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Medical board complaints: Do's and don'ts

CHRONIC CONDITIONS

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MARCH 25, 2020

VOL. 97 NO. 6

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- Beat new competitors
- Master care coordination challenges
- Promote your value

CAREER Find the best employment fit
TECH Recognizing cyber threats
LEGAL Medical board complaints: Do's and don'ts
CHRONIC CONDITIONS Close care gaps—and boost your rating
**FLUZONE® HIGH-DOSE QUADRIVALENT (INFLUENZA VACCINE)**
CONSISTENT REAL-WORLD EVIDENCE SINCE LAUNCH

**FIRST LICENSED IN 2009,** Fluzone High-Dose has been proven in a randomized controlled trial to prevent 24% more cases of influenza versus Fluzone® (Influenza Vaccine), a standard-dose comparator, in adults 65+.1-7

Primary endpoint of the study was the occurrence of laboratory-confirmed, protocol-defined, influenza-like illness caused by viral strains regardless of their antigenic similarity to vaccine components.

In a randomized controlled trial for immunogenicity and safety, the most common local and systemic adverse reactions to Fluzone High-Dose vaccine include pain at the injection site, myalgia, malaise and headache.8

**SINCE LAUNCH,** studies have demonstrated that Fluzone High-Dose reduced influenza-related complications such as hospitalizations, versus standard-dose influenza vaccine comparators.1-4

These results were demonstrated in large-scale retrospective observational studies within the following influenza seasons.

The efficacy of Fluzone High-Dose (trivalent formulation) is relevant to Fluzone High-Dose Quadrivalent since both vaccines are manufactured according to the same process and have overlapping compositions.

<table>
<thead>
<tr>
<th>LAUNCH</th>
<th>17%</th>
<th>(95% CI: 9-24) fewer cardiorespiratory hospitalizations1</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-2011</td>
<td>17%</td>
<td>(95% CI: 10-23) fewer cardiorespiratory hospitalizations2</td>
</tr>
<tr>
<td>2011-2012</td>
<td>19%</td>
<td>(95% CI: 10-26) fewer cardiorespiratory hospitalizations3</td>
</tr>
<tr>
<td>2012-2013</td>
<td>19%</td>
<td>(95% CI: 11-26) fewer cardiorespiratory hospitalizations3</td>
</tr>
<tr>
<td>2013-2014</td>
<td>18%</td>
<td>(95% CI: 12-23) fewer cardiorespiratory hospitalizations3</td>
</tr>
<tr>
<td>2014-2015</td>
<td>25%</td>
<td>(95% CI: 2-43) fewer influenza &amp; pneumonia hospitalizations2</td>
</tr>
<tr>
<td>2015-2016</td>
<td>31%</td>
<td>(95% CI: 8-48) fewer influenza-related hospitalizations3</td>
</tr>
<tr>
<td>2016-2017</td>
<td>9%</td>
<td>(95% CI: 7-11) fewer influenza-related hospital encounters4</td>
</tr>
<tr>
<td>2017-2018</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **~3.6M 65+ person-influenza seasons from Veterans Health Administration (VHA) and Medicare.**
  - Endpoints included All-Cause, Cardiorespiratory, and Pneumonia & Influenza Hospitalizations. Across all 5 seasons, the 3 endpoints were statistically significant. However, every endpoint was not statistically significant every season.4

- **~74,000 adults 65+ from VHA.**
  - Primary outcome was any hospitalization from pneumonia or influenza. Exploratory endpoints, which included outpatient visits from pneumonia or influenza, laboratory-confirmed influenza, all-cause outpatient visits, and all-cause hospitalizations, were consistently positive, even if not always statistically significant.2

- **~24,000 adults 65+ from Oregon’s Immunization Database3**

- **~13M Medicare beneficiaries.**
  - Fluzone High-Dose was significantly better compared to standard-dose influenza vaccine and acjvanted comparators, and similar to cell-based comparator for influenza-related hospital encounters.4

SANOFI PASTEUR, Discovery Drve, Swiftwater, Pennsylvania 18370. www.sanofi.us
SAUS.FLDHQ.19.12.6275 © 2020 Sanofi Pasteur Inc. 01/20 Printed in USA
Fluzone High-Dose Quadrivalent is a vaccine indicated for active immunization for the prevention of influenza disease caused by influenza A subtype viruses and type B viruses contained in the vaccine. Fluzone High-Dose Quadrivalent is approved for use in persons 65 years of age and older.

