Medical Economics®

SMARTER BUSINESS. BETTER PATIENT CARE.

MedicalEconomics.com

NOVEMBER 25, 2014
VOL. 91 NO. 22

CODE WITH CONFIDENCE

Optimize your coding strategy for 2015

PAGE 17

ADVANSTAR
MEDICAL COMMUNICATIONS GROUP

OPIOIDS WITH ABUSE-DETERRENT PROPERTIES WON'T STOP ALL ABUSE

BUT THEY'RE A RESPONSIBLE PLACE TO START

Products with abuse-deterrent properties can't do it all, but they can make the opioids you prescribe harder to abuse—and make all clinicians part of the solution to prescription opioid abuse.

Do you know the percentage of prescription analgesics abusers get for free from friends or family members for non-medical use? The answer might surprise you.

GO *to responsibleopioidrx.com to learn more.*

PURDUE

Twitter Talk

Other people and organizations tweeting about issues that matter to you

RICHARD VAUGHN MD
@RVAUGHNMD
Good read. "smallest independent primary care practices, physician owned, provide better care at lower overall cost" http://bit.ly/1qNNnm0

MOUNT SINAI HOSPITAL
@MOUNTSINAINYC
#Obesity is one of the most important risk factors for #cancer, second to tobacco" - Dr. Paolo Boffetta @ TischCancer http://bit.ly/1u0rM3i

STEPHEN SCHIMPFF, MD
@DRSCHIMPFF
Physician frustration is rampant but lets reframe the resolution question http://bit.ly/1s1rcyk #primarycare

A. PATRICK JONAS, MD
@APJONAS
Report: Recruiters have trouble filling primary care openings http://sbne.ws/r/q85a #FMREVOLUTION

join us online

facebook.com/MedicalEconomics
twitter.com/MedEconomics

PART OF THE ModernMedicine NETWORK

Medical Economics is part of the ModernMedicine Network, a Web-based portal for health professionals offering best-in-class content and tools in a rewarding and easy-to-use environment for knowledge-sharing among members of our community.

Medical Economics®

SMARTER BUSINESS. BETTER PATIENT CARE.

GEORGIANN DeCENZO **Executive Vice President**
440-891-2778 / gdecenzo@advanstar.com

KEN SYLVIA **Vice President, Group Publisher**
732-346-3017 / ksylvia@advanstar.com

DAVID A. DePINHO **Publisher/Group Editor**
732-346-3053 / ddepinho@advanstar.com

PUBLISHING & SALES

MONIQUE MICHOWSKI
National Account Manager
732-346-3098 / mmichowski@advanstar.com

ANA SANTISO
National Account Manager
732-346-3032 / asantiso@advanstar.com

MARGIE JAXEL
Director of Business Development, Healthcare Technology Sales
732-346-3003 / mjaxel@advanstar.com

TOD McCLOSKEY
Account Manager, Display/Classified & Healthcare Technology
440-891-2621 / tmccloskey@advanstar.com

JOANNA SHIPPOLI
Account Manager, Recruitment Advertising
440-891-2615 / jshippoli@advanstar.com

DON BERMAN
Business Director, eMedia
212-951-6745 / dberman@advanstar.com

MEG BENSON
Special Projects Director
732-346-3039 / mbenson@advanstar.com

GAIL KAYE
Director of Marketing & Research Services
732-346-3042 / gkaye@advanstar.com

HANNAH CURIS
Sales Support

RENÉE SCHUSTER
List Account Executive
440-891-2613 / rschuster@advanstar.com

MAUREEN CANNON
Permissions
440-891-2742 / mcannon@advanstar.com

EDITORIAL

GEORGE G. ELLIS JR., MD, FACP
Chief Medical Adviser

JEFFREY BENDIX, MA
Senior Editor
440-891-2684 / jbendix@advanstar.com

CHRIS MAZZOLINI, MS
Content Manager
440-891-2797 / cmazzolini@advanstar.com

DONNA MARBURY, MS
Content Specialist
440-891-2607 / dmarbury@advanstar.com

ALISON RITCHIE
Content Associate
440-891-2601/aritchie@advanstar.com

KEN TERRY
GAIL GARFINKEL WEISS
Contributing Editors

ART

ROBERT McGARR
Group Art Director
440-891-2628 / rmcgarr@advanstar.com

PRODUCTION

KAREN LENZEN
Senior Production Manager

AUDIENCE DEVELOPMENT

JOY PUZZO **Corporate Director**
CHRISTINE SHAPPELL **Director**
JOE MARTIN **Manager**

REPRINTS
877-652-5295 ext. 121 / bkolb@wrightsmedia.com
Outside US, UK, direct dial: 281-419-5725. Ext. 121

ADVANSTAR

JOE LOGGIA
Chief Executive Officer

TOM EHARDT
Executive Vice President, Chief Administrative Officer & Chief Financial Officer

GEORGIANN DeCENZO
Executive Vice President

CHRIS DeMOULIN
Executive Vice President

REBECCA EVANGELOU
Executive Vice President, Business Systems

JULIE MOLLESTON
Executive Vice President, Human Resources

TRACY HARRIS
Senior Vice President

DAVE ESOLA
Vice President, General Manager Pharm/Science Group

MICHAEL BERNSTEIN
Vice President, Legal

FRANCIS HEID
Vice President, Media Operations

ADELE HARTWICK
Vice President, Treasurer & Controller

Customer service 877-922-2022 **Advertising** 732-596-0276 **Back Issues** 218-740-6477
Editorial 800-225-4569 **Classifieds** 800-225-4569 **Reprints** 877-652-5295, ext. 121
Subscription Correspondence *Medical Economics*, P.O. Box 6085, Duluth, MN 55806-6085

Referenced in MedLine®

Medical Economics®
SMARTER BUSINESS. BETTER PATIENT CARE.

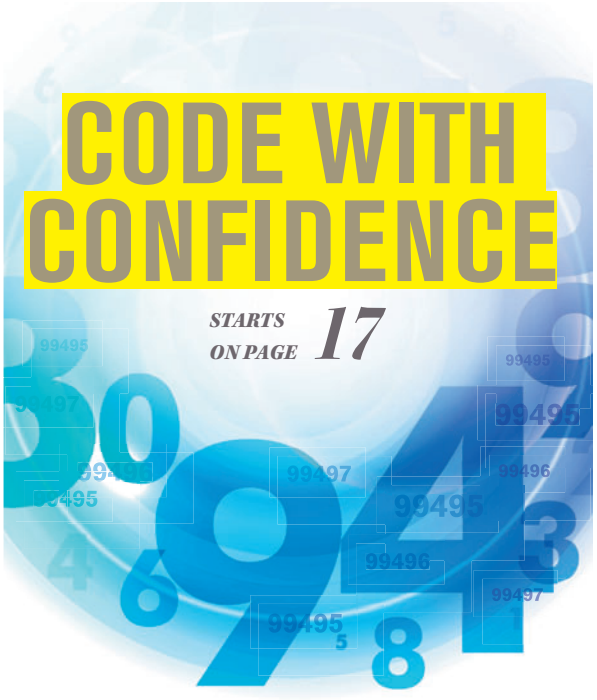
NOVEMBER 25, 2014

Volume 91
Issue 22

COLUMNS

MISSION STATEMENT

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



COVER STORY | MONEY

How to optimize your coding strategy for 2015.

STARTS ON PAGE 17

- Proper coding for transitional and chronic care management
- E/M visits: Billing the correct level of care

IN DEPTH

Money $

Operations

Trends *

Policy

MEDICAL ECONOMICS *(USPS 337-480) (Print ISSN: 0025-7206, Digital ISSN: 2150-7155) is published semimonthly (24 times a year) by Advanstar Communications Inc., 131 W. First St., Duluth, MN 55802-2065. Subscription rates: one year $95, two years $180 in the United States & Possessions, $150 for one year in Canada and Mexico, all other countries $150 for one year. Singles copies (prepaid only): $18 in US, $22 in Canada & Mexico, and $24 in all other countries. Include $6.50 for U.S. shipping and handling. Periodicals postage paid at Duluth, MN 55806 and at additional mailing offices. Postmaster: Send address changes to Medical Economics, PO Box 6085, Duluth, MN 55806-6085. Canadian GST Number: R-124213133RT001 Publications Mail Agreement number 40612608. Return undeliverable Canadian addresses to: IMEX Global Solutions, PO Box 25542 London, ON N6C 6B2 CANADA. Printed in the USA.*

Cover: Getty Images/iStock/360/Vastas

The board members and consultants contribute expertise and analysis that help shape the content of Medical Economics.

PAGE 39

"Take some time to brush up on evaluation and management coding and perform a self audit."

—**Renee Dowling** CODING CONSULTANT

EDITORIAL BOARD

Mary Ann Bauman, MD
Internal Medicine
Oklahoma City, OK

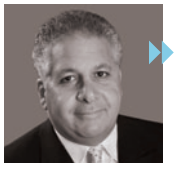
Elizabeth A. Pector, MD
Family Medicine
Naperville, IL

John L. Bender, MD
Family Medicine
Ft. Collins, CO

Patricia J. Roy, DO
Family Medicine
Muskegon, MI

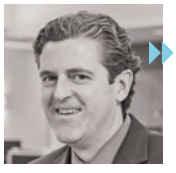
Maria Y. Chandler, MD, MBA
Business of Medicine, Pediatrics
Irvine, CA

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



George G. Ellis Jr., MD
Internal Medicine
Youngstown, OH

Salvatore S. Volpe, MD
Internal Medicine-Pediatrics
Staten Island, NY



David C. Judge, MD
Internal Medicine
Cambridge, MA

Craig M. Wax, DO
Family Medicine
Mullica Hill, NJ

Jeffrey M. Kagan, MD
Internal Medicine
Newington, CT

ask us

Have a question for our advisers? Email your question to **medec@advanstar.com**.

EDITORIAL CONSULTANTS

PRACTICE MANAGEMENT

Judy Bee
www.ppgconsulting.com
La Jolla, CA

Keith Borglum, CHBC
Professional Management and Marketing
Santa Rosa, CA

Kenneth Bowden, CHBC
Berkshire Professional Management
Pittsfield, MA

Michael D. Brown, CHBC
Health Care Economics Indianapolis, IN

Frank Cohen, MPA
www.frankcohengroup.com
Clearwater, FL

Virginia Martin, CMA, CPC, CHCO, CHBC
Healthcare Consulting Associates
of N.W. Ohio Inc. Waterville, OH

Rosemarie Nelson
MGMA Healthcare Consultant Syracuse, NY

Mark D. Scroggins, CPA, CHBC
Clayton L. Scroggins Associates Inc.
Cincinnati, OH

Gray Tuttle Jr., CHBC
The Rehmann Group Lansing, MI

Michael J. Wiley, CHBC
Healthcare Management
and Consulting Services Bay Shore, NY

H. Christopher Zaenger, CHBC
Z Management Group Barrington, IL

Karen Zupko
Karen Zupko & Associates Chicago, IL

TAXES & PERSONAL FINANCE

Lewis J. Altfest, CFP, CPA
Altfest Personal Wealth Management
New York City

Robert G. Baldassari, CPA
Matthews, Carter and Boyce Fairfax, VA

Todd D. Bramson, CFP
North Star Resource Group Madison, WI

Glenn S. Daily, CFP
Insurance consultant New York City

Barry Oliver, CPA, PFS
Thomas, Wirig, Doll & Co.
Capital Performance Advisors
Walnut Creek, CA

Gary H. Schatsky, JD
IFC Personal Money Managers New York City

David J. Schiller, JD
Schiller Law Associates Norristown, PA

Edward A. Slott, CPA
E. Slott & Co. Rockville Centre, NY

HEALTH LAW & MALPRACTICE

Barry B. Cepelewicz, MD, JD
Garfunkel Wild, PC Stamford, CT

John M. Fitzpatrick, JD
Wheeler Trigg Kennedy, LLP Denver, CO

Alice G. Gosfield, JD
Alice G. Gosfield and Associates
Philadelphia, PA

James Lewis Griffith Sr., JD
Fox Rothschild Philadelphia, PA

Lee J. Johnson, JD
Mount Kisco, NY

Lawrence W. Vernaglia, JD, MPH
Foley & Lardner, LLP Boston, MA

HMG-CoA reductase is part of the LDL-C metabolism story[1]

But PCSK9 also plays an important role in LDL-C regulation[2]

New pathway discoveries are uniting the cholesterol conversation.

By inhibiting HMG-CoA reductase and reducing cholesterol biosynthesis, statins help lower LDL-C.[1] PCSK9, another important protein involved in cholesterol metabolism, promotes degradation of the LDL receptor, thereby increasing LDL-C levels.[2] **In discussions of cholesterol metabolism, the roles of HMG-CoA reductase and PCSK9 should go hand in hand.**

Join the conversation at **DiscoverPCSK9.com**.

HMG-CoA = 3-hydroxy-3-methylglutaryl coenzyme A; **PCSK9** = proprotein convertase subtilisin/kexin type 9; **LDL-C** = low-density lipoprotein cholesterol.

References: 1. Toth PP. *Drugs*. 2010;70;1363-1379. **2.** Zhang D, Lagace TA, Garuti R, et al. *J Biol Chem*. 2007;282:18602-18612.

AMGEN®

Cardiovascular

ONLINE EXCLUSIVE

FEDERAL HEALTH PROGRAMS FACE FUNDING CUT

A broad coalition of more than 100 healthcare organizations has written to Congressional leaders urging them to avoid a 'primary care cliff' by maintaining funding sources for a variety of healthcare-related programs, including the National Health Services Corps, Teaching Health Centers, and Community Health Centers, that are due to expire at the end of the year. Find details at http://bit.ly/10FCD3Q

Immunization resource center

Stay up-to-date with the latest developments in immunization and vaccination therapies at **MedicalEconomics.com/immunization**

Top Headlines Now @ME*online*

#1 MEDICAL SOCIETIES LOBBY TO EXTEND MEDICAID PAYMENT PARITY
Groups ask Congress for two-year extension of funding. Learn more at http://bit.ly/1rHigZl

#2 CCHIT TO CLOSE UP SHOP
The Certification Commission for Healthcare Information Technology says future is too uncertain. Details at http://bit.ly/1u2rqq2

#3 DESALVO TO WORK TWO JOBS
Former ONC director will continue leadership there while working with Ebola response team. See the full story at http://bit.ly/1wEPMWm

Twitter Talk

Follow us on Twitter to receive the latest news and participate in the discussion.

