the ability of family physicians to exchange patient

data seamlessly and coordinate care with the other healthcare providers in their area.

"We have a central community repository, where any provider in the community, regardless of their electronic health record, can see the lab information on the patient, any hospital encounter, and any other encounters that have been shared," says Tim Roberts, chief executive officer of the Michiana Health Information Network (MHIN), South Bend's health information exchange (HIE) network.

Since its founding in 1999, MHIN has served more than 1,500 providers in the northern Indiana and southern Michigan region. Recently, MHIN introduced a new feature to its network that enables a family physician to receive real-time alerts when a patient visits the ED or is discharged from the hospital. This allows the provider to contact the patient and schedule a follow-up appointment.

Although the majority of the providers in their network use Cerner for their EHR system, Roberts says the program's initial challenge wasn't implementing new technology. Instead, it was persuading healthcare providers to breakdown their silos.

"When it comes to [HIE], the technology, while it's difficult, it's probably the easier thing to do," says Roberts. "The difficult thing is getting a group of providers to come together and share a vision of how they want to improve patient care in a community and not compete on data. It took this community about five years to get everyone to buy-in to that vision, but once you get over that hurdle, everything else moves quickly."

But for family physicians still grappling to communicate with other providers in their area, interoperability can't come soon enough. "The lack of interoperability is probably more frustrating than having a paper chart," Filer says. "We know what it could be, and we've been sold this story. There's a lot of frustration and anger in my colleagues across the country. They have invested important, scarce dollar resources in practices, and they're not getting what they paid for."

In June, the Office of the National Coordinator for Health Information Technology (ONC) released its plan to achieve interoperability nationwide by 2024. Filer, who is on her fourth EHR system, says vendors will need to collaborate in order to drive progress.

> "SMALL PHYSICIAN PRACTICES ARE REALLY STRUGGLING ... THE PEOPLE WHO ARE GOING TO REMAIN INDEPENDENT ARE GOING TO DO IT IN A DIRECT-PAY MODEL."
>
> — RYAN NEUHOFEL DO, MPH, NEUCARE FAMILY MEDICINE, LAWRENCE, KANSAS

Some states, such as Massachusetts, are pushing for state-based HIE networks, but Zaenger says he believes South Bend's model is best replicated on a smaller scale.

"We could do this kind of stuff on a small community level, if we could get everybody on the same page and then move forward," he says. "I can tell you that my discussions with doctors today about EMR [electronic medical records] are not about whether you like the product or not. It's about, can you send a message to your specialist? Can you receive one? Can you communicate and download data from a hospital?"

## EMERGING PRACTICE MODELS

Ten years from now, more family physicians likely will look toward practice models that free them from the administrative headaches tied to traditional fee-for-service payments.

After completing residency in 2011, Ryan Neuhofel DO, MPH, opened NeuCare Family Medicine, in Lawrence, Kansas. His practice operates under a direct-pay model, where for a membership fee, Neuhofel provides his patients with same-day visits, point-of-care testing, house calls, video consultations, and other primary care services.

While practices that operate under fee-for-service models may cram their appointment schedule to boost their bottom line, Neuhofel sees an average of six to eight patients per day, and his appointments last much longer than the typical visit. His appointments usually last 30 to 45 minutes, but they can go up to an hour for new patients or those with chronic illnesses.

Neuhofel says he knew even in medical school that an insurance-based model wasn't for him.

"I came into the healthcare system very naïve," Neuhofel says. "I realized very early on that the system was broken and that doctors and patients were both very dissatisfied with the ways things were done."

"I had invested a lot of time and money in becoming a doctor, and I still wanted to be one, but I just did not see myself being happy long-term in any of those traditional options that were available."

By avoiding the challenges associate with insurance, Neuhofel says he's able to lower his overhead costs by about half when compared to a traditional family practice.

# Building a successful PCMH

Achieving the goals of the patient-centered medical home model requires aligning three vital components

1

## Health information technology

**Health information technology (IT) can support the PCMH model by collecting, storing, and managing personal health information, as well as aggregating data that can be used to improve processes and outcomes. Health IT also can support communication, clinical decision making, and patient self-management.**

2

## Workforce

**A strong primary care workforce including physicians, physician assistants, nurses, medical assistants, nutritionists, social workers, and care managers is a critical element of the PCMH model. Amid a primary care workforce shortage, it is imperative to develop a workforce trained to provide care based on the elements of the PCMH.**

3

## Finance

**Current fee-for-service payment policies are inadequate for achieving PCMH goals. Providers are not routinely compensated for care coordination or enhanced access, contributions of the full team are often not reimbursed, and there is no incentive to reduce duplication of services across the care continuum. Payment reform is needed to achieve the PCMH potential.**

Source: Agency for Healthcare Research and Quality

As the industry heads toward increased regulation and hospital consolidation, the direct-pay model may provide an alterative for family physicians to maintain independent practice.