**IMPORTANT SAFETY INFORMATION FOR FLUZONE HIGH-DOSE QUADRIVALENT VACCINE**

Fluzone High-Dose Quadrivalent should not be administered to anyone who has had a severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine, including egg protein, or after previous dose of any influenza vaccine.

Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of the vaccine.

If Guillain-Barré syndrome has occurred within 6 weeks following previous influenza vaccination, the decision to give Fluzone High-Dose Quadrivalent should be based on careful consideration of the potential benefits and risks.

If Fluzone High-Dose Quadrivalent is administered to immunocompromised persons, including those receiving immunosuppressive therapy, the immune response may be lower than expected.

Vaccination with Fluzone High-Dose Quadrivalent may not protect all recipients.

For Fluzone High-Dose Quadrivalent, in adults 65 years of age and older, the most common injection-site reaction was pain; the most common solicited systemic adverse reactions were myalgia, headache, and malaise. Other adverse reactions may occur.

Please see brief summary of the full Prescribing Information on the following page.

2010-2011 through 2014-2015 Study Limitations: VHA has a 98% male population, which tends to have greater disease burden than the general population. No diagnosis codes, whether parts of medical or billing records, could capture conditions that are difficult to measure or are unmeasured.

2015-2016 Study Limitations: VHA has a 98% male population, and the PERR method could not be applied to the baseline period because the outcome was not observed here, possibly resulting in an underestimation of VE of Fluzone High-Dose.

2016-2017 Study Limitations: Results may be biased as the measures for exposure and risk (such as frailty) were not comprehensive. Some influenza-related hospitalizations, particularly non-respiratory hospitalizations, may not have been tested and detected as local area hospitals did not have uniform policies.

2017-2018 Study Limitations: Outcomes may not represent laboratory-confirmed influenza infections.

To order Fluzone High-Dose Quadrivalent, go to VaccineShoppe.com® or call 1-800-VACCINE (1-800-822-2463).

Fluzone High-Dose Quadrivalent is manufactured and distributed by Sanofi Pasteur Inc.

Fluzone High-Dose Quadrivalent (CPT® code 90662) is a covered benefit under Medicare Part B.

CPT (Current Procedural Terminology) is a registered trademark of the American Medical Association.


**Fluzone® High-Dose Quadrivalent**

Influenza Vaccine

Face flu with confidence

TO LEARN MORE
VISIT WWW.SANOFIFLU.COM
AND TO ORDER NOW
VISIT WWW.VACCINESHOPPE.COM
Fluzone® High-Dose Quadrivalent (Influenza Vaccine), Suspension, for intramuscular injection
2018-2019 Formula

Brief Summary of Prescribing Information

1 INDICATIONS AND USAGE
Fluzone® High-Dose Quadrivalent is a vaccine indicated for active immunization for the prevention of influenza caused by influenza A subtype viruses and type B viruses contained in the vaccine.

Fluzone High-Dose Quadrivalent is indicated for use in persons 65 years of age and older.

2 DOSAGE AND ADMINISTRATION
For intramuscular use only

2.1 Dose and Schedule
Fluzone High-Dose Quadrivalent should be administered as a single 0.7 mL injection by the intramuscular route in adults 65 years of age and older.

2.2 Administration
Inspect Fluzone High-Dose Quadrivalent visually for particulate matter and/or discoloration prior to administration. If either of these conditions exists the vaccine should not be administered.

Before administering a dose of vaccine, shake the prefilled syringe.
The preferred site for intramuscular injection is the deltoid muscle. The vaccine should not be injected into the gluteal area or areas where there may be a major nerve trunk.

Do not administer this product intravenously.

Fluzone High-Dose Quadrivalent should not be combined through reconstitution or mixed with any other vaccine.

4 CONTRAINDICATIONS
A severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine [see Description (11) in the full prescribing information], including egg protein, or to a previous dose of any influenza vaccine is a contraindication to administration of Fluzone High-Dose Quadrivalent.

5 WARNINGS AND PRECAUTIONS
5.1 Guillain-Barré Syndrome
If Guillain-Barré syndrome (GBS) has occurred within 6 weeks following any previous influenza vaccination, the decision to give Fluzone High-Dose Quadrivalent should be based on careful consideration of the potential benefits and risks.