ELECTRONIC DATA TRANSFER
#ONC promises healthcare interoperability by 2024 http://ow.ly/Dfdny

HOSPITAL READMISSIONS
RT @cmio: Regarding readmissions, one healthcare leader says hospitals are missing the obvious http://ift.tt/1DFhFQg

EBOLA TREATMENT
#WorldHealthOrganization (#WHO) plans on speeding up development & deployment of experimental #Ebolavaccines http://ow.ly/Do52y

AFFORDABLE CARE ACT
ICYMI: Doctor's feeling more positive about #ACA in 2014 http://ow.ly/Dfjak

FLU TREATMENT
#Fluseason is beginning. Here's what you need to know http://ow.ly/Ddvj8

OPIOID USE
An estimated 27 million patients in the United States take #opioids for #chronic pain. http://ow.ly/DySUR

FDA DRUG APPROVALS
Here's a list of #FDA #drugapprovals and indications http://ow.ly/DyRW2

join us online

facebook.com/MedicalEconomics
twitter.com/MedEconomics

from the Trenches

> Not only is our valuable time, for which we get paid, going to waste, but we are so hampered by these [electronic health record] systems that effectively the number of patients we are able to serve in one day is significantly reduced. That…translates into poorer care for those we do see and denied access to care for those we don't.
>
> **William M. Gilkison, MD,** GREENWOOD, INDIANA

GOOD MEDICAL CARE REQUIRES PHYSICAL CONTACT WITH PATIENT

After reading Jeffrey Bendix's article, "Technology Opens New Avenues for Patient Communication" in your October 10 issue, I feel that anyone's enthusiasm for video visits and e-visits should be dampened by the lack of physical contact between doctor and patient. Inevitably patients will suffer and malpractice lawyers will be busy as a result.

Call me old-fashioned, but physical exam is important in diagnosis and treatment of disease.

Rosalind Shorenstein, MD, FACP
SANTA CRUZ, CALIFORNIA

EHRs MAKE NO SENSE FINANCIALLY FOR DOCTORS

On page 16 of your October 10, 2014, issue was an article with the headline, "Physician Survey: EHR Waste 48 Minutes Daily."

The article states a survey by the American College of Physicians found that "every respondent reported losing some time each day because of EHR [electronic health record] use," and that the "mean loss for attending physicians was 48 minutes." That disturbingly means that more than half of the respondents lost MORE than 48 minutes a day. That really bothers me.

Not only is our valuable time, for which we get paid, going to waste, but we are so hampered by these systems that effectively the number of patients we are able to serve in one day is significantly reduced. That, to me, translates into poorer care for those we do see and denied access to care for those we don't. We are forced to spend more time focusing on the computer and less time communicating with our patients.

Physician productivity has been severely impacted by EHRs as this survey so accurately displays. Before EHRs, I could easily see 32-36 patients a day. After implementation of an EHR that number dropped to 25-28 on a good day.

The really disturbing rub in all this is the effect on a practice's bottom line. Forty-eight minutes translates into seeing four to six fewer patients a day which then translates into hundreds of dollars in lost revenue. And for all this great technology you only have to spend $25,000 per doctor outright and pay God-know-how-much monthly to "support" the system. And we all know how reimbursement has declined over the years.

This whole scenario makes no financial sense to me. It leads hard-working solo practitioners like me to throw in the towel and become an employee of a practice entity, or retire as I did.

Continued on page 14

> Like Pavlovian dogs, many physicians have been conditioned over the past 50 years to see the threat of malpractice hovering over almost every patient that they see. Defensive medicine is no longer just a reaction, it has become ingrained in the minds of most doctors and many consider defensive medicine...as the standard of care.

Edward Volpintesta, MD, BETHEL, CONNECTICUT

SIGNUP

To subscribe to eConsult go to medicaleconomics.modernmedicine.com/medical-economics/enewssignup

TELL US

medec@advanstar.com

Or mail to:
Letters Editor, Medical Economics, 24950 Country Club Boulevard, Suite 200, North Olmsted, Ohio 44070. Include your address and daytime phone number.

Letters may be edited for length and style. Unless you specify otherwise, we'll assume your letter is for publication. Submission of a letter or e-mail constitutes permission for Medical Economics, its licensees, and its assignees to use it in the journal's various print and electronic publications and in collections, revisions, and any other form of media.

Continued from page 7

So the conclusions of this alarming study should really upset us as they do me.

The one's who really suffer, though, are those patients we could see in those 48+ minutes who are told we have no appointment times. It's a darn shame. Suggestions are made to employ a scribe, which is a good idea, but I can't recall there being any CPT [current procedural terminology] codes for the work of a scribe. Are there?

Oh, well. It's the way of today's medical world like it or not. EHRs and their proponents are well-intentioned, but computers do intrude on our ability to provide good care and service to our patients. I fail to see how they bring about better care other than if effective interoperablity can be accomplished. To excess, they document data adequately and accurately if input is correct. But they will never be able to replace the human factor so important in the doctor-patient relationship.

William M. Gilkison MD
GREENWOOD, INDIANA

DEFENSIVE MEDICINE HAS BECOME STANDARD OF CARE FOR MANY DOCTORS

Re your article, "Does malpractice reform reduce defensive medicine practice?" (*Medical Economics eConsult,* October 17, 2014):

I am not surprised that easing malpractice standards did not change defensive medical practices.

Like Pavlovian dogs, many physicians have been conditioned over the past 50 years to see the threat of malpractice hovering over almost every patient that they see.

Defensive medicine is no longer just a reaction, it has become ingrained in the minds of most doctors and many consider defensive medicine for all practical purposes as the standard of care.

As heretical as that sounds, the point is that bad habits are hard to break and it is not surprising, in fact it is to be expected emergency rooms have not seen much change in defensive medicine.

A new way of dealing with malpractice suits is needed, one that compensates patients fairly but at the same time treats physicians fairly as well for the current system has too many loopholes that permit frivolous suits and force physicians to practice defensively.

Special health courts have been discussed and should be given more attention by lawmakers.

Edward Volpintesta, MD
BETHEL, CONNECTICUT

CMS ACO INITIATIVE TO BOOST CARE IN UNDERSERVED AREAS

A new initiative by the Centers for Medicare and Medicaid Services (CMS) will make it easier for small, rural accountable care organizations (ACOs) to succeed.

CMS says the program, called the ACO Investment Model, will provide up to $114 million in funding for as many as 75 ACOs, targeting rural and underserved areas across the country. CMS says the upfront funding will allow these ACOs to invest in the infrastructure needed to better coordinate care.

For ACOs that joined the Medicare Shared Savings Program in 2012 or 2013, the application deadline is December 1. For those who joined in 2014 or plan to join in 2016, applications will be available in the summer of 2015. Visit CMS' ACO Investment Model website for application details.

CMS touts the Pioneer ACO Model and the Medicare Shared Savings Program as having saved Medicare more than $372 million. However, recent data released by CMS shows that some of the ACOs within its Pioneer program struggled to achieve savings.

STUDY: PRACTICE CONSOLIDATION, HOSPITAL OWNERSHIP DRIVES UP COSTS OF CARE

Small, private practices are increasingly merging with larger healthcare organizations, but two new studies show that less competition and increased hospital ownership of practices may lead to higher healthcare costs.

The first study, conducted by researchers at the University of California, looked at the total expenditures of 4.5 million patients in California covered by a commercial health maintenance organization from 2009 to 2012. The costs included professional, hospital, laboratory, pharmaceutical, and ancillary services. It found that the average total expenditures per patient were 10.3% higher for hospital-owned practices and 19.8% higher for health system-owned practices than those at physician-owned practices.

The second study examined the costs of 10 types of office visits in 1,058 counties across the United States. Researchers at Stanford University used the Hirschman Herfindahl Index to determine the level of competition within the counties. They found that in the least-competitive markets, private provider organizations paid 8.3% to 16.1% more for the same service.

Both studies were published in the Journal of the American Medical Association.

> "We saw substantial amounts of concentration in the markets we studied, which raises concerns about potentially harmful implications for consumers. Higher health care spending due to increased prices paid to physicians without accompanying improvements in quality, satisfaction, or outcomes would generate inefficiency in the health care system."

WHAT PHYSICIANS NEED TO KNOW

EBOLA

INFECTION IS RARE

INCUBATION PERIOD

UP TO **21** DAYS

Ebola is not contagious during the incubation period.

Ebola can be spread only through direct contact with the blood or bodily fluids of someone with the disease, with objects contaminated with the virus, or with infected animals.*

RISK OF EXPOSURE

HIGH comes from percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids, and direct contact with a dead body in an Ebola-affected area without appropriate personal protective equipment (PPE)*

LOW These are brief contact with an Ebola patient (e.g., shaking hands) and exposure to a patient without appropriate PPE. People also can become sick with Ebola after coming in contact with infected wildlife.

*According to the Centers for Disease Control and Prevention (CDC)

The latest outbreak Has been spreading through the West African countries of Guinea, Liberia, Sierra Leone, and Nigeria beginning in March 2014.

Ebola is a hemorrhagic fever thought to come from bats.

DISCOVERED IN **1976**

5 MAJOR OUTBREAKS

6,500 DEATHS

SYMPTOMS*

FEVER HIGHER THAN **101.5° F** (38.6° C)

- Severe headache
- Muscle pain
- Weakness
- Diarrhea
- Vomiting
- Abdominal pain
- Unexplained hemorrhage

Symptoms usually appear eight to 10 days after exposure, but can present anywhere from two to 21 days.

	2	3	4	5	6	7
8	**9**	**10**	11	12	13	14
15	16	17	18	19	20	21

HEALTHCARE WORKERS are in a unique position to separate the facts from the fears concerning the Ebola virus in the United States. Make sure you and your staff members are educated about the virus and able to answer any questions from patients, and are prepared in the unlikely event of an Ebola case in your practice.

Changes and updates to safety protocols will be posted first on the CDC website, so make sure a staff member is designated to check the website regularly. The website also features printable infographics and posters that can be used to train your staff about handling patients who might have Ebola.

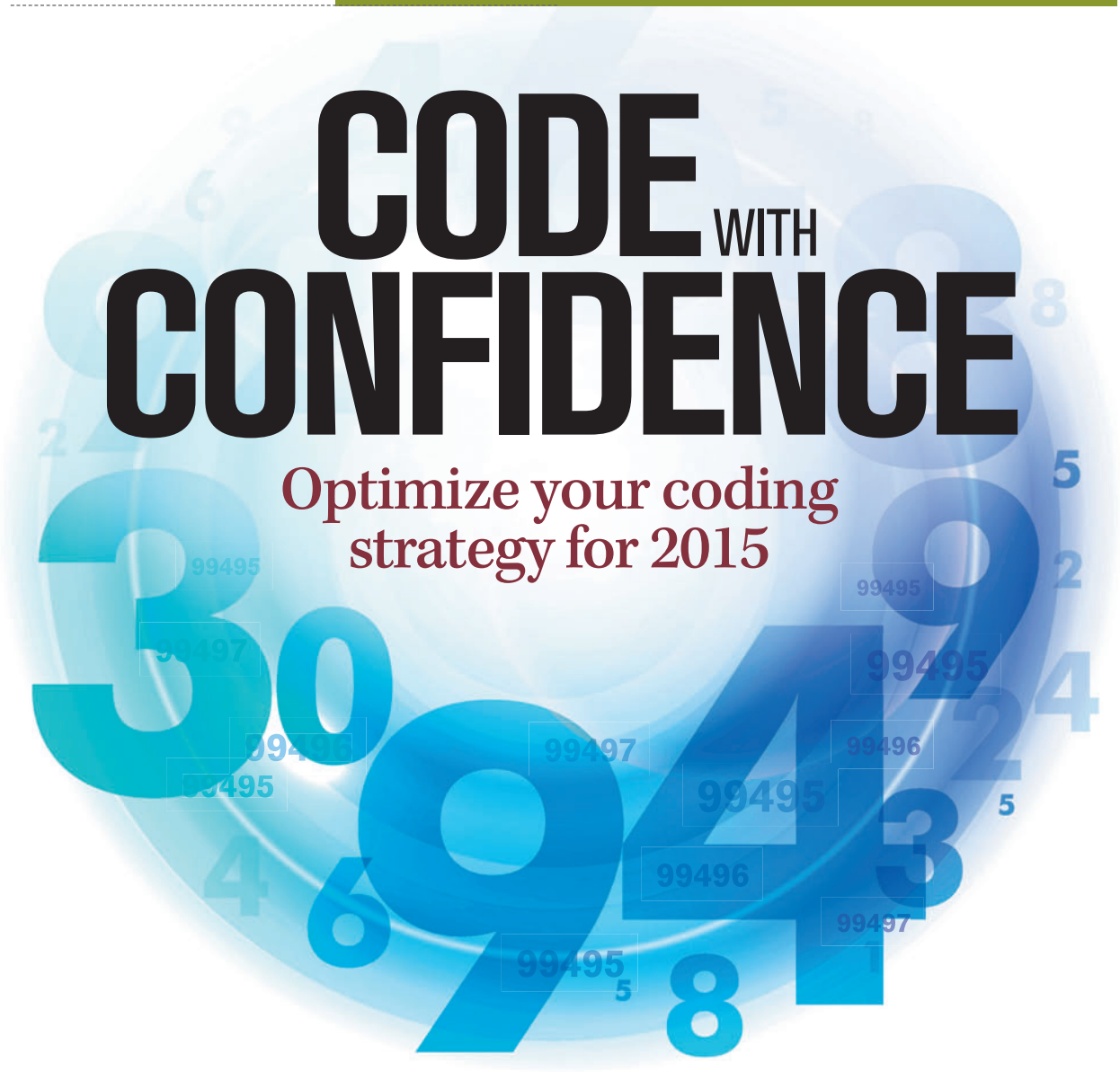
The American Medical Association has created an Ebola Resource Center for physicians and hospitals to reference. The resource center includes a provider checklist, created by the CDC,that encourages all healthcare facilities to review infection control policies and the proper protocol for notifying officials of potential cases. The CDC recommends that healthcare providers stay alert to patients who show symptoms of Ebola and who have recently traveled to one of the affected countries.

SLIDESHOW **Read more about ebola:** bit.ly/1yRlZlo

Getty Images/iStockVectors/kosmozoo

CODE WITH CONFIDENCE

Optimize your coding strategy for 2015



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

Primary care physicians (PCPs) trying to boost their practice revenue usually consider a variety of options, from adding an ancillary service to moonlighting at the local emergency department. Sometimes, however, the easiest source of additional income is hiding in plain sight, in their own billing and coding procedures.