"[Physicians] don't want to be employed. They want to maintain their autonomy," says Neuhofel. "But because of the administrative and regulatory burden, I fear that's not going to be possible and feasible long term to have a solo or small practice in an insurance-based world.

"The hospitals can absorb some of that administrative burden," he adds. "But small physician practices are really struggling. I think there's going to be a division. I think the people who are going to remain independent are going to do it in a direct model."

While this model offers an exciting and disruptive approach, practice management consultant Owen Dahl, MBA, FACHE, cautions that it's not a good fit for every market. If an area has a large number of primary care providers, it may be a challenge to get patients who are willing to pay the membership fee, in addition to their insurance premiums.

"If anyone is seriously considering it, they need to take a deep look at their current practice pattern and see what's going on," Dahl says. He recommends family physicians make small operational changes in their practice to increase efficiency. For example, direct contracts with local employers to perform annual employee wellness visits for could help primary care physicians regain some of the market frequently lost to retail clinics.

## LOOKING TO THE FUTURE

As a family physician caring for patients from newborns to the elderly, Filer jokes that she will never be without a job. For practicing physicians, it's a time of great change, but Filer says the future looks bright.

"If we can work through the attribution issues, payment and IT, we will have a system that's far more patient focused," she says.

Although the path to get there may be fraught with challenges, Blackwelder says he's confident that the value of the family physician as a thorough and comprehensive care provider will not go unnoticed.

"By the time we look at the future there will be a strong recognition of the family physician and their role," Blackwelder says.

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# The Last Word

# POSITIVE PATIENT EXPERIENCE LINKED TO QUALITY MEASURE IMPROVEMENTS

*by* **JEFFREY BENDIX, MA** *Senior Editor*

Leaving your patients with a good feeling about their office visit may not just help your reviews on websites like Yelp and Healthgrades.com. It could also result in better patient outcomes.

**AS AMERICANS** increasingly use online rankings and reviews when choosing a healthcare provider, a new study suggests a link between the way patients experience their care and other measures of healthcare quality, including adherence, clinical outcomes and patient safety while in a hospital.

The study, published online in Health Care Research and Review, analyzes literature on the association between patient experience measures and other healthcare quality measures. The authors focus on articles that use results of the Consumer Assessments of Healthcare Providers and Systems (CAHPS) and the CAHPS hospital survey, which are considered the most widely used source of patient experience measures. They define "patient experiences" as "any process observable by patients, including subjective experiences, objective experiences and observations of physician, nurse or staff behavior."

According to Rebecca Anhang Price, Ph.D., the study's lead author, about two-thirds of the studies reported findings from surveys regarding experiences of outpatient care, with most of those evaluating the relationship between care experiences and patient behaviors, such as adherence to provider recommendations, and processes of care, including adherence to clinical guidelines. "Our findings regarding the relationship between care experiences and clinical outcomes are largely informed by studies in the inpatient setting," Price adds.

The authors divide their findings into five categories: patient behavior, clinical processes, clinical outcomes, efficiency and safety. In patient behavior they found studies showing that better provider communication is positively associated with adherence to hypoglycemic medications among patients with diabetes, better diabetes self-management among veterans, improved adherence to hypertension medications among African-American patients and to tamoxifen among breast cancer patients.

In the clinical processes category, patients' ratings of their hospitals are positively associated with the hospitals' performance on the Centers for Medicare and Medicaid Services' process measures for pneumonia, congestive heart failure, acute myocardial infarction (AMI) and surgical care.

Under clinical outcomes, the authors cite a pair of studies showing that, controlling for other factors, patient reports of better patient-centered care have a significant association with better survival one year after discharge for AMI treatment, and higher patient ratings of hospitals were associated with lower hospital inpatient mortality rates among AMI patients.

In the category of efficiency, the authors find that "some aspects of patient-centered care may help to reduce unnecessary healthcare use." For example, they cite a study showing that patients' ratings of their hospitals' care and discharge planning were associated with lower 30-day readmission rates for AMI, heart failure and pneumonia. Another study showed that children whose parents report longer waits for primary care visits were more likely to have emergency department visits for non-urgent reasons.

When it comes to safety, the authors say, positive patient experiences have been associated with lower prevalence of patient care complications such as pressure ulcers, post-operative respiratory failure and pulmonary embolism.

The authors conclude by noting that the studies they reviewed "reveal no inherent trade-off between strong performance on patient experience indicators and performance on clinical quality measures."

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