The 1976 swine influenza vaccine was associated with an elevated risk of GBS. Evidence for a causal relation of GBS with other influenza vaccines is inconclusive; if an excess risk exists, it is probably slightly more than 1 additional case per 1 million persons vaccinated. GBS has also been temporally associated with influenza disease. (See references 1 and 2 in the full prescribing information.)

5.2 Preventing and Managing Allergic Reactions
Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of the vaccine.

5.3 Altered Immunocompetence
If Fluzone High-Dose Quadrivalent is administered to immunocompromised persons, including those receiving immunosuppressive therapy, the immune response may be lower than expected.

5.4 Limitations of Vaccine Effectiveness
Vaccination with Fluzone High-Dose Quadrivalent may not protect all recipients.

6 ADVERSE REACTIONS
6.1 Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse event rates observed in the clinical trial(s) of a vaccine cannot be directly compared to rates in the clinical trial(s) of another vaccine and may not reflect the rates observed in practice. One clinical study has evaluated the safety of Fluzone High-Dose Quadrivalent.

Study 1 (NCT03282240, see https://clinicaltrials.gov) was a randomized, active-controlled, modified double-blind pre-licensure trial conducted in the U.S. The study compared the safety and immunogenicity of Fluzone High-Dose Quadrivalent to those of Fluzone High-Dose (trivalent formulation). The safety analysis set included 1777 Fluzone High-Dose Quadrivalent recipients, 443 Fluzone High-Dose recipients, and 450 investigational Fluzone High-Dose containing the alternate B influenza strain recipients.

The most common reactions occurring after Fluzone High-Dose Quadrivalent administration were injection-site pain (41.3%), myalgia (22.7%), headache (14.4%), and malaise (13.2%). Onset usually occurred within the first 3 days after vaccination. The majority of solicited reactions resolved within three days of vaccination.

Table 1 displays solicited adverse reactions for Fluzone High-Dose Quadrivalent compared to Fluzone High-Dose reported within 7 days after vaccination and collected using standardized diary cards.

Table 1: Study 1: Frequency of Solicited Injection-Site Reactions and Systemic Adverse Events within 7 Days after Vaccination with Fluzone High-Dose Quadrivalent or Fluzone High-Dose, Adults 65 Years of Age and Older

<table>
<thead>
<tr>
<th></th>
<th>Fluzone High-Dose Quadrivalent (N=1761-1768) Percentage</th>
<th>Fluzone High-Dose (N=885-889) Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local Reactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection Site Pain²</td>
<td>41.3</td>
<td>36.4</td>
</tr>
<tr>
<td>Injection Site Erythema³</td>
<td>6.2</td>
<td>5.7</td>
</tr>
<tr>
<td>Injection Site Swelling³</td>
<td>4.9</td>
<td>4.7</td>
</tr>
<tr>
<td>Injection Site Induration³</td>
<td>3.7</td>
<td>3.5</td>
</tr>
<tr>
<td>Injection Site Bruising³</td>
<td>1.3</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Systemic Reactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myalgia²</td>
<td>22.7</td>
<td>18.9</td>
</tr>
<tr>
<td>Headache³</td>
<td>14.4</td>
<td>13.6</td>
</tr>
<tr>
<td>Malaise³</td>
<td>13.2</td>
<td>13.4</td>
</tr>
<tr>
<td>Shivering³</td>
<td>5.4</td>
<td>4.7</td>
</tr>
<tr>
<td>Fever⁴</td>
<td>0.4</td>
<td>0.9</td>
</tr>
</tbody>
</table>

* NCT03282240
11N is the number of vaccinated participants with available data for the events listed
2 Safety results for the Fluzone High-Dose and investigational Fluzone High-Dose containing the alternate B influenza strain recipients were pooled for the analysis.
3 Grade: A type of AE that interrupts usual activities of daily living, or significantly affects clinical status, or may require intensive therapeutic intervention.
4 Grade: 3: > 100 mm
5 Grade: 2: > 102.1°F (39.0°C)

Based on data from Fluzone High-Dose, solicited injection site reactions and systemic adverse reactions were slightly more frequent after vaccination with Fluzone High-Dose compared to a standard-dose vaccine.

Unsolicited non-serious adverse events were reported in 279 (15.7%) recipients in the Fluzone High-Dose Quadrivalent group and 140 (15.7%) recipients in the Fluzone High-Dose group. The most commonly reported unsolicited adverse event was cough.

Within 180 days post-vaccination, 80 (4.5%) Fluzone High-Dose Quadrivalent recipients and 48 (5.4%) Fluzone High-Dose recipients experienced a serious adverse event (SAE). None of the SAEs were assessed as related to the study vaccines.