Getty Images/iStock/360/vlastas

Coding for 2015

New opportunities for billing non-face-to-face encounters

WHETHER DUE TO FEAR of being audited, outdated practice workflows, or simple lack of knowledge, PCPs too often are billing and coding in a way that "leaves money on the table," says Boyd R. Buser, D.O., FACOFP, vice president for health affairs and dean of the Kentucky College of Osteopathic Medicine, and a member of the Current Procedural Terminology (CPT) editorial panel.

The "money left on the table" challenge—and accompanying financial opportunity—will grow in 2015, when Medicare will begin paying for chronic care management (CCM) services. The relevant CPT codes (99487, 99489, 99490) are for managing the care of patients with two or more chronic conditions (defined as conditions expected to last at least 12 months or until the patient's death) outside of face-to-face visits.

The CCM codes are time-based, and can be billed by the physician as well as other clinical staff members. The codes can only be billed once per month per patient, so practices will need to track and aggregate all the time spent on relevant activities throughout the month. "It's going to involve pulling some of the clinical staff into a process that's not usually tracked well, because it's not face-to-face care," says Nancy Enos, FACMPE, CMPA, principal of Enos Medical Coding in Warwick, Rhode Island.

NEW OPPORTUNITY TO BILL SERVICES SEPARATELY

The opportunity the CCM codes represent is the ability to bill separately for services that previously were bundled in other codes, and to bill for non face-to-face services. The Centers for Medicare and Medicaid Services has proposed a payment rate of $41.92 for the codes that would be paid once per month per qualified patient. Eligibility to bill for the codes includes additional stipulations, including that patients have 24/7 access to care management services, and that the CCM services be delivered using an electronic health record.

When it comes to codes that Medicare is already paying for, those covering transitional care management (TCM)—the management of a patient's transition from an inpatient to a community setting,—represent an untapped source of revenue for many PCPs. First proposed in 2012, Medicare began paying for TCM services at the start of 2013 under CPT codes 99495 and 99496.

Among their requirements is contact with the patient within either two or seven business days following discharge, and a face-to-face visit within either seven or 14 days of discharge, depending on the complexity of the medical decision-making involved in the patient's care. In addition, the services covered under the codes can only be billed once per month per patient, and only on the 30th day following the patient's discharge from the inpatient facility.

BARRIERS TO BILLING FOR TRANSITIONAL CARE

Because of the somewhat unusual requirements surrounding the codes, "a lot of providers aren't taking the time to report them, because they think it's too cumbersome to keep track of," says Raemarie Jiminez, CPC, CBP, vice president for member and certification development at the American Academy of Professional Coders.

The interval between when the patient is seen and when the services can be billed has caused difficulty for some primary care practices, says Jeannine Z. Engel, MD, FACP, a frequent lecturer on coding issues for the American College of Physicians. "Generally when you see a patient and there's some kind of note in your system, you drop a bill based on that note," she says. "But you can't drop a bill on the day you see the patient [under the TCM codes], and that's challenging for practices."

Consultants, and practices that have billed TCM codes say two steps are crucial to success. The first is knowing when a patient is discharged, since that triggers the timetable for the other required activities.

PROVIDER, HOSPITAL COORDINATION IS KEY

"The key is coordination between the physician's office and the hospital," says David Ellington, MD, FAAFP, a family practitioner in Lexington, Virginia and a member of the CPT editorial panel. "As soon as the codes came out our practice called the administrator of our local hospital. Now we get a discharge summary by e-mail the day of the patient's discharge, so we can start work on our end and contact the patient."

Administrators at Via Christi Clinic in Newton, Kansas, began working on a system for tracking transition care management patients in 2013, says Terry L. Mills, MD, FAAFP, medical director of patient care systems for Via Christi Health, the clinic's parent entity. The process, which is used at four of Via Christi's 13 ambulatory locations, is overseen by patient care coordinators, who check area hospitals daily to ascertain which of their doctor's patients have been discharged.

Via Christi developed a one-page flow sheet for tracking relevant dates and recording patient information such as required therapies and medication reconciliation. When a patient is discharged, Mills explains, the care coordinator begins a flow sheet and pulls the patient's records. The coordinator tries to contact the patient within 48 hours of discharge, as required under the TCM codes, and documents the efforts on the flow sheet.

'THE FLOW SHEET DRIVES THE WHOLE PROCESS'

"The flow sheet drives the whole process. When it is completed, everything Medicare requires to bill the code is performed, available, and served up to the physician," he says.

Mills estimates that the TCM process prevents about 50 readmissions annually among the 10 PCPs at his clinic. "When you do the math, you realize the system cost savings are huge," he says.

Mills says that he uses the TCM codes four or five times per month in his own practice, with about two-thirds billed at the 99495 level and the remainder at the 99496. "The care is more organized, more understandable to the patient, and I'm rewarded as well. So that's a win-win," he says.

Via Christi's results are not surprising, says Ellington. "The transition care codes are a perfect example of how good care comes out of good coding," he says. "These codes have focused attention on the time when a patient goes home from the hospital, and the importance of coordinating care to cut down on readmissions. When that work is recognized and rewarded, it gets done and gets done well."

CODING FOR END-OF-LIFE DIRECTIVES

Another non face-to-face service PCPs can consider in 2015 is time spent helping patients plan end-of-life care directives, using CPT codes 99497 and 99498. Code 99497 includes the first 30 minutes of explaining and discussing advance directives with the patient, a family member, or designated surrogate. Code 99498 covers each additional 30 minutes of counseling. As of mid-October, it was not known if Medicare would reimburse for the services.

"Conversations like this go on every day around the country, and it's been a problem for physicians to bill for them," if it was the only reason for the patient's visit, Ellington says. "In the past there was no evaluation and management code that accurately described that work. Now they'll have it."

Telehealth is another source of non face-to-face billing revenue. Since 2000, Medicare has paid for some telehealth services, such as office or outpatient visits, individual psychotherapy and pharmacologic management. Eligible beneficiaries are limited to those living in rural health shortage-designated areas or counties outside a Metropolitan Statistical Area. Providers submitting telehealth service claims should use the code for the service, along with the modifier "GT."

Requirements for billing Transitional Care Management services

CPT code 99495	CPT code 99496
Face-to-face visit within 14 days of discharge from inpatient setting	Face-to-face visit within 7 days of discharge from inpatient setting
Medical decision-making of at least moderate complexity	Medical decision-making of high complexity
Communication (defined as phone call, e-mail exchange, or face-to-face) with patient or caregiver within two business days of discharge	Communication with patient or caregiver within two business days of discharge

The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient setting and continues for the next 29 days. The reported date of service should be on the 30th day.

Source: Centers for Medicare and Medicaid Services, Medicare Learning Network

Coding for 2015

Evaluation and management: Bill the correct level of care

THE EVALUATION and management (e/m) patient visit is the foundation of most physician practices, but many practitioners are uncertain how to choose the correct Current Procedural Terminology (CPT) code for an e/m visit, thereby losing revenue.

The underlying problem is two-fold, according to coding experts. First is not understanding how the coding system for e/m visits (CPT codes 99201 through 99205 for new patients, and 99211 through 99215 for returning patients) works. Second is inadequately documenting to support their choice of code.

When uncertain what code to use, many physicians' instinct is to avoid risk by down-coding. When the American Academy of Professional Coders (AAPC) conducted a review of 60,000 physician billing audits in 2012, they found that more than a third of the records were either undercoded or under documented. That represented an average of $64,000 in foregone or at-risk revenue per physician.

"Doctors think from a clinical perspective, which they should," says Raemarie Jiminez, CPC, CPB, vice president of member and certification development for the AAPC. "They're not thinking about documenting the record to support the codes. That's where coders come in, to say 'I know all this is going on in your head, but we need you to properly describe it so that you qualify for the level of service you provided.'"

COMPLEXITY LEVEL IS KEY TO CODING

As explained in the Medicare Learning Network's 2010 "Evaluation and Management Services Guide," the correct code for an e/m visit generally is tied to the complexity of the visit, which in turn is determined by the number of problems and the extent to which they are addressed.

Three components determine the appropriate billing level for an e/m visit: history,

Continued on page 21

E/M coding in practice: Three scenarios

Deciding which level of service for evaluation and management (E/M) encounters can be complicated. Presented below are three patient encounter scenarios and level of care judgments made by George G. Ellis Jr., MD, FACP, the chief medical adviser for *Medical Economics*, and Nancy Enos, FACMPE, CMPA, a coding expert and principal with Enos Medical Coding, Warwick, R.I.

Scenario 1

Encounter	Ellis	Enos
A returning patient presents with cough, shortness of breath, and wheezing. Physician performs a detailed history of present illness/past history/family history, a detailed review of systems, and a detailed physical examination. The patient is prescribed an antibiotic and steroids, and given an in-office breathing treatment.	Encounter should be billed as **99214** because it includes detailed HPI, ROS, review of PMH, family histories, etc., and prescribing of new medications.	Encounter should be billed as **99214**, based on complexity of medical decision-making

Continued on page 21

Continued from page 20

examination, and medical decision-making. Each of these, in turn, has various levels of complexity and sub-components. For example, a history can be "problem-focused," "expanded problem-focused," "detailed," or "comprehensive." The proper level of complexity is determined by the presence or absence of documentation for four sub-elements: chief complaint, history of present illness, review of systems, and past, family, and/or social history.

The complexity levels for an examination are the same as those for history, while the complexity levels for medical decision-making are "straightforward," "low complexity," "moderate complexity," and "high complexity."

Among the three components, medical decision-making represents the biggest challenge in terms of documentation and interpretation, says Jeannie Z. Engel, MD, FACP, associate professor at the University of Utah School of Medicine and a frequent lecturer on coding for the American College of Physicians. "History and exam lend themselves to check boxes and objective quantification, whereas medical decision-making cannot be so easily quantified," Engel says.

DOCMUENTATION IS CRUCIAL

The key to supporting medical decision-making choices—as well as most other aspects of coding—is to thoroughly document what was done for the patient and why. Engel recommends approaching documentation in a "problem-based" way.

"Document the medical issues you are dealing with during the visit," she says. "Not only is it good patient care, but it also facilitates an external coder or auditor being able to pick out the number of diagnoses you're dealing with, which is a major part of medical decision-making."

Common examples of not fully documenting decision-making, she adds, are

Continued from page 20

Scenario 2

Encounter	Ellis	Enos
A follow-up appointment. Patient is morbidly obese, with diabetes, hypertension, and hyperlipidemia. Patient is counseled for poorly-controlled diabetes (A1C level=13). Physician performs detailed HPI/past medical history/family history, detailed review of systems, detailed physical exam that includes a diabetic foot exam. Patient is counseled on lab results. No changes to patient's medications.	Encounter should be billed as **99214** because it includes detailed HPI, ROS, review of PMH, family histories, etc., as well as review of labs and patient education.	Encounter should be billed as **99214**, based on complexity of medical decision-making.

Scenario 3

Encounter	Ellis	Enos
A follow-up appointment. Patient is morbidly obese, with diabetes, hypertension, and hyperlipidemia. Patient is counseled for poorly-controlled diabetes (A1C level=13). Physician performs detailed HPI/past medical history/family history, detailed review of systems, detailed physical exam that includes a diabetic foot exam. Patient is counseled on lab results, and placed on insulin due to noncompliance with diet.	This encounter should be billed at **99215** due to counseling patient on administering insulin and its risks and benefits, the need for more intense glucose monitoring, counseling on importance of diet/exercise, complications of uncontrolled diabetes, and risks of hypoglycemia.	Encounter should be billed at **99214** level based on complexity of medical decision-making The table of risk guided the coder to "moderate" with prescription management, but it is not high because the drug doesn't require intensive monitoring.

What level of care would you code them? Tell us at **medec@advanstar.com**.

doctors neglecting to note explicitly that they've personally reviewed imaging, and obtained historical information about a patient from someone other than the patient, such as a family member or caregiver. "All these are things we often do as physicians, but if you don't include having done it you don't get credit for it," she says.

Another common error is confusing familiarity with the patient with complexity of decision-making, says Nancy Enos, FACMPE, CMPA, principal of Enos Medical Coding in Warwick, Rhode Island. "The medical decision-making might be at a level to support a 99214 because the patient has multiple problems and the doctor is looking at lab results and they have a medical history to support it, they still have a tendency to bill it as a 99213 because the patient is familiar to them and is doing well, and they don't want to get into trouble," Enos says.

Enos adds that the 99213 level should be used for "a healthy patient with an uncomplicated illness like a virus or sinusitis, not one with something like hypertension or A-fib. That's much more complicated," she says.

EHRs CAN LEAD TO UPCODING

The widespread use of electronic health record (EHR) systems has in some ways contributed to physicians' coding problems by prompting doctors to document at a level beyond what the encounter really requires—upcoding—says Boyd R. Buser, D.O., FACOFP, a member of the CPT editorial panel.

"Now you start getting beyond the question of whether you've documented the service properly to whether the service you've documented was medically necessary. And that's where a lot of physicians start getting into trouble," he says.

"The e/m calculator tool sometimes will suggest a code that's too high just based on the information the EHR automatically populates," says Enos. "In the old days, with paper charts, auditors would say, 'If it wasn't documented it wasn't done.' Today, my mantra is, 'If it wasn't done, don't document it.'"

LEVEL OF CARE CODING KEY COMPONENTS

CPT Code	Presenting problem	Patient history	Examination	Medical decision-making
99201	is self-limited or minor; the physician typically spends 10 minutes face-to-face with the patient and/or family	problem focused	problem focused	straightforward
99202	low to moderate severity; the physician typically spends 20 minutes face-to-face with the patient and/or family	expanded problem focused	expanded problem focused	straightforward
99203	moderate severity; the physician typically spends 30 minutes face-to-face with the patient and/or family	detailed	detailed	low complexity
99204	moderate to high severity; the physician typically spends 45 minutes face-to-face with the patient and/or family	comprehensive	comprehensive	moderate complexity
99205	moderate to high severity; the physician typically spends 60 minutes face-to-face with the patient and/or family	comprehensive	comprehensive	high complexity

Source: Centers for Medicare and Medicaid Services

Financial Strategies

EFFECTIVE COLLECTION AGENCY USE: THE IMPORTANCE OF INTERNAL POLICIES

by **ROBERT C. SCROGGINS, JD, CPA, CHBC** *Contributing author*

Increasing patient accountability for the cost of healthcare means physician practices likely will need to improve their internal collection processes and consider contracting with an outside collection agency. But choosing a good collection agency is the second priority. The first is establishing well-thought-out and specific internal procedures for collecting as much as possible before turning to an outside collection agency.

WE ARE SEEING our clients turn to collection agencies more often now than ever over the past 30 years.

From the 1980s through just a few years ago there was far less patient responsibility involved with the cost of healthcare, because most of the cost was covered by the insurance providers.