6.2 Postmarketing Experience
The following additional adverse events have been spontaneously reported during the postmarketing use of Fluzone High-Dose, Fluzone, or Fluzone Quadrivalent and may occur in people receiving Fluzone High-Dose Quadrivalent. Because these events are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to vaccine exposure. Adverse events were included based on one or more of the following factors: severity, frequency of reporting, or strength of evidence for a causal relationship to Fluzone High-Dose, Fluzone, or Fluzone Quadrivalent.

- **Blood and Lymphatic System Disorders:** Thrombocytopenia, lymphadenopathy
- **Immune System Disorders:** Anaphylaxis, other allergic/hypersensitivity reactions (including urticaria, angioedema)
- **Eye Disorders:** Ocular hyperemia
- **Nervous System Disorders:** Guillain-Barré syndrome (GBS), convulsions, febrile convulsions, myelitis (including encephalomyelitis and transverse myelitis), facial palsy (Bell’s palsy), optic neuritis/neuropathy, brachial neuritis, syncope (shortly after vaccination), dizziness, paresthesia
- **Vascular Disorders:** Vasculitis, vasodilatation
- **Respiratory, Thoracic and Mediastinal Disorders:** Dyspnea, cough, wheezing, throat tightness, oropharyngeal pain, and rhinorhea
- **Gastrointestinal Disorders:** Vomiting
- **Skin and Subcutaneous Tissue Disorders:** Stevens-Johnson syndrome
- **General Disorders and Administration Site Conditions:** pruritus, asthenia/fatigue, chest pain, chills
8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy
Fluzone High-Dose Quadrivalent is not approved for use in persons <65 years of age. There are limited human data on Fluzone High-Dose and no animal data available on Fluzone High-Dose Quadrivalent to establish whether there is a vaccine-associated risk with use of Fluzone High-Dose Quadrivalent in pregnancy.

8.2 Lactation
Fluzone High-Dose Quadrivalent is not approved for use in persons <65 years of age. No human or animal data are available to assess the effects of Fluzone High-Dose Quadrivalent on the breastfed infant or on milk production/excretion.

8.4 Pediatric Use
Safety and effectiveness of Fluzone High-Dose Quadrivalent in children younger than 18 years of age have not been established.

8.5 Geriatric Use
Safety, immunogenicity, and efficacy of Fluzone High-Dose Quadrivalent have been evaluated in adults 65 years of age and older [see Adverse Reactions (6.1) and Clinical Studies (14) in the full prescribing information].

Manufactured by:
Sanofi Pasteur Inc.
Swiftwater PA 18370 USA

INHDQ-BPLR-SL-NOV19 Revised: November 2019
Are retail clinics a threat—or an opportunity?

Primary care is undergoing a retail boom. Major companies, from Walmart to CVS and dozens of others, are opening retail clinics to provide basic healthcare services to patients without the need for an appointment. Meanwhile, hospital conglomerates are opening their own clinics, including both retail and urgent care.

Primary care physicians watch this trend unfold grimly. What they see are competitors supported by billion-dollar investments undercutting the basic services that physicians perform. How can traditional practices compete?

*Medical Economics* dove into this trend to explore this question for our cover story in this, our March 25, 2020, issue. And while, yes, there are strategies physicians can put in place to compete, another strategy for surviving this retail boom is to embrace a new role that requires improved care coordination and building stronger relationships with your patients—two things that are the strength of our primary care physicians.

Our interviews with physicians showed us that they are not going to cede ground in the healthcare space because they plan to lean on their strengths of treating complex patients with complex needs. As Gary LeRoy, MD, the president of the American Academy of Family Physicians told us, “Just because it’s called primary care, doesn’t mean that it’s easy care, because there’s nothing easy about what we do.”

Another feature in this issue is on medical board complaints. Physicians obviously focus on malpractice lawsuits, but medical board complaints can be just as damaging. One of our legal expert explains how to prepare if you face such a complaint and walks you through the steps of the process.

In addition, this issue features articles covering:
- how primary care physicians can improve their care quality and star ratings;
- negotiating employment contracts and how to find the best fit; and
- tips for training your staff to recognize cyber threats.

As always, if you have feedback on our content, story ideas, or would like to contribute to *Medical Economics*, please reach out to our editors at medec@mjlifesciences.com.

Mike Hennessy, Sr.
Chairman and Founder
of MJH Life Sciences

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any physicians are getting questions from their patients about the corona virus outbreak that has dominated the news in recent weeks. While the outbreak is not a public health crisis in the United States, many patients are fearful about the virus. So, what can physicians do to provide accurate information for their patients?

Michaela Fleming sat down with Christina Tan, MD, to discuss what physicians need to know about the corona virus outbreak and how they can ease their patients concerns.

MEDICAL ECONOMICS: What do we know so far about the origins of this novel coronavirus?

TAN: What is making this virus so concerning, is that with any sort of emerging infection, we don’t have a lot of room for information preliminarily, so we don’t know whether there’s the potential for widespread community transmission. So right now we’re in the process of just gathering more information. We know that with an emerging infection that most individuals have not been exposed to, there’s always concerned that, you know, we’re going to see serious illnesses, we’re going to see the potential for pandemic spread. We’re cautiously watching what’s going on.

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CODING INSIGHTS

Chronic care management coding requirements

Our office is billing the Chronic Care management code **99490** each month for some of our sicker patients, but I want to make sure we’re doing it right. What has to be documented to qualify?

A: The **99490** is designed to capture clinical staff time of at least 20 minutes in a calendar month that is devoted to the activities associated with chronic care management (CCM).

So first you need to be sure that the basic criteria are met: The two or more chronic conditions that place the patient at risk are “established, implemented, revised or monitored” in the care plan and the qualifying activity of staff.

Once that is determined, it’s about leaving a footprint in the medical record that outlines the CCM-related activity. You need to make very obvious the total time spent, the month, the identity (including credential) of the clinical staff involved—and what specific CCM activities were performed.

Best practice is to have the CCM patient information in a “plan” document. At the top of that document make a template that allows for monthly contact info, time, date, etc.

Below that, list the various named activities per chronic condition followed. Then cover the other components:

- Assessment/support for treatment regimen adherence and medication management,
- Ongoing review of patient status, including review of lab and other studies not reported as an E/M service,
- Patient and/or caregiver education to support self-management,
- Independent living and ADLs,
- Communication with home health/other agency,
- Facilitating access to care and services,
- Management of Care Transitions.

These are listed in the CPT manual in the subsection text just before code **99490**. You don’t have to do all these things every month—these are just general categories of things you might do. If you have something else in that section one month, add it.

Focus your form on identifying the interim chronic problem-related activity that month. Often, we see a plan written a year ago, copied endlessly, with a scrawled signature—and it gives no information on who did what.

CCM codes aren’t for every time a patient calls for a refill—it’s about supporting the management of specific chronic conditions. CMS expects that there is real physician time directing or coordinating these staff activities. Make that easy to see.

Q: When billing consults, does the provider have to indicate in the medical record that they “CC” the referring provider? Is there anything in writing about this? We are getting denials from payers after medical records are reviewed.

A: The consult requirement isn’t just a “CC.” Look in your CPT book—that’s where the generally recognized consult requirements are. Aside from a documented request for the consults, the consultant’s opinion must also be documented and communicated by written report. And they mean back to whatever source requested the consult.

If the medical record is shared between the requesting and consulting physicians, you don’t need a separate report. That said, it doesn’t hurt to document that the “results have been made available to the requesting provider” (better with a name). That’s all the “cc” is—an indication that something was shared.

Bill Dacey, MHA, MBA, CPC, is principal in The Dacey Group, Inc., a consulting firm dedicated to coding, documentation and compliance concerns for physicians. Send your coding questions to medec@mmhgroup.com.
Doctors are fond of complaining that they didn’t go to medical school to practice business, but independent physicians do spend much of their time on their practices’ finances.

That requires mastering revenue cycle management (RCM), the financial process practices use to administer all the functions associated with claims processing, payment, and revenue generation.

At the level of the individual patient, RCM begins when that patient makes an appointment and ends when all claims and payments resulting from that appointment and subsequent services have been settled. At a higher level, it means ensuring that the practice generates enough income to pay its expenses and yield a profit.

RCM has never been easy, but the move to value-based care and reimbursement, as well as more risk-based payer contracts, has made it harder than ever. A 2016 survey by research firm Black Book found that 90 percent of small, independent practices were unprepared financially and technologically to implement value-based care.