Now, however, almost half of all coverage is provided under high-deductible health plans (HDHPs) with the patient responsible for the first several thousand dollars of expense. This patient responsibility portion of the cost is where delinquency and bad debt occurs.

The problem

The processes used when coverage was primarily under health maintenance and preferred provider organizations are not adequate in the world of HDHPs. Now, instead of $20 to $50 copays for routine encounters, the patient's responsibility is often 3 to 10 times that amount, or even more when it involves procedures.

To add to the problem, doctors' practices typically are not very good at discussing finances with patients. This wasn't the case before the widespread use of managed care and copays. When coverage was provided under indemnity plans, patients were primarily responsible for the cost of ambulatory care and were accustomed to paying for the services they received, just like purchasing other goods and services. Managed care essentially pushed the matter of cost out of sight since the party paying for the care was not the one rendering the service or receiving the care. And that which is out of sight tends to be out of mind.

Consequently, most doctors and practice staff members today have not had to address finances with patients to any meaningful extent. Like most things in life, if you don't have to deal with something, you don't develop the behaviors important to the activity.

The solution

Should practices simply send delinquent accounts to a third-party collection agency?

Collection agencies can play a role in effectively managing accounts receivable. However, practices frequently turn to collection agencies prematurely. The proper role of a collection agency is to handle outstanding accounts receivable that have gone through the practic'ses established internal processes without success.

The cost of employing a collection agency is significant, generally ranging from 20% to as high as 50% of the amount collected.

It is important to understand how an agency will go about collecting delinquent balances. Because an agency represents the practice in the eyes of the patient, it is important to know what the agency will say to patients and what actions it may take to collect outstanding accounts.

Using a collection agency is different than other services. If the practice's internal processes are well-designed and followed, then the collection agency should need to collect very little. Sometimes our clients lament that their collection agency isn't collecting much and thus not doing its job

Financial Strategies

well. Many times we find that is because the practice's internal collection processes are effective, consequently the collection agency is receiving the most difficult of accounts to work.

The way to test an agency's effectiveness is to use two agencies, give each a similar blend of accounts, see which one collects more and use that one.

The more important task, however, is to establish effective internal processes before turning accounts over to an outside collection agency. The internal processes should include a financial policy provided to each patient, in advance, so that expectations are clearly established.

Developing the internal process

Key elements of well-developed internal processes are:

- **Flagging charts of patients with delinquent balances and if a patient is expected back in the office soon, being prepared to address the outstanding balance in person.**
- **Training staff and doctors on how to have financial discussions with patients. Determine who in the practice will be effective at this. Develop scripts for staff and physicians to use to guide their conversations. And have a designated location for financial discussions with patients. The front desk/reception area is not the best spot.**
- **Sending statements as soon as any portion of the patient's responsibility has been determined, even if some charges are still pending with insurance.**

DOCTORS PRACTICES ARE NOT VERY GOOD AT ADDRESSING FINANCES WITH PATIENTS. THIS WASN'T THE CASE PRIOR TO THE INTRODUCTION OF MANAGED CARE AND COPAYS.

The collection letter

Include dunning messages with monthly statements sent to the patient, and tailored to the age of the outstanding balance. If a patient fails to pay after two statements are sent then a series of separate letters should begin.

Letters are more effective than dunning messages and phone calls. Dunning messages are passed over as computer generated and just part of the statement. Phone calls generally are not effective if placed during the day when the patient usually isn't home or can be dodged because of caller ID.

We provide a pre-collection letter service for our clients and many collection agencies do this as well.

Some of the elements of the letter process important to achieving an effective result are:

- **A third party will do a better job making sure the letters are going out because they will be looking for a list of delinquent accounts monthly. When handled by internal staff, separate pre-collection letters become a low priority behind charge entry, payment posting, routine insurance follow up and monthly statements.**
- **Letters should be in addition to statements so that they stand out and have a better chance of getting to the decision-maker in the family.**
- **Letters should go out on practice letterhead but not under the doctor's or staff member's signature. The third party sending the letter should sign it. Be aware of the name used so when patients call in response to a letter everyone in the practice will know to direct the call to the billing department. Using a third party's signature will help direct a patient's unhappiness away from the doctor or the person ultimately handling the phone call.**
- **Letters need to go out consistently. Without consistency patients will naturally disregard the effort.**

MORE ONLINE

Do high deductibles mean high risk for physicians?
http://bit.ly/1covcvZ

8 tips for reducing collection agency referrals
http://bit.ly/1xBjGcy

Robert C. Scroggins, JD, CPA, CHBC, *is a management consultant and principal with ScrogginsGrear, Inc., in Cincinnati, Ohio. Send your financial and practice management questions to* ***medec@advanstar.com****.*

WHEN TO REFER
How physicians can better manage the process [35]

CODING INSIGHTS
Avoid level-of-care audits for evaluation and management [39]

Operations

Building better care teams with non-physician providers

As the numbers of nurse practitioners and physician assistants surge, primary care physicians can improve patient care and increase revenue by bringing them into the fold

by **SUSAN KREIMER** *Contributing author*

HIGHLIGHTS

01 Hiring nurse practitioners and physician assistants can enable physicians to focus on the most complex cases.

02 Laws regarding the scope of practice for non-physician providers vary by state.

03 Liability concerns can be alleviated by well-designed and clear protocols and open, regular communication between physicians and the providers they supervise.

Amid an intensifying shortage of physicians in primary care and some specialties, hiring a nurse practitioner (NP) or physician assistant (PA) could alleviate some overflow and boost revenue while enabling physicians to augment patient access to providers. But creating a well-run clinical team requires successful coordination among physicians, NPs and PAs.

THE UNITED STATES FACES a projected shortage of more than 130,600 physicians by 2025, including 65,800 primary care doctors, according to the Association of American Medical Colleges. Demand will surge as the aging population increases and as millions of uninsured patients gain coverage under the Affordable Care Act.

These shifts in the provider workforce mean many practices and medical groups increasingly are hiring nurse practitioners and physician assistants to help improve the care they provide and increase their revenue streams. This movement is encouraged by new care models that call for better team-based care.

"The rapid expansion in the use of new primary care models, such as the patient-centered medical home, has potentiated the need for more skilled clinicians from

all healthcare disciplines, especially nurse practitioners and physician assistants," says David A. Fleming, MD, FACP, president of the American College of Physicians and chairman of the department of medicine at the University of Missouri School of Medicine in Columbia, Missouri.

With too few doctors to fulfill current and future needs in some rural and urban areas, "physicians are a very precious resource." Because of their lengthy and costly training, "we need to use them in the very best way possible," says Phyllis Arn Zimmer, MN, FNP, president of the Nurse Practitioner Healthcare Foundation in Bellevue, Washington. This means allocating time for physicians to handle complex cases that require advanced diagnostic and treatment expertise.

Nurse practitioners can provide general primary care for adults and children—for example, by performing well-woman exams and helping patients and families manage chronic illnesses. "A healthcare provider's role isn't to be the director of a patient's care," Zimmer says. "For many years, the provider made the diagnosis and told the patient what to do. We're really evolving away from that thinking—and trying to empower patients to make their own informed decisions."

In a well-run practice, guiding patients toward healthcare decisions becomes an outgrowth of a successful partnership between doctors and nurse practitioners or physician assistants. The best partnerships consider combined strengths and expertise in determining how best to address patients' needs, says John McGinnity, MS, PA-C, DFAAPA, president of the American Academy of Physician Assistants and program director of physician assistant studies at Wayne State University in Detroit.

Employing a physician assistant allows a doctor to focus on more complex cases, reduce patient waiting times, and raise a practice's income by 18%, McGinnity says. "What doctor wouldn't want an extra week of leave each year, a better bottom line, higher patient satisfaction, and stronger patient outcomes?" he adds.

A nurse practitioner also can be a major asset in managing patient flow. Even a busy practice can accommodate more patients, says John Giampietro, MD, an internist who works with his wife, Susan Apold, PhD, ANP-BC, a nurse practitioner, in New Rochelle, New York.

"Patients are happier when they can be seen more frequently—in time. Everybody's thing today is drive-through medicine, so the nurse practitioners can certainly increase access to care. Nobody wants to wait," says Giampietro, who has been in private practice since 1985. "You drive down the highway and the advertisements for the emergency room are 15-minute waiting."

In New York and some other states, nurse practitioners may take a patient's medical history, perform a physical exam, order tests to confirm or disprove a suspected diagnosis, and prescribe medicine independently. Apold sees her own patients and bills under her name, with Medicare reimbursing at a rate of 85% of the amount paid to a physician for the same service, she notes, citing an example for comparison.

Before joining her husband's practice as a nurse practitioner in 1997, she worked as

WORKING WITH NPs AND PAs

5 ways to minimize liability

1. Do your homework Be rigorous in checking the credentials of any nurse practitioner or physician assistant you consider hiring.

2. Check with your insurance carrier Ensure that your medical liability insurance covers you for supervising non-physician providers.

3. Clarify scope of practice Physicians must create clear, written scope-of-practice instructions for practitioners and physician assistants. Points that must be addressed include how they should communicate with supervising physicians and the allowed scope of practice and any limitations to it.

4. Monitor and supervise Supervising physicians should monitor nurse practitioners and physician assistants to ensure they are working at the top of their licenses, but not exceeding their training and the laws of the state. Physicians should create a positive relationship with providers to encourage open communication and questions.

5. Use technology Electronic health record systems can be designed to require the signature of both the supervising provider and non-physician provider on any diagnosis or treatment plan. Check with your vendor to explore these options.

a registered nurse in hospitals and home health, and taught nursing. "We talk a lot when we're seeing patients," Apold says. "It's very mutual, very collaborative."

That collaboration goes both ways. It never hurts for a doctor to ask for a physician assistant's or nurse practitioner's input. "I always tell people to keep your mind open, because since we're all committed to helping patients do better, we each have something to add," says Reid Blackwelder, MD, FAAFP, board chairman of the American Academy of Family Physicians.

Everyone involved in a patient's care also shares responsibility and potential liability. It is critical for a doctor "to incorporate appropriate communication, recognize limits of training and experience, create opportunities for teaching, and support the continued clinical growth of each person," says Blackwelder, a family physician in Kingsport, Tennessee. "Perhaps the most important part of team care is making sure that any team member is never put in a situation beyond their training, experience or competence."

Nurse practitioners can perform up to 90% of the functions that family practice physicians undertake. There are about 500 nurse-managed clinics across the country, primarily in inner city and rural areas, says Ken Miller, PhD, RN, CFNP, president of the American Association of Nurse Practitioners. Each clinic manages about 5,000 patient visits annually.

Last year, nurse practitioners handled more than 900 million patient visits. The number of nurse practitioners is growing. In June, the association's figures, compiled from nursing boards' data, accounted for more than 192,000 nurse practitioners—an increase from 189,000 early this year.

LIABILITY CONCERNS

Bringing non-physician providers onboard can increase liability risks for a practice.

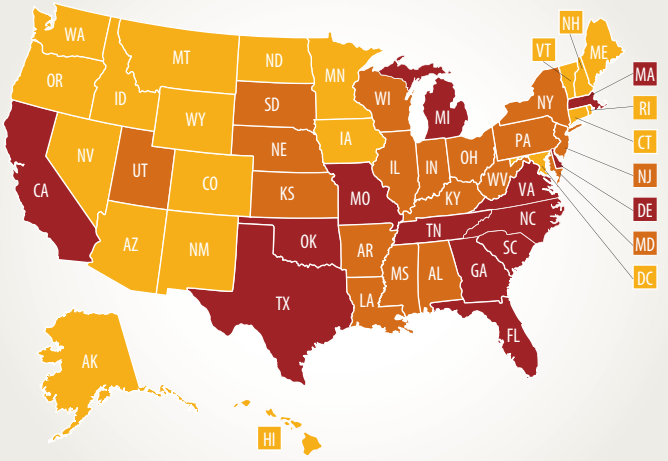
While nurse practitioners are sued for malpractice at a lower rate and for lower judgements than physicians, practices must be aware that physicians can have increased liability, because a supervising physician inevitably will be drawn into a lawsuit involving a nurse practitioner or physician assistant.

Licensed by state nursing boards, nurse practitioners are liable for their own actions and can be sued for malpractice. While a physician may be called in as a co-defendant, he or she is not responsible for the nurse practitioner's negligence, Miller says.

Lawsuits against nurse practitioners and physician assistants are uncommon, but most cases filed against them also name the supervising physician. Settlements that exclude the physician are rare, according to PIAA, formerly known as the Physician Insurers Association of America.

The association conducted a national review of closed claims from 1985 to 2013 involving "advanced practice providers"—which included ➔32

SCOPE OF PRACTICE LAWS FOR NURSE PRACTITIONERS, BY STATE



Full practice states

Nurse practitioners (NPs) can evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments, including prescribing medication.

Reduced practice

NPs can engage in at least one element of practice, but are required to sign a collaborative agreement with a physician.

Restricted practice

States requires supervision, delegation or team-management of NPs by physicians.

Source: American Association of Nurse Practitioners, May 2014

➔27 only nurse practitioners and physician assistants. Indemnity payments averaged $243,136 (unadjusted to present value)—higher than the $227,215 average for all healthcare specialties.

Family practice and internal medicine topped the list of closed claims and paid claims, but this may reflect the larger number of advanced practice providers in these fields. Diagnostic errors are the most prevalent medical liability claim involving these providers, the association reports.

Physicians should take steps to protect themselves from a liability standpoint when integrating nurse practitioners or physician assistants into their practices, and these actions should begin before hiring. Steps include:

- **Rules and regulations for these providers are different in each state, so physicians must understand the supervision and scope-of-practice rules of their state.**
- **Before hiring, make sure any candidate has the required credentials and has met all of the state's educational and licensing requirements. This is not a one-time action: physicians must continuously monitor their employees to ensure their professional license remains in good standing.**
- **When hiring, make sure you notify your malpractice insurance carrier. Professional associations for nurse practitioners and physician assistants recommend that these providers maintain their own malpractice policies as well.**
- **A well-developed set of written protocols for the non-physician provider is critical, and may be required depending on the supervision rules of the state. These protocols should include instructions for how to handle cases they will commonly see.**

One of the best ways to prevent problems is to foster an environment where questions and interaction are encouraged between physicians and the providers they supervise.

DEGREES OF INDEPENDENCE

Laws governing the scope of practice and level of independence for nurse practitioners and physician assistants vary from state to state. Some regulations specify that a physician must be present on the premises during office appointments, while others do not.

"The trend is toward less 'over-the-shoulder supervision,' and telecommunication is often permitted," says Jim Cawley, MPH, PA-C, a professor of prevention and community health and physician assistant studies at The George Washington University in Washington, D.C.