Difficult though it may be, efficient and disciplined RCM is key to a practice’s ability to remain independent. “Effective revenue cycle management isn’t going to guarantee your practice’s financial success, but neglecting revenue cycle management might result in its failure,” says Melissa Lucarelli, MD, a family physician in Randolph, Wis., and a member of the Medical Economics editorial advisory board.

A MOVE TO OUTSOURCING

As RCM becomes increasingly demanding, more practices are turning to vendors to handle part or all of it.

The Black Book study predicted that the U.S. market for physician and ambulatory RCM outsourcing and extended business office services would grow by 42 percent between the end of 2016 and the beginning of 2019. The same survey of 2,000 independent physician practices found that 59 percent of providers intended to outsource some or all of their billing.

“High-impact drivers of the physicians practice outsourcing market include the increasing emphasis on compliance and risk
Revenue cycle management and the need for more efficient and cost-effective processes,” Black Book Managing Partner Doug Brown says in the study.

The rising costs of operating a practice also underscore the importance of RCM. A 2018 Medical Group Management Association study found that over the past five years median operating costs for primary care practices have risen by 13 percent, from $391,798 to $441,559 per physician. And while revenue can fluctuate, expenses such as salaries, rent, insurance, and equipment payments must be paid on a regular, fixed schedule.

Outsourcing RCM is comparable to a primary care physician referring a patient to a specialist, says Todd Van Meter, senior vice president, ambulatory care, for Optum360, a revenue cycle management firm based in Eden Prairie, Minn.

The specialist has greater resources, knowledge, and expertise than the generalist to handle the situation, he says. And unlike a practice whose primary mission is providing healthcare, a vendor is focused solely on RCM, making it easier for them to stay current on regulatory and reporting requirements while discovering new efficiencies.

Lucarelli says outsourcing much of her RCM has been a boon for her small, rural practice. “These are tasks we could do and we used to do, but the system does the heavy lifting and the drudgery stuff that keeps us away from the medical stuff we want to do,” she says.

She uses her EHR vendor for coding, billing, verifying insurance coverage, interfacing with payers, and other functions. The system has been particularly helpful for meeting reporting requirements under the Merit-based Incentive Payment System, as well as providing upgrades, such as free interfaces with labs.

“There is no way that I would go back to the old way and be able to provide medical care the way I want to,” she says.

**KEEPING IT IN THE PRACTICE**

Not all practices find it beneficial to outsource RCM, however.

Associated Physicians is a 20-doctor independent practice in Madison, Wis., that offers comprehensive primary care services, including physical therapy, nutrition counseling, and diabetes education while operating its own lab.

The accompanying volume and complexity of paperwork, reporting, and regulations would push some practices to outsource their RCM, but Associated Physicians does nearly everything with its own employees. “We want to remain independent. Part of that independence is wanting to do as much inside as possible,” says Executive Director

**Choosing an RCM vendor**

Using an RCM vendor does not have to be an all-or-nothing proposition. Many independent physicians, like Melissa Lucarelli, MD, a solo practitioner in Randolph, Wis., choose to outsource some functions and keep others in-house.

She recommends developing policies and processes for each phase of RCM, from pre-authorization to collections, then scrutinizing them to determine if it makes financial sense to outsource it. That self-examination led her from doing virtually everything in-house to outsourcing most of the work. Whether outsourcing some or all RCM functions, here are guidelines for selecting a vendor.

- Choose a reputable and experienced vendor. Ask about qualifications, certifications, and association memberships. Check references.
- Know what you’re paying for. Vendors offer a variety of services and packages and comparison shopping can be confusing. Make sure you get what you need and aren’t paying for services you don’t need. Ask an experienced attorney to review the contract.
- Make sure the vendor provides a customizable and usable dashboard. This is a practice’s interface with RCM and if it’s hard to use or difficult to read the operation will suffer.
- Get analytics. A good RCM vendor will not only handle coding and billing, but offer real-time analytics tools that filter data, generate the necessary reports, and make it easy to identify problem areas that should be addressed.
- Make sure the vendor provides regular updates. Reimbursement is constantly changing, and RCM software must be current to avoid problems with denials and failure to meet reporting and performance standards.
- Check the vendor’s customer service record and references and know exactly what type and how much help your contract stipulates.
- Make sure the vendor’s data is compatible with your EHR system and that you will be able to run your own reports.
- Set agreed-upon performance goals. You’re hiring a vendor in order to improve RCM and having benchmarks in place will let you know if that’s being accomplished.
Terri Carufel-Wert, RN, MHA.