How much independence a physician assistant may exercise often depends on the individual structure of a practice and a doctor's willingness to delegate responsibility. Some doctors feel more comfortable delegating than others. "The most effective practice arrangements I've seen is where that happens," Cawley says. His research shows that the longer a physician assistant works with a specific doctor, the greater the autonomy.

"Medical sociologists have labeled this progression 'negotiated performance autonomy' and suggest that it is an ideal descriptor of the PA-physician dyad in clinical practice," he explains. "PAs are major economic assets to physician practices, but their employment needs appropriate supervision in conformance with state medical practice laws that have protection of the public as their basis."

HOW PHYSICIANS BUILD CARE TEAMS

In terms of compensation, physician assistants are typically salaried employees of the practice. Their payment arrangements often include bonuses and additional incentives.

As for reimbursement from insurers, Cawley says, a practice generally has two options: billing for the physician assistant's service under the "incident to" clause of Medicare regulations and collecting 100% of the physician's fee, or billing with the physician assistant's name under Medicare Part B and receiving 85% of that amount.

At Arizona Arthritis and Rheumatology Associates, John Tesser, MD, and his team of three physician assistants share clinical work to manage the high-volume case load. Due to a shortage of rheumatologists, this approach helps meet the needs of patients in the Phoenix area who suffer from a variety of rheumatic disorders. Delegating is an essential ingredient in optimizing the workflow and revenue of a burgeoning practice, Tesser says.

A physician assistant in ➔34

Medical Economics®

SMARTER BUSINESS. BETTER PATIENT CARE.

Medical Economics' **enewsletters are weekly and FREE!**

Be successful in your practice, with our help


Why you shouldn't believe CNN about physician bankruptcies – Inbox

Message

Why you shouldn't believe CNN about physician bankruptcies

Lois A. Bowers, Editor-in-Chief, Medical Economics

You are subscribed to the *Medical Economics* eConsult.

Print Subscribe | Digital Edition Subscribe

Medical Economics eConsult

SMARTER BUSINESS. BETTER PATIENT CARE.

April 17, 2013

Web Version | Digital Edition | Share with a colleague

Like Tweet

TODAY'S HEADLINES

Why you shouldn't believe CNN about physician bankruptcies

There's only one problem with a recent CNN article about a spike in physician-practice bankruptcies: We have no idea whether its basic premise is even true. » Full article

Share »

Should specialty professors earn 43% more than their primary care peers?

Primary care professors reported a median compensation of $203,777, compared with $291,101 for specialty professors, according to a survey from the MGMA. » Full article

Share »

ADVERTISEMENT

Immunization: Medical Economics Business of Health

Stay up-to-date with the latest vaccination and immunization therapies. Watch video, read articles, use tools, and learn with CME. More

Primary care physicians still waiting on ObamaCare Medicaid pay boost

The increased Medicaid fees were included in the ACA as a way to encourage primary care doctors to treat the additional patients who will receive Medicaid coverage. » Full article

Share »

What the U.S. can learn from other countries about controlling health costs but would prefer not to

"All of these strategies—almost to a fault—are resisted or demonized here. Instead, we'll likely continue to try things that have never worked or have no evidence behind them." » Full article

Share »

TAKE OUR SURVEY

Compliance with expanded HIPAA provisions begins later this year. Will you be ready?

- What expanded HIPAA provisions?
- Yes, I will be ready.
- No, I will not be ready.

Click here and see what your colleagues are saying too

VIDEO ARTICLES TOOLS CME

Medical Economics BUSINESS of HEALTH

Immunization

Stay up-to-date with the latest vaccination and immunization therapies

RELATED ARTICLES

- Physician groups criticize Obama budget for GME cuts
- Walgreens retail clinics expand into chronic care
- ACP releases new patient education materials
- Everything you need to know about the PQRS program
- How to comply with the Stark laws
- Explore fixes to your EHR system before deciding to replace it

Medical Economics

FREE in the App Store

MedicalEconomics.com/MedicalEconomicsApp

Editorial Questions? Contact the Editorial Team. Click Here.

Sales, Reprints, Classified questions? Contact the Sales Team. Click Here.

POWERED BY ModernMedicine ADVANSTAR

Receive timely information on the latest developments in primary care practice management, finances, health law, and other matters vital to your livelihood by signing up for *Medical Economics* eConsult, delivered to your emailbox every week.

SIGN UP TODAY!

To sign up, visit MedicalEconomics.com/enewssignup

➔32 Tesser's office obtains a new patient's history, performs a physical exam, and formulates a differential diagnosis and treatment plan. After reviewing this information, Tesser visits the patient along with the physician assistant and fine-tunes the diagnostic work-up and plan for therapy.

"They know rheumatology extremely well, and they're very seasoned," he says of his physician assistants. One of them has worked with him for 26 years, and two others for 11 years each. "I'm really just confirming much of what they find most often."

Also, practicing medicine this way is more productive. "As I can delegate much of the lower-level documentation and review of incoming data, it unburdens me so that I have the time to perform the higher-level decision-making critical to patient care," Tesser says. "And it enhances revenue in the practice."

Tesser is on the premises, so he bills under his name when one of the physician assistants sees a patient in the office. Each physician assistant earns a base salary and a percentage bonus above a certain threshold, depending on how much revenue comes into the practice, Tesser says.

On subsequent visits, patients typically alternate between seeing Tesser or a physician assistant, but he's available to his staff at all times for brief counsel. In complex cases, he sees a patient through the initial stages until the condition stabilizes. "I'm always the anchor for the team," he explains. At the end of the day, he reviews all physician assistants' notes on new patients and many returning patients before signing off on them.

"As a team, we can see many more patients and extend rheumatology care and expertise to the community," he says. For new employees, however, Tesser recommends that physicians allow physician assistants to "shadow" them while seeing patients.

Kevin Maben, MD, works closely with two nurse practitioners as a general pediatrician in Rio Rancho, New Mexico, as part of Presbyterian Healthcare Services in Albuquerque. Half of the week he functions as a pediatrician, the other half as a medical informaticist for the health organization's electronic health record system, EpicConnect.

Maben works in both capacities from the pediatric clinic. On the days when he's not scheduled to see patients—Tuesdays and Fridays—the nurse practitioners serve as "access providers" for in-office urgent care. This includes "same-day sick visits—anything a parent may call for," Maben says, whether it's a suspected cold, flu, asthma exacerbation or other complaint.

These types of last-minute appointments help prevent unnecessary visits to an urgent care facility or an emergency room. The patient incurs a lower copay, and the healthcare system benefits from a cost savings.

Sometimes a nurse practitioner may consult with a pediatrician when there are lingering doubts about an appropriate course of action. A pediatrician also should feel free to tap a nurse practitioner's expertise. In a recent situation, Maben says, the culprit causing severe pain appeared to be appendicitis, and the office referred the patient to a hospital.

"It's very similar to what happens between pediatricians; we ask each other's opinion," he explains. It may help to have "another pair of eyes to look at" a rash, for example.

Nurse practitioners also have the authority to sign school forms, such as an action care plan for a child or adolescent who suffers from asthma, he says. For pediatric patients with type 2 diabetes, pre-diabetes or obesity, nurse practitioners can educate about the benefits of proper nutrition and exercise. Before the fall semester, nurse practitioners help with a flurry of requests for school and sports physicals.

Whatever the task at hand, physicians overseeing nurse practitioners, physician assistants and other personnel must ensure that patient care is evidence-based, competent and safe, says Fleming.

"Physicians have always had some level of accountability for the practice and behavior of other members of their healthcare team, when it comes to the welfare of the patients for whom they are collectively responsible," he says. ◘

MORE ONLINE

Incident-to billing: Your coding questions answered
http://bit.ly/1p2VKQh

The referral dilemma

Managing patients and liability concerns

When deciding whether to send a patient to a specialist, primary care physicians must consider what's best for the patient

by **BETH THOMAS HERTZ** *Contributing author*

HIGHLIGHTS

01 While knowing patients may be more important than condition-specific expertise, failure to refer can lead to liability issues.

02 Unless a primary care physician knows a specialist is incompetent, he or she is generally liable only for the care they deliver or oversee directly.

Primary care physicians (PCPs) often refer patients to specialists when they face a complicated or perplexing diagnosis, or one that is beyond their purview. But is that always the right decision for the patient? Some experts say that it absolutely is, but others say knowing the patient is more valuable than being an expert in one specific area.

An additional element of the question is the fear of malpractice allegations for a referral, or lack of one.

Referrals are a growing issue in the United States. A study published in 2012 in the *Archives of Internal Medicine* showed that the incidence of physicians referring patients to other physicians nearly doubled from 1999 to 2009, growing from 4.8% to 9.3%. That represents a jump from 40.6 million referrals annually to 105 million.

KNOW THY PATIENT

Richard Roberts, MD, JD, a past president of the American Academy of Family Physicians, says that in his Madison, Wisconsin practice, caring for multiple generations in some families gives him unique insights into what may be going on with a patient. "Knowing the person is way more important than knowing the disease," he says.

PCPs should be confident they are doing well by their patients, he says.

"I refer when needed, of course, but we can probably manage 90 to 95 percent of what comes in the door," he says. "If you are sending out more than 5 to 10 percent of your patients, you are probably referring out too much."

He cites statistics that reinforce his belief that PCPs can handle many conditions on their own.

"If you take a population of 10,000 people and increase the number of specialists in that population by 1 per 10,000 people, the death rate goes up 2%. If you increase it by a combination of primary care providers—internal medicine, pediatricians, and family medicine—by that amount, the death rate goes down 5%. If you add family doctors alone, the death rate goes down 9%," Roberts says. "Doing more is not always doing better. Doing more can sometimes mean someone gets hurt."

> "I REFER WHEN NEEDED, OF COURSE, BUT WE CAN PROBABLY MANAGE 90 TO 95 PERCENT OF WHAT COMES IN THE DOOR."
>
> –RICHARD ROBERTS, MD, JD, PAST PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

For example, he says, about one-third of all medical procedures done in the U.S. are unnecessary by each specialty's own criteria. Specialists don't perform unnecessary procedures out of greed or poor skills. Most sincerely want to help their patients, he says, but compares it to asking a mechanic to fix a noise in your car.

"The mechanic will lift the hood and start tinkering with the engine even if it's the radio that's making the noise because he doesn't do radios, he does engines," he says.

A REQUIREMENT TO REFER

However, Ann Whitehead, RN, JD, vice president, risk management & patient safety for the Cooperative of American Physicians, Inc., a physician-owned organization offering medical professional liability protection, cautions that failure to refer can sometimes result in litigation.

"Physicians are very much aware of (the potential for lawsuits) and know they should work within the bounds of whatever their practice parameters are," she says. "PCPs are usually generalists and overseers of care. They provide preventive care and routine treatment, but if the issue related to the patient's illness is outside their specialty, it is almost required that they refer them out."

Whitehead predicts that as medicine becomes more complex, referrals to specialists will continue to increase.

"Most PCPs allot 15 minutes to see a patient. That is not enough time to fully assess a patient with multiple different diagnostic problems. They might identify those problems and then refer out to a specialist to take care of them," she says.

DOCUMENTING YOUR RATIONALE

Whitehead says there is little liability risk in referring to a specialist. Unless the PCP knows the specialist is somehow incompetent, he or she is generally only liable for the care they deliver or oversee directly. Even sending a patient to the "wrong" specialist carries little risk, she adds.

"It all comes down to the physician's examination and documentation in the medical record for why they are providing that referral," she says. If the differential diagnosis shows it's justified, then the physician has done the right thing.

"This is not an exact science. Specialists are there to rule something in or out," she says. "If you have five things on your differential diagnosis for this patient and two of them are not really within the realm of your practice, and you think they are significant, then you need to document in your records why you are referring, what you have explained to the patient, and that it is important they get that consultation with the specialist."

Given the current reimbursement environment, "it is a no-lose situation now for a PCP to refer to a specialist," she adds.

GIVE THE PROBLEM A LITTLE TIME

Roberts says he generally follows a "rule of three": If he hasn't figured out a patient's problem within three visits, he seeks help, either from a colleague in his office or an outside referral.

Part of his rationale is that about 40% of conditions cannot be categorized at the initial presentation. Over time, however, the condition may become clearer. Often that is the time frame in which the patient is seeing the specialist, making it easier for him or her to diagnose.

But he notes that specialists aren't always able to provide ➔38

WE ARE UNMATCHED IN REWARDING OUR MEMBERS FOR PRACTICING GOOD MEDICINE

As a company founded by doctors for doctors, we believe that doctors deserve more than a little gratitude for an outstanding career. That's why we created the Tribute® Plan—to reward our members for their loyalty and commitment to superior patient care with a significant financial award at retirement. How significant? The highest distribution to date is $138,599. This is just one example of our unwavering dedication to rewarding doctors.

Join your colleagues—become a member of The Doctors Company.

CALL 888.536.5346 OR VISIT WWW.THEDOCTORS.COM

UNMATCHED REWARDS

THE DOCTORS COMPANY

Tribute Plan projections are not a forecast of future events or a guarantee of future balance amounts.
For additional details, see www.thedoctors.com/tribute.

> "IT ALL COMES DOWN TO THE PHYSICIAN'S EXAMINATION AND DOCUMENTATION IN THE MEDICAL RECORD FOR WHY THEY ARE PROVIDING THAT REFERRAL."
>
> —ANN WHITEHEAD, RN, JD, VICE PRESIDENT, RISK MANAGEMENT & PATIENT SAFETY, THE COOPERATIVE OF AMERICAN PHYSICIANS, INC.

➔36 answers either, which can be reassuring in a way. For example, he has a 71-year-old active patient who couldn't straighten his elbow. The patient had seen two specialists and received conflicting advice about what to do. Roberts was able to tell him to go ahead with surgery since he knew him to be an active person who wouldn't be happy leading a sedentary life.

"That happens all the time," he says. "Specialists often think they are the final word, but patients come back to me every day to decide what to do."

WHEN YOU DO REFER

Kenneth T. Hertz, FACMPE, principal in the Medical Group Management Association, says that who you refer to is very important. In general, PCPs make referrals to physicians who are in the same networks or with whom they have a relationship.

If a specialist delivers poor care to your patient or doesn't send you a note afterward, stop referring to that person. Hopefully, he or she will notice and ask why. Respond with an honest, specific answer if that happens, he suggests.

Since it is incumbent upon PCPs to be sure they get notes back from the specialist, Hertz advises they have a system to track this, possibly through their electronic health records. And once they receive the notes, it is equally important to review them.

"Liability arises if you don't read or respond appropriately," he says. "Not only that, but it's just good medicine."

Roberts cautions PCPs to be aware of who referred patients are actually seeing. Is it the physician you recommended or a nurse practitioner? He calls to complain to the specialist if he or she doesn't see the patients themselves.

"Don't assume they have an evil intent if they don't act how you would like for them to. They may just be very busy, but that doesn't mean you shouldn't let them know your preferences," he says.

Insurance restrictions may limit who you can refer to, but don't hesitate to appeal a restriction if no one on the "approved" list is right for your patient, he adds.

DEALING WITH THE NONCOMPLIANT PATIENT

You can refer a patient to a specialist, but you cannot force the patient to go. Thoroughly documenting the referral protects you from liability.

"If they have made the referral and explained to the patient why they are making it and documented that, it's really the patient's responsibility to make the appointment and follow up with the doctor," says Whitehead.

Next time you see the patient in your office, ask why he or she didn't see the specialist and document the answer, she adds. This "closes the loop" on the referral.

Hertz advises that when a patient's problem is urgent, someone on your staff should set up an appointment with the specialist while the patient is still in your office. If the problem is important but not critical, your office can provide the names of several potential specialists and let the patient choose which one to see. ◘

+ MORE ONLINE

Does liability for your patient continue after referral?
http://bit.ly/1E11z3U

Coding Insights

THE EVALUATION AND MANAGEMENT CODES AUDITORS FOCUS ON

Q We know that evaluation and management (E/M) codes are being scrutinized during insurance auditor reviews. Which codes are auditors focusing on?

A: IF YOU ARE billing 99215, 99223 and 99222, be sure to read the latest information released by Comprehensive Error Rate Testing (CERT). Incorrect coding of E/M services continues to be an area of concern as demonstrated by recent CERT claim reviews.

Wisconsin Physician Services (WPS) Medicare analysis of recent CERT findings in J8 reveals three E/M CPT codes (with fifteen or more services reviewed in the sample) were incorrectly coded at a rate of at least 44%.

To avoid being part of these statistics, take some time to brush up on E/M coding and perform a self audit. Although this is a specific example related to WPS, excessively billing these high-level E/M codes will trigger an audit by any auditing entity across the country.

The chart to the right illustrates these procedure codes and the percentage of cases for which the medical records submitted did not support the level of service billed. ◘

MORE ONLINE

How to use the new evaluation and management codes in 2014
http://bit.ly/1xFDkEd

*The answers to this reader's question was provided by **Renee Dowling**, a coding and billing consultant with VEI Coding Consulting Services in Indianapolis, Indiana. Send your practice management questions to medec@advanstar.com.*

E/M CODES UNDER SCRUTINY

CPT Code Reviewed by CERT Contractor (Claims submitted 07/01/12-06/30/13)	Percentage of Services Incorrectly Coded
99215 – Office or other outpatient visit for the evaluation and management of an established patient, which **requires at least two of these three key components:** • Comprehensive history • Comprehensive exam • Medical decision making of high complexity	78%
99223 – Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components. • Comprehensive history • Comprehensive exam • Medical decision making of high complexity	52%
99222 – Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: • Comprehensive history • Comprehensive exam • Medical decision making of moderate complexity	44%

Source: Centers for Medicare and Medicaid services

FIGHTING BACK
One physician explains why he stays in practice [46]

RUNS IN THE FAMILY
The practice of medicine, passed on from parent to child [48]

Trends

FIGHTING BACK SERIES

The fight for clinical control

As the healthcare industry strives to cut costs, physicians are experiencing far greater clinical pressures from payers and regulators

by **JUDY PACKER-TURSMAN** *Contributing author*

HIGHLIGHTS

01 Payers want to be sure patients meet clinical hurdles for treatment, with evidence-based clinical protocols driving many of these decisions.

02 One consequence is that physicians are spending more time dealing with administrative burdens rather than treating patients.

Administrative challenges are nothing new to physician practices. But physicians and practice administrators across the United States now describe significant struggles to adapt to what amounts to far greater involvement from payers and regulators related to clinical decisions on a variety of fronts, such as prior authorizations, case manager involvement and network cancellations.

AS PHYSICIANS FIGHT to retain clinical control, small practices report facing heavier workloads and time requirements for handling prior authorizations related to imaging and prescription drugs. They are mostly out of the loop with outside case managers getting more involved with their patients' care. Sometimes they are getting ousted from health plans' provider networks with no warning; and, if they get back in before open enrollment ends, they are unsure of how to stay in-network year-to-year or how to communicate such uncertainty to irked patients.

The "unfortunate part" is the need to handle a rising number of prior authorizations and other administrative tasks, which "is really driving a wedge in the physician/patient relationship," says Melissa Gerdes, MD, chair of the American Academy of Family Physicians' Commission on Quality and Practice.

"I don't think patients are aware this is happening at all, and they just get frustrated" when they learn that procedures and medications won't receive insurance coverage, says Gerdes, who practices part-time and serves as vice president and chief medical officer for Dallas-

➔41

➔40 based Methodist Health System's outpatient services and accountable care organization strategy.

Gerdes says that a decade ago, when she was in full-time practice, she had to handle perhaps two prior authorizations out of 150 patient visits per week; now she is handling 15 to 20 prior authorizations for 100 patient visits per week.

"I think every day you get one more grain of sand that makes it more difficult to stay in private practice...and takes away the joy of practice and contributes to burn-out," says Robert Eidus, MD, a family physician in Cranford, New Jersey. He works with 21 other physicians in a five-site primary care practice; his site has two physicians and a nurse practitioner.

Putting a price tag on physicians' escalating administrative costs is daunting, and estimates vary widely. But some practices have the advantage of calculating for a smaller universe.

"My guess for us is it costs in excess of $30,000 a year for all prior authorizations, including imaging, pharmaceuticals, tests – and that's principally staff time," says Brian Forrest, MD, who practices with two other family physicians in Apex, North Carolina. "But it's also patients we couldn't see because of the time we spent on prior authorizations. Sometimes patients may wonder why it's taking so long [to see the doctor], and it's prior authorizations."

The problem is getting worse, Forrest adds. "Two to three years ago for radiology, we only had one company requiring prior authorizations, now it's most carriers. With medications, now 80% to 90% of insurance plans require prior authorization, and Medicare Part D is very expensive for patients if it's not a preferred drug."

REMOVING 'REASONABLE DOUBT'

Citing research indicating that about 30% of medical procedures in the U.S. are wasteful, David Mirkin, M.D., chief medical officer for Milliman MedInsight, says prior authorization "is here and coming back with more emphasis because it works."

"There's always reasonable doubt [about necessity of services]," Mirkin says, "and one of the things doctors are not very good at is providing all the information needed to remove that reasonable doubt."

Mirkin says that payers' scrutiny of medical necessity and the appropriateness of clinicians' decision-making will be increasingly important. Network cancellations also will continue as health plans compare the efficiency of participating physicians, he says. "If I'm using more services, they're going to wonder, 'Why am I an outlier?'...Unless somebody can show the quality of my care is 10 times better, why should [insurers] pay more?...ACOs are working with lower-cost doctors in their networks already."

Practicing physicians respond that their aim is to provide the best care for their patients—and to have sufficient time away from administrative tasks to do so.

Robert Wergin, MD, president of the American Academy of Family Physicians (AAFP), says the academy supports responsible use of resources. But he says the academy, as an advocate for many small physician practices trying to stay afloat on low margins, also seeks more standardization and simplification of administrative processes, and that the AAFP emphasizes the significant burdens placed the current system imposes on patients and physician practices.

Wergin, who works in a small practice of eight family physicians and three physician assistants in rural Nebraska, recalls spending about three hours successfully appealing a payer's denial of a breast-cancer patient's MRI. The process included calls and letters to the payer and supporting documentation from her medical and radiation oncologists. He says her plan's physician-reviewer called to apologize, approved the MRI and conceded the matter never should have gone past the first-level appeal. "But they never sent me a check for three hours" of administrative work, he says.

PHYSICIAN BURNOUT

Eidus recalls that when he began practicing 37 years ago, solo practitioners typically employed a nurse or perhaps a nurse and a receptionist. They used a pegboard paper billing system, collected most of their money by cash, and gave patients a form to send to their insurance companies.

Other than completing the patient's medical chart, perhaps 1% to 2% of the physician's time was spent on matters other than patient care and overhead costs were about 35%.

"Today, overhead is about 70% and we have many more employees; and despite having many more employees, physicians are spending about 40% of their time in

> "I think every day you get one more grain of sand that makes it more difficult to stay in private practice ... and takes away the joy of practice."
>
> –ROBERT EIDUS, MD, FAMILY PHYSICIAN, CRANFORD, NEW JERSEY

> Sometimes patients may wonder why it's taking so long [to see the doctor], and it's prior authorizations."
>
> — BRIAN FORREST, MD, FAMILY PHYSICIAN, APEX, NORTH CAROLINA

activities not directly related to patient care," Eidus says. "That involves completing forms, prior authorizations, refills and a host of other issues."

The result of gradually adding administrative duties is that doctors must see more patients per hour, he says, and time spent with patients is compressed, making it difficult to do comprehensive care.

"If a doctor has to see 25, 30 patients a day and on top of that has several hours of administrative activity, that contributes to burnout," Eidus says. "It's a bad recipe."

PRIOR AUTHORIZATIONS

Deborah Walker Keegan, Ph.D., MBA, president of Medical Practice Dimensions, Inc., says that reducing care costs is the primary driver of the prior authorization trend.

Payers want to be sure the patient meets clinical requirements for the service, with evidence-based clinical protocols driving many of these decisions, she says. Payers also will say they want to be sure patients are not receiving unnecessary care.

"Unfortunately," Keegan says, "it can take a nurse or medical assistant up to 45 minutes simply to obtain a medication authorization, and some of these authorizations have to be escalated peer to peer to involve the physician, consuming valuable physician and staff time."

Given that prior authorizations consume significant time and resources in most medical practices, Keegan says that administrative simplification is needed. She suggests trying to concentrate this work with one or two staff members, rather than having each physician's nurse or medical assistant involved in the process. "This serves to standardize and streamline the work; however, it is still labor-intensive," she says.

In large practices with pharmacy staff, she says, she often asks clinical pharmacists or pharmacy technicians to handle medication prior authorizations, thus "focusing this work with staff who have the requisite knowledge and expertise." While small practices won't have the luxury of using clinical pharmacists, she says they, too, can consolidate staffing, "rather than everybody doing everything."

Doctors understand why prior authorizations for imaging were created and the potential benefits in reducing costs and unnecessary radiation exposure to patients, Eidus says. However, he says, utilization management firms might cite cost savings if, for example, a patient with back pain doesn't get an outpatient MRI but ends up getting one in the emergency department. In such cases, he says, "costs may be way higher and [yet] the utilization management company is taking credit for saving the MRI when it really didn't."

Eidus describes the use of prior authorization as "a very blunt tool." If his office sends a prior authorization request that gets denied because of what is described as missing information, he says, "it ends up with a 20-minute phone call to a medical director somewhere."

Prior authorization also is applied across the board, he says, even for doctors using evidence-based clinical guidelines who have aligned financial incentives to contain costs, such as pay-for-performance, patient-centered medical homes and shared-savings arrangements.

Medication prior authorizations "have been getting worse because of Medicare Part D," Eidus says. When a beneficiary switches health plans, what used to be in-formulary may become out-of-formulary. "That's a problem," he says.

According to Eidus, the most pressing emerging concern involves supplies for diabetes management. "Pharmacies are getting very intrusive...and want doctors to testify their patients are testing blood sugars [in order] to give out supplies," he says. "Some pharmacies are asking us to send office notes to them."

Drug companies are marketing directly to people with diabetes, he says, "so we have patients switching to new [brands] every month ... and we get a new order to write on supplies." This is not an area that patients misuse, making it hard to understand what is driving payers' requests for information, he says.

"If the federal government wants to get involved in certifying the effectiveness of test strips, let them do that," he says. "But don't put us in the middle...We assume they're all effective."

Pulmonary medications, which are still generally brand-name, and diabetes medications with injectable insulins, which might average $200 to $300 a month if patients had to pay out-of-pocket, "are probably the toughest, where we're most likely to get a call or a fax

➔44


Want more? We've got it.
Just go mobile.
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.
get it at medicaleconomics.com/gomobile
Medical Economics
SMARTER BUSINESS. BETTER PATIENT CARE.
iPad is a registered trademark of Apple Inc.

➔42 saying, 'You need to do a step edit and prior authorization,'" says Forrest, the family physician in North Carolina. "It takes a lot of time."

It wasn't until a few years ago that a major payer in North Carolina rolled out radiology prior authorization for anything beyond a plain film X-ray, Forrest recalls. "When that first happened, it was shocking," he says. Now, he says, "We may have one to four radiology prior authorizations on any given day. That could take up to two hours" to process.

CASE MANAGERS: ADDING AN EXTRA LAYER

When payers put case managers in the mix, "it's almost like they're adding an extra layer" with patients in the middle, says Keegan, the medical practice consultant.

At this point, practices can't use them to extend the care team, getting notes or updates when they interact with patients in a formalized back-and-forth manner, because of liability, privacy and other concerns. "Can we use these virtual case managers as part of the official care team? We're just not there yet," she says.

Eidus says the situation with case managers is becoming very confusing. "On any one case, you may have four or five people touching that patient who calls himself a case manager and is interacting with the patient," he says. They may include the health plan's case manager; a hospital case manager handling discharge planning; a case manager for the healthcare delivery model, such as an accountable care organization (ACO); and, as in his practice, a care coordinator.

"It's really difficult to figure out who's doing what," and to communicate so as to avoid overlapping services, Eidus says. For example, "the health plan's care coordinator is dealing directly with the patient, and most of the time we don't get any information from them," he says. "Sometimes we get a basic letter, but not log notes on what

How network cancellations impact a practice

by **Judy Packer-Tursman**

About a year ago, James R. Pinke, M.D., an ophthalmologist in solo practice in Connecticut, received letters from a trio of insurance carriers outlining their plans to create special networks of "five-star" physicians for 2014. Then came a letter in late October with unexpected contents: Pinke would be removed as an in-network provider for UnitedHealthcare's 2014 Medicare Advantage (MA) network, effective February 1. He was not alone: more than 2,000 other Connecticut physicians also were being ousted.

Overnight, everything changed for Pinke Eye Center in Shelton, where he has practiced for 31 years. When he started out, about 500 of his active patients were covered by United's MA plan. Medicare comprises fully 87% of Pinke's practice--and United's MA plan is second only to traditional fee-for-service Medicare plus supplemental insurance for his patients.