The practice employs 11 back office personnel, including coders and billing and payment specialists. While that’s a substantial amount of overhead, Carufel-Wert and Business Operations Manager Margaret Wilkinson, CMC, say the team saves money by performing at a very high level.

Communication and coordination are key, Carufel-Wert says. Everyone, from physicians to billing clerks, works from the same guidelines, and new providers are quickly trained on office procedures. The coders are so well-versed in regulations that they seldom make billing errors and even occasionally correct commercial payers, she adds.

Employees are cross-trained on jobs so there’s no drop-off in performance when someone is absent. The staff analyzes potential new practice offerings and equipment to determine if reimbursement will make them profitable.

The practice is proactive with patients as well. Whenever possible, it obtains payment upfront and frequently has to educate patients about what their insurance covers and how much it pays.

The hard work pays off. The average time between billing and reimbursement from payers and patients is 22 days, which Wilkinson says is much less than average.

“We had to do a lot of training and educating, but we are now able to deliver quality care at an affordable price,” Wilkinson adds.

A PERSONAL TOUCH

Newton Family Physicians has done its own RCM for its entire 37 years of existence and expects to continue to do so, says practice administrator Melissa White.

“We find it just works better for us,” says White. The practice in Newton, N.C, has six physicians and four nurse practitioners. Doing its own RCM requires three full-time equivalent employees doing coding, billing, and other back-office tasks, while White and a part-time employee handle collections.

The practice has considered using a vendor and probably would save money by doing so, White adds, but worries that introducing a third party would hurt long-standing patient relationships in the rural communities it serves.

For example, the practice, which offers no-interest payment plans, knows when a patient has lost a job or been sick and will take that into consideration during billing, White says. “It’s not always about saving two cents,” she says. “From a community perspective, we just have better reception.”

RCM PATTERNS

As part of his RCM, Jeffrey Kagan, MD, an internist and member of the Medical Economics editorial advisory board, meets with his accountant annually to project income and expenses for his two-physician practice in Newington, Conn.

The accuracy of those predictions determines whether the practice is profitable or if Kagan must tap into a line of credit to pay himself and employees. After 25 years in practice, he has identified reimbursement patterns, such as slower and fewer patient payments in the first half of the year because people have not yet met their insurance deductibles. This trend has gotten worse as more employers switch to high-deductible plans, he says.

The practice uses an outside vendor for billing and occasionally hires a collection agency, but performs other functions itself. Kagan does everything he can to get patients to pay co-pays and other costs at the time of their appointment.

“If I can get my money in three months, I’m thrilled,” he says. “There are some who take longer, but none of my expenses get held up for three months.”

He has had to get stricter with non-paying patients. His staff also knows to verify insurance eligibility before an appointment. “It only takes a few minutes, but it probably takes an hour to fix it later,” he says.
Before physicians decide to join a practice or a hospital, they should know if doing so aligns with their professional and personal goals. This is an important decision, and before they take it, doctors should do the necessary research to determine if their prospective new employer is right for them.

UNDERSTANDING THE CULTURE OF A LARGE PRACTICE

Doctors should get a feel for the culture of the new employer—i.e., its internal dynamics, how people relate to one another, how personalities mesh, and if there is life after office hours. “You’re looking at whether or not you like the individual physicians in the group,” says Russell Still, CVA, CHBC, executive vice president of Medical Management Associates, a healthcare consulting firm in Atlanta that provides management resources and counsel for physicians in private practice. “You want to find out if they’ve had other employed physicians and, if they’re not there anymore, you want to talk to them to find out why they left.”

The new doctor also should understand the work ethic is of the physicians who lead the organization. “If you’re looking for balance in your life, do they have balance in theirs?” asks Still. “Are they just working all the time?”

How decisions are made, and by whom, and how much autonomy and decision-making power doctors have is a critical cultural issue. “Ask if decisions are made by physicians or by business people in the boardroom,” says Robert M. McLean, MD, FACP, president of the American College of Physicians and medical director of clinical quality for the Northeast Medical Group, in New Haven, Conn.

While McLean thinks that non-physicians may be qualified to make those decisions at times, he nevertheless says that “frequently, doctors have more trust in physicians making the big management decisions. That often is a major cultural factor.”

If doctors want to be part of the management structure, they should say that up front. “You should be very clear that you want to be more participatory and exercise some leadership,” says Scott Joy, MD, MBA, FACP, medical director of Colorado Care Partners.
and chief medical officer of the Continental Division of the HCA Physician Services Group in Denver.