"Effectively, we would have had to shut our doors. That's how many United Medicare Advantage patients we had," says Tina Pinke, the practice administrator who is also the ophthalmologist's wife.

According to Tina Pinke, the practice received no explanation from United concerning her husband's initial exclusion from its 2014 MA network. "It's very threatening to any practice to be removed from a very large Medicare Advantage network with no feedback," she says, noting that her husband has performed more than 30,000 cataract procedures "with no problems, no 'black letters,' nothing."

United spokesperson Betsy Chin says the company's decisions regarding network inclusion "are influenced by multiple factors, but they are locally driven and based on a combination of geography, quality and efficiency. When making decisions about our network, we focus on ensuring that our members will have ready access to care and also consider providers' relative performance on industry quality metrics and their ability to deliver high-quality care for the most members in the most cost-efficient manner."

Initially, Pinke stayed on United's 2014 online provider directory. Brokers knew of insurers' narrowing networks, but they had been given directories and still saw Pinke among listed network physicians. So did patients.

"There was mass confusion about who was in and who was out," Tina Pinke says, explaining her husband's name was on and off the list for a while. After two weeks, a United provider services representative returned the practice's phone calls and confirmed that Pinke would be removed

they're doing...nor do we get it from the hospital or ACO [case managers]....They would say, 'You're not [providing information to us] either.'"

Eidus says his care coordinator might reach out to an ACO's care coordinator, or if his patient is hospitalized, to the hospital's case manager; but this occurs on a case-by-case basis. His staffer "has the advantage of having access to our own records and the most accurate patient information," he says.

Forrest says outside case managers typically call his patients if they are hospitalized or getting certain medications, or they contact him and suggest a new approach. "I'll be frank. I pretty much ignore that totally, because making those decisions is between me and my patients," he says.

He estimates that one or two North Carolina insurers' case managers contact his practice per week, perhaps sending a fax suggesting a cheaper alternative; sometimes pharmacy benefit managers use their own case managers to suggest that patients could save money by using different drugs.

Less frequently—perhaps two to three times annually because of his patients' fairly low hospitalization rate—Forrest hears from hospital case managers. "I don't mind that. That doesn't seem like I'm being micromanaged, although sometimes patients don't like it," he says.

Gerdes, who wears two hats as a practicing physician and as an ACO executive, says only a small number of 220 participating physicians in Methodist Health System's Medicare Shared Savings Program plan didn't want to work with the Medicare ACO's nurse navigators. "We're trying to target what doctor offices want, not just give them more paperwork," she says, "so we've had good acceptance." Nurse navigators help plan members with complex needs for therapies and home-based services, she says, "and I don't know many practices that could do it themselves."

from the MA network.

Subsequently, the practice tried phoning 500 patients to alert them that Pinke wouldn't be in-network, explaining that meant he couldn't take United's MA patients – most of them elderly and coming to him for 30 years with active eye diseases such as glaucoma – after February 1, 2014.

The town's only other ophthalmologist also had been removed from United's 2014 MA network, leaving no ophthalmologists in-network at the local hospital, Tina Pinke recalls. Two local medical societies, along with Pinke and several other physicians, became vocal about the matter and hundreds of people attended a town hall meeting. On December 4, days before the MA open enrollment period ended, Pinke received a letter from United saying he was back in its 2014 MA network.

"None of our patients were notified, though," Tina Pinke says. "It caused a lot of animosity—patients blaming us, thinking Dr. Pinke did something wrong. It puts you totally on the defensive." She says it caused a "tremendous amount of disruption" to the practice, lengthening office visits because of explanations to patients at check-in and again by the ophthalmologist during exams.

United's initial letter to Pinke last fall "said you could appeal, and we immediately sent a certified letter, but we never received acknowledgment of the appeal," and United's followup letter in December didn't mention it, Tina Pinke says. "It just said, 'After further review of our network, we decided to include you.'" She isn't sure whether the Fairfield and Hartford county medical societies' legal involvement on behalf of members played a role.

In the end, she estimates that Pinke's practice lost about two dozen Medicare patients, "because they thought they had to go find another provider, so they did."

United's Chin says the insurer is approaching its 2015 MA network formation differently in Connecticut and elsewhere. "We have made several enhancements to our process based on our experience and the feedback we received from providers, members and other stakeholders," she says. "Specifically, we have made improvements to our provider and member communications, and have enhanced our notification process so that member notices will be mailed as soon as possible following provider notices."

United also will provide accurate information about a physician's network status for 2015, Chin says. "For providers who will no longer participate in the network, we will reflect a termination date in our online directories at least 30 days prior to the change taking effect," she says. "and the directory will display that they are not accepting new [United MA] members as patients."

The Pinke Eye Center also is handling matters differently this year. "In October, we will hand out letters to anybody coming into our practice to be aware of open enrollment and make sure their doctors are in their network," says Tina Pinke. "We got business cards from local insurance brokers to help patients find resources [if they request assistance] because we can't be giving people insurance advice."

Tina Pinke worries that she could learn the practice is being excluded from a network at any time, "and I have no way to prevent it or to help the patients understand why it would happen."

"I really am holding my breath to see what's going to happen in 2015...Believe me we're struggling. It's a very scary time right now for us and for our patients," she says. "They're narrowing the networks, increasing out-of-pockets. It's a nightmare and tough, especially in a solo practice, to keep your head above water."

FIGHTING BACK SERIES WINNER

Lemons to lemonade
Why I remain in practice

A physician with decades of experience reveals how he maintains his enthusiasm for the medical profession

by **GEORGE FERENCZI, MD, MBA**

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 winners in the Aug. 25, Sept. 25 and Oct. 25 issues, and will unveil one more winning entry in the Dec. 25 issue. 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.

Just looking at this makes me depressed," says one of my partners as he laid down the recent edition of the medical newsletter announcing the latest details of Medicare's meaningful use requirements. I, along with just about every physician I know, could certainly relate to how he felt. We all face spiraling decreases in reimbursement; continued unfunded mandates requiring us to expend money and increasing time on initiatives without proven value, and upgrades (I call them downgrades) to our EHR [electronic health record]that mean more time entering data in ever- greater detail that most of us feel benefit neither our patients nor us.

We are portrayed in the media as being incompetent, money-hungry, uncaring, arrogant, all the while walking around with targets on our back for the ever-increasing number of trial attorneys looking to cash in the tort system of medical malpractice.

Hospitals and insurance companies, not to mention state and federal agencies are dictating more and more how we practice medicine, and we, as a profession, appear impotent in altering this process. As I heard someone say, "They keep torturing us, and we have nothing left to confess."

Truth be told, we bear at least some of the blame for what has happened to us. Through lack of our involvement, the organizations that are supposed to represent us no longer do, as they were co-opted by small groups of entrenched medical politicians and administrators more interested in maintaining their well-paying fiefdoms than leading us toward solutions.

We have also done a poor job of policing our own ranks by allowing the establishment of a legal system that makes it almost impossible to weed out the bad apples in our ranks without incurring costly litigation and high personal liability.

We have also allowed outside forces to pin the blame on all the ills in the system directly on us, rather than those who have been garnering the lion's share of the profits in the healthcare pie: the insurance companies, the pharmaceutical industry, and the IT and health equipment industry.

Notice, there has been no government intervention to rein in their profits, though they account for almost 70% of healthcare expenditures.

The paying public should be given a bill that reflects the true allocation of costs. For example, that $100 aspirin bill they received while in the hospital should state: cost of aspirin-$0.05; cost of meeting Joint

Commission requirements to dispense aspirin-$35.00; cost of uncompensated care hospital is required to provide by law-$30.00; cost of meeting unfunded state and federal mandates-$34.95. Then patients would better understand where their money is going, and who is responsible.

Change is inevitable. Buffeted as we are by the winds of change, I remain optimistic that as long as there are those of us who can remember why we chose this career in the first place, our profession will survive.

I have reached the age where I have relaxed fit skin to match the clothes I wear, and I continue to practice, despite all the frustrations I share with my partners, as well as the rest of you out there, not to maintain my standard of living, but because I love what I do. I was fortunate to discover a long time ago the wisdom in Winston Churchill's statement: "We make a living by what we get. We make a life by what we give."

Here, then, is the prescription that has worked for me, and hopefully, will do the same for you:

1 The biggest payoff I've had in medical practice has been my relationship with my patients. We in medicine are given an incredible gift—the immediacy of a relationship with another person, with a lot of the veils that many of us cover ourselves with lifted. If you take the time to ask your patients to share their stories with you, you will discover some incredible tales of heroism, pathos, love, and history.

You will be changed, as I have, by dying patients who have taught me about dignity in the face of indignity, about courage to fight battles no one knows how to win, about the power of hope over despair, about grace and the strength of the human spirit. I'm reminded daily to live as if I am dying, for none of us finish this ride alive, but appreciating the ephemeral nature of our existence helps to focus our attention on all that is good and beautiful around us.

I have a patient, 96 years old, who still lives by herself, drives her own car, sends me e-mails, has a wonderful sense of humor, makes the best lemon cakes ever for my wife and I on our respective birthdays, and gives me hope for the future. Doing something well means caring about the person for whom you are doing it.

2 The other reason I still work at this stage of life is I enjoy learning something new. One of the gifts of our profession is that you can never get bored. There are so many new discoveries, so many advances each day that it's hard to keep up. That's the reason I've been involved in teaching medical students and house staff for the past 38 years. There is no better motivator to keep up in your field than the stimulation that comes from teaching someone else.

If at all possible, become involved in teaching, if not in a formal program, at least in your hospital. Teach your nurses, your colleagues, your staff, and you'll find yourself learning the most of all.

3 Live below your means. If you don't spend to the maximum of your income, if you don't carry debt, you won't feel anxious when reimbursement falls, and feel pressured to see more patients to keep afloat. It's hard to enjoy a patient encounter when you set a five-minute limit on the visit.

4 Get involved with your community. We have all been given great gifts, and the rewards that come from giving back to others are immense. We all have the opportunity to add a few threads to the texture of the world. Make yours more beautiful!

5 Form your own physician support group. We all face similar challenges, share similar frustrations. In my community, we try to make it a point to get together once every month or so over a meal, and talk about our issues. We vent, but also attempt to come up with solutions to problems within our own hospital and offices. I can't say we have been successful in each instance, but sharing the load has lightened the burden.

In her book *God Never Blinks*, Regina Brett observes: "Happiness is not getting what you want. Happiness is wanting what you have." ◘

George Ferenczi, MD, MBA, is a gastroenterologist at the Glendora Digestive Disease Institute in Glendora, California. He is a clinical professor of Medicine athe University of Southern California.

When practicing medicine RUNS IN THE FAMILY

by **ALISON RITCHIE** *Content associate*

When she was 12 years old, Ashley Smith Lane remembers putting on her father's white coat and walking around his Alabama clinic as though she were a doctor.

Now, at the age of 28 and in her second year of residency, she's no longer pretending.

HIGHLIGHTS

01 Watching parents who are physicians practice medicine often has a profound impact on a child's decision to purse the same career.

02 With all of the regulatory changes and new administrative burdens in healthcare, some physicians say they are reluctant to encourage their own children to follow that career path.

"Growing up as a doctor's child, you see the best part of it, and you see the time constraints," Lane says. "I grew up going to house calls with my dad, going to the ER [emergency room] when he had to admit a patient. It's definitely a lifestyle that you have to choose."

Lane is the third generation of physicians in her family, following in the footsteps of both her father and grandfather. Through the years, they have witnessed the transformation of healthcare firsthand, along with the advent of new technology and changes in private practice.

Her grandfather, George Smith Sr., MD, began his career as a pharmaceutical representative, where he says he gradually found his calling to pursue medicine. He began practicing on July 1, 1966, a day that dramatically changed healthcare when Medicare became available.

His son, George Smith Jr., MD, says he respected his father's job from an early age. "I used to carry [my father's] bag on house calls when I was a little boy," he says. "A lot of patients came by the house, and he treated people in our living room. I saw the respect and the admiration that my daddy's patients had for him."

In April 1986, a month before his daughter Ashley was born, Smith Jr. joined his father's practice. Today, they still work together at Clay County Medical Clinic in Lineville, Alabama, and they marched side-by-side with Lane in the processional as she received her medical degree from the University of Alabama.

SMALL-TOWN MEDICINE

While growing up in Milford, Nebraska, Brett Wergin recalls that when walking around town with his father, Robert Wergin, MD, FAAFP, it seemed as though he knew everyone.

He recalls one evening when several neighborhood kids knocked on their front door. The kids had just been in a bike accident, and they had recognized his father's car parked in the driveway. His father immediately rushed the kids to his practice and stitched up their injuries.

Three generations of treating patients

"I used to carry [my father's] bag on house calls when I was a little boy. A lot of patients came by the house, and he treated people in our living room. I saw the respect and the admiration that my daddy's patients had for him."

—George Smith, Jr., MD

"Growing up as a doctor's child, you see the best part of it, and you see the time constraints. I grew up going to house calls with my dad, going to the ER [emergency room] when he had to admit a patient. It's definitely a lifestyle that you have to choose."

—Ashley Smith Lane, medical resident

"When I started, we kept patient records on a five by sevev card in a file box, and we pulled them out when the patient came in. You wrote down what the problem was, what you found, and what you did about it. You could write that all on one line. An office visit was around $4, and there was no such thing as third-party reimbursement."

— George Smith, Sr., MD

It was seeing those interactions between his father and patients that influenced his decision to pursue family medicine.

"At an early age, I was with my dad if he had to run to the clinic for something, or if he had to go to the hospital to do rounds, he would to take me with him," Brett says. "I got to observe the way he spoke to [his patients] and the way they spoke to him. It was like he was a part of their family. Patients felt very comfortable confiding in him. It was amazing to witness."

Brett is now a fourth-year medical student at the University of Nebraska Medical Center in Omaha, his father's alma mater. Robert, meanwhile, is now the president of the American Academy of Family Physicians.

"Watching my dad growing up, he was definitely working hard and he certainly had limited time. But it never really seemed like it was a job," Brett says. "It looked like he enjoyed what he was doing every day."

WITNESSING MEDICINE'S TRANSFORMATION

Through three generations, the Smiths say they have seen the evolution healthcare has undergone. Smith Sr. says that for him, the biggest advances have come through new medical technology, including the widespread adoption of electronic health records (EHRs).

"When I started, we kept patient records on a five by seven card in a file box, and we pulled them out when the patient came in. You wrote down what the problem was, what you found, and what you did about it," Smith Sr. says. "You could write that all on one line. An office visit was around $4, and there was no such thing as third-party reimbursement."

Smith Sr. and his son agree that EHRs and quality metrics have added documentation headaches for physicians that often distract from patient encounters.

But Brett says current medical students

“THERE ARE SOME GENERATIONAL DIFFERENCES IN HOW WE APPROACH THE PRACTICE OF MEDICINE, BUT GOOD PATIENT CARE HASN’T GONE OUT OF STYLE.”

– GEORGE SMITH, JR., MD

have an advantage when it comes to using this new technology.

“I don’t think people in my dad’s generation could have ever imagined having a phone that they carry around with them in their back pocket that has the name of every medicine. All that information is right in front of you,” he says.

“My generation grew up with this technology, and we’ll be getting trained only on electronic medical records. We won’t know anything else.”

FUTURE GENERATIONS

With all of the regulatory changes and new administrative burdens in healthcare, some physicians say they are reluctant to encourage their own children to follow that career path.

In an exclusive survey by *Medical Economics*, 43% of physicians say they would recommend their child or a friend’s child pursue a career in medicine, while 33% say they would try to dissuade their child from pursuing that career path. That’s down from 46% recommending a medical career to their child in 2011.

Other surveys have reached similar conclusions. A 2012 survey from The Physicians Foundation found that only 42% of physicians would recommend medicine as a career to their children or other young people.

In that same survey, however, nearly 67% of respondents said if they could do it all over again, they would still choose a career as a physician.

“Sometimes when you go to a doctor’s lounge, there can be a lot of negativity. Most of it pertains to all of the rules and regulations, meaningful use and those sort of things,” Robert Wergin says. “But if you ask the doctor, ‘Do you enjoy the time you spend with your patients?’ I don’t think you get much variance in that response. They’re still very satisfied with that experience of taking care of someone.”

Smith Jr. says that at first he did have mixed feelings about his daughter’s decision to pursue family medicine.

“There’s a great deal of satisfaction about doing family medicine in a small town. But there’s a difference to it now, especially lifestyle wise, and I just wanted to make sure that she was ready for that,” he says. “Medicine has changed a lot since 1966, and it’s changed a lot since 1986. There are so many other demands on our time other than patient care.”

After seeing many of his colleagues suffer burnout, Smith Jr. says it will be important for the next generation of physicians to pace themselves.

“I think Ashley’s generation has a better idea in what they want in terms of lifestyle and how they want to approach piecing together their career with the rest of their life and their family,” Smith Jr. says. “I’m confident that this generation understands their priorities and will get it right for them. There are some generational differences in how we approach the practice of medicine, but good patient care hasn’t gone out of style.”

As medicine continues to evolve, Brett says he’s optimistic that one aspect will always stay the same.

“There’s one thing that I hope never changes about medicine–that will be the same 100 years ago and 100 years from now: The physician-patient relationship,” Brett says. “Those meaningful interactions you have in the room with your patient.”

SHARE YOUR STORY

Does the practice of medicine run in your family?

Tell your fellow physicians your story by sending an email to **medec@advanstar.com.**

Legally Speaking

RESTRICTIONS GROWING ON PHYSICIAN SPEECH IN EXAM ROOM

by **JOHN G. MARTIN, JD, MICHAEL G. DIFIORE, JD,** *and* **JESSICA F. SONPAL, JD** *Contributing authors*

An open relationship between physician and patient is crucial to good healthcare. But are there limits to what physicians can ask their patients? Laws restricting doctors' freedom to discuss certain topics with patients, enacted primarily to promote a particular political viewpoint, are nothing new. Still, physicians must be mindful of this troubling trend.

IN 2011, the state of Florida enacted the Firearm Owners Privacy Act (FOPA). That law regulates what doctors may ask patients during examination and treatment.

Specifically, it prohibits physicians from:

- **inquiring about patient firearm ownership unless the physician believes in good faith that it is relevant to the patient's medical care or safety;**
- **entering information regarding firearm ownership in a patient's medical record if it is irrelevant to the patient's medical care or safety; and**
- **discriminating against or unnecessarily harassing a patient regarding firearm ownership.**

Physicians who violate the act may be subject to disciplinary sanctions including reprimands, fines and license suspension, restriction or termination.

History of restricting physician speech

Such laws governing what a physician can or cannot ask a patient are not new.

In 1988, the Reagan Administration enacted regulations that prohibited employees of Title X (low income) clinics from discussing or recommending abortion as a method of family planning, as part of the Republicans' efforts to make it more difficult for poor women to obtain abortions. (Congress had already prohibited the use of federal funds to pay for abortions.)

In 1990, Pennsylvania passed a law requiring doctors to give a variety of information to women seeking abortions, including material created by the government that described the fetus, and a list of adoption agencies, all designed to dissuade patients from having an abortion.

The federal government, through the Drug Enforcement Administration (DEA), has threatened physicians with loss of their license to prescribe controlled substances if they discuss marijuana with patients, even in states that have legalized medical marijuana.

Although the law has long recognized that doctors and patients have a fundamental First Amendment right to be able to speak frankly and openly (embodied in the doctor-patient privilege), courts, particularly the Supreme Court, have been willing to permit the narrow political objectives of government actors to override the interests of the doctor and patient.

Both of the abortion requirements discussed above were approved by the Supreme Court, and, while one lower Court struck down the DEA regulations on medical marijuana, the Supreme Court declined to hear the case.

The firearm law

It was against this backdrop that Florida passed FOPA. There can be little question that the Act was intended to further one political viewpoint: the pro-gun position.

Florida Governor Rick Scott characterized the law as a protection of Second Amendment rights: "I believe the citizens have a right to bear arms . . .I believe that we should be able to lead our lives

Legally Speaking

without people intruding on them." Apparently, however, Governor Scott did not believe that doctors and patients have a right to engage in confidential communication without the government intruding on them.

Doctors challenge the law in court

When a group of Florida doctors challenged FOPA in federal court the initial result was encouraging.

The District Court struck the law down as an unconstitutional abridgement of the First Amendment rights of doctors and patients. The Court listened to the American Academy of Pediatrics, as well as other healthcare provider groups, and concluded that doctors should be permitted to discuss any matter which they believe poses a health and safety risk to patients.

As one physician testified in opposing FOPA, he not only asked parents about firearms in the home, he asked about swimming pools, teenage drivers' text messaging habits, and alcohol and tobacco use, all of which had implications for his patients' health and safety. (In the U.S. more than 500 children were killed by firearms in 2009, and over 7,000 were shot.)

In addition, the Court rejected the state's position that questions about firearms posed by doctors threatened to abridge the Second Amendment rights of patients.

Courts, particularly the Supreme Court, have been only too willing to permit the narrow political objectives of government actors to override the interests of the doctor and patient.

However, on appeal the Eleventh Circuit Court of Appeals reversed the District Court and reinstated FOPA, rejecting the lower court's conclusion that the doctor-patient relationship and the need for open communication overrode the need to protect gun owners from being asked questions they did not want to answer.

In essence, the appellate court divorced the concepts of physician "speech" and physician "treatment" and rejected the argument that a doctor's inquiries regarding firearm ownership constitute speech.

The appellate court also likened FOPA to routine regulation of the medical profession: "a state may police the boundaries of good medical practice by routinely subjecting physicians to malpractice liability or administrative discipline for all manner of activity that the state deems bad medicine, much of which necessarily involves physicians speaking to patients."

True enough, but malpractice liability is ordinarily imposed when a physician fails to meet the appropriate standard of care, something typically determined by the medical profession, not elected politicians. To suggest that prohibiting doctors from asking a question about a particular topic is akin to protecting patients from malpractice is, if nothing else, a bit of a reach.

Implications for physicians

The physician-patient relationship necessarily includes an element of trust. Patients seek out physicians when they are ill and vulnerable, believing that the physician both possesses the skill required to heal the particular ailment and genuinely desires to help. Patients are told that the doctor's office is a safe, confidential place, where they are free to fully disclose all information without concern for judgment.

Laws like FOPA not only chip away at this key element of the doctor-patient relationship, but they place a burden on the doctor to self-censor, for reasons other than the best interests of the patient.

There are plenty of other topics that patients may prefer not to discuss with their physicians (alcohol and drug use, sexual activity, smoking habits, etc.). Are they next on the chopping block? Is it within the purview of a state's legislature to set the boundaries of what general background information physicians believe is relevant in assessing patient health?

If a patient is unhappy with his or her physician's questioning habits, should the onus not be on the patient to find another doctor rather than to invite the government into the examination room?

Unless the Supreme Court steps in and re-establishes the fundamental nature of First Amendment protection for doctor-patient conversations, doctors are well-advised to make sure they are aware of, and abide by, whatever government restrictions on their treatment discussions apply in their jurisdictions.

Sadly, that list seems to be growing.

The authors are attorneys at Garfunkel Wild, P.C. in Great Neck, New York. Send your legal questions to ***medec@advanstar.com****.*

FINANCIAL ADVISERS FOR DOCTORS

Those companies listed in *Medical Economics 2012 Best Financial Advisers for Doctors* display this symbol in their ads.

Medical Economics 2012 Best Financial Advisers for Doctors

★ FLORIDA

Medical Economics Magazine,
"Best Financial Advisers for Doctors,"
Austin Frye, JD, MBA, CFP®

Recognized for assisting physicians in strategically planning the **Growth, Protection and Preservation** of their wealth.

Frye Financial Center of South Florida
Guiding medical professionals throughout all phases of their careers and retirement.

20900 West Dixie Highway | Aventura, FL 33180 |305-931-3200
www.fryefinancial.com

★ NEBRASKA

PHYSICIANS' EXCLUSIVE FINANCIAL ADVISORS

JUSTIN NABITY

- Debt Management
- Asset Protection - Insurance
- Retirement & Investment Strategy
- Contracts and Partnership Agreements
- Partnership Financial Evaluations

PHYSICIAN ADVISORS
A Family of Doctors and Award-Winning Wealth Advisors™

PhysicianAdvisorsLLC.com | 877.744.9474

Your connection to the healthcare industry's best financial resources begins here.

Medical Economics 2013 BEST Financial Advisers For Doctors

Advertise today:
Patrick Carmody • Healthcare Marketing Advisor • pcarmody@advanstar.com • 1.800.225.4569, ext.2621

PRODUCTS & SERVICES

MEDICAL EQUIPMENT

PRACTICE FOR SALE

NATIONAL

RECRUITMENT

NATIONAL

MARKETPLACE

RECRUITMENT

NEW HAMPSHIRE

IN SOUTHERN NEW HAMPSHIRE, WE CAN MAKE YOUR PRACTICE PERFECT!

Enjoy four season recreations with no sales or income tax. Relax in a safe family setting close to Boston, mountains and seacoast. Generous salary, paid vacation/CME, retirement plan, disability plus family health and dental benefits provide job security for the physician & family. Affiliate with a progressive 200+ bed community hospital providing state-of-the-art diagnostic services and a high quality "Magnet status" nursing staff. St. Joseph Hospital/SJPS are looking for well-trained physicians in the following areas:

Internal Medicine Opportunity
Outpatient care in single specialty group with 1:10 Call plus Hospitalist support.

Board Certified Neurologist
General Neurology practice seeks BC Neurologist to take over for retiring physician. Position both in & out patient, EMG, EEG with a Call of 1:7 weekend and 2:4 weekday.

Family Practice Physicians
Out-patient primary care (no obstetrics) single-specialty group with a 1:14 Call, after hours nurse triage service and Hospitalist support.

Experienced BC Geriatrician
The RD Senior Center at St. Joseph Hospital specializes in treating the unique medical, emotional and mental health needs of older adults. Call is 1 in 10 with Hospitalist support.

Urgent Care Opportunity; both full and part time located in Milford, NH

Contact: Sharon Dionne, CMSR, CPC at (603) 882-3000 or sdionne@sjhnh.org or check us out at www.stjosephhospital.com • No J-1 positions available.

Advertiser Index

* Indicates a demographic advertisement.

The Last Word

STUDY: ACA DEMANDS MAY DETER FAMILY DOCS FROM TREATING KIDS

by **DONNA MARBURY, MS** *Content specialist*

The availability of primary care services for children is declining, as fewer family physicians are seeing children, according to a recent Annals of Family Medicine study. The study's authors say they are concerned that the Affordable Care Act policies that are increasing coverage for adults are spreading the services of current family physicians too thin.

THE PERCENTAGE of family physicians caring for children dropped from 78% in 2000 to 68% in 2009. That's a significant decrease considering that family physicians see nearly one third of children and children make up about 10% of their practice.

"Policy discussions regarding looming physician shortages and the implementation of healthcare reform have focused predominantly on adults," say the study's researchers from the Robert Graham Center for Policy Studies in Family Medicine and Primary Care. "The costs of adult-related healthcare can overwhelm those of children's care, leaving children's health services to be an afterthought in the minds of many policy makers."

Male family physicians, those who are older and those in a group practice are less likely to provide care to children. Also, in years when family physicians are taking recertification exams, they see fewer child patients.

The survey was given to family physicians taking the American Board of Family Medicine maintenance of certification exam between 2006 and 2009. Because the survey was a mandatory part of the test, it has a 100% response rate of 37,020 physicians.

Family physicians in the South and the West see fewer child patients than do Northeastern physicians. The Washington D.C. area had the lowest percentage of family physicians treating children at 45%; while 84% of Nebraska's family physicians treat children.

THE COSTS OF ADULT-RELATED HEALTHCARE CAN OVERWHELM ... LEAVING CHILDREN'S CARE AS AN AFTERTHOUGHT

"Family physicians, especially in rural and underserved areas, may face impossible demands to care for a larger insured population, resulting in decreased capacity to provide care for children," the study's authors say.

"Additionally, current geographic maldistribution of the child health care physician workforce is leading to difficulty with access to care for many children and families."

When family physicians practice obstetrics, they also treat more children, according to the study. Incentives for medical students who want to go into family medicine and the pediatric programs in medical schools should be strengthened to make the profession more profitable and less stressful, the study says.

"Strengthening existing partnerships and forging new collaborative relationships among general pediatric, obstetric, and family medicine educators may also be important if we are to ensure a well-trained, geographically well-distributed child physician workforce," the study's authors say. "Policy makers must consider how ongoing discussions of payment reforms, principally aimed at value-based purchasing and broader population management, influence access to care for children in areas with few providers."

RECOMMEND CORICIDIN® HBP:

Cold & Flu Relief Designed for People with Hypertension

Like many of your patients, S. Epatha Merkerson has hypertension. Since decongestants may raise blood pressure, these patients need a therapy made for them. Recommend Coricidin® HBP because it's a smart choice – it's decongestant-free and specially made to relieve cold and flu symptoms without raising blood pressure.

Use as directed.

American Heart Association®

The makers of Coricidin® HBP proudly support the American Heart Association's efforts to improve heart health.