“During the negotiation, ask what committees you can serve on—such as EHR or quality improvement,” Joy says. “You’re going to have better opportunities to be on committees by making that part of the contract that you negotiate.”

“Frequently, doctors have more trust in physicians making the big management decisions. That often is a major cultural factor.”

— ROBERT M. MCELEAN, MD, FACP, PRESIDENT OF THE AMERICAN COLLEGE OF PHYSICIANS; MEDICAL DIRECTOR OF CLINICAL QUALITY FOR THE NORTHEAST MEDICAL GROUP, NEW HAVEN, CONN.

Doctors should ask the practice leaders why they want to hire a new member. “You’d be surprised, but sometimes people don’t ask why they’re looking,” says Wanda Parker, a principal with the HealthField Alliance, in Danbury, Conn.

Parker also suggests doctors ask prospective employers about their expectations for a new employee or associate—i.e., what duties do they want the new doctor to assume? How many and what types of patients do they want the doctor to see? What are their long-term goals for the doctor? What are the quality metrics they want the doctor to satisfy? How will the doctor mesh with the other physicians and non-physician members of the staff?

Culture also includes what doctors are allowed to do aside from seeing patients. Can they teach or do research or donate their services elsewhere?

“Sometimes they don’t want people to do outside activities because they feel it detracts from their commitment to the practice,” says Parker. “In other cases, the practice will be absolutely thrilled if the doctor volunteers for the local football team to be their sports medicine doctor.”

**BUY-IN VAGUENESS AND OTHER RED FLAGS**

Investigating the organization’s culture also should help doctors detect any problems that might dissuade them from signing on. A huge warning sign is any vagueness or reluctance about spelling out the precise conditions, and costs, of becoming a partner in the future.

“The big red flag for me is when they won’t talk about the ultimate buy-in to the practice,” says Still. Doctors who get nothing more than a general promise of partnership someday may never attain that status and end up feeling like victims of a bait-and-switch ploy.

If doctors have particular expectations about when and under what circumstances they would become partners, they must protect themselves by getting those expectations spelled out in the contract.

Another potential problem is that the fee a physician ordinarily must pay to become a partner could be prohibitively expensive, where a doctor might have to borrow money to do it.

“Doctors should always know up front what the buy-in’s going to be and how it’s going to be calculated,” Parker says. “And what happens when one of those partners leaves? Will they have to buy that person out?”

Frequent turnover, either among staff, the leadership or physicians, is another worrisome indicator, according to Joy.

Average tenures can vary, where doctors leave for personal reasons, differences with the practice leaders, or, increasingly, the desire to remain independent instead of staying with groups that affiliate with hospitals/health systems. There really isn’t a set average tenure for group practices, though Still suggests a new doctor may be with the practice for two to four years before becoming a partner.

“Doctors should ask about how long the practice manager’s been there and what the average staff and physician turnover are.”

A parallel concern is when a practice that may be financially pressed skimps on staff to save money and thereby makes it harder for physicians to do their work.

“If you don’t have enough care coordinators or medical assistants to do some of the data management legwork, it’s going to be really hard to meet some of the quality metrics,” says McLean.

The best way to find out about staffing levels is to ask and, if given a tour of the office, request a tour during work hours, be aware of how many staff are present, take notes and ask about staff responsibilities.
COMPENSATION AND CONTRACTS

Not only should doctors know what their pay will be and how it’s determined, they should understand exactly what their contract means, and what issues the practice is willing to negotiate up front.

Still says it’s possible to find out the local pay rates for physicians who do similar work, and advises hiring a consultant who has access to survey data or works in physician hiring not only in your specialty but in the local market.

That information might also be available online from sources such as the American Medical Group Association or a compensation and benefits analysis firm such as Sullivan & Cotter, or a local library.

Moreover, doctors should know what formula a prospective employer uses to determine salary and other benefits.

“How much of the formula is balancing productivity expectations versus other things—around quality and value, data, oversight and management—that take time and energy?” McLean says.

Also, is some of the compensation formula based on quality bonus payments and shared savings contracts? In that regard, McLean offers a hypothetical example: If the insured savings that totaled 70 percent of a practice’s shared savings in a given year are completely gone the following year, would the practice try to compensate for that loss by cutting back or eliminating quality bonuses?

Determining the compensation isn’t always as simple as quoting a flat-rate salary.

“Sometimes, if you have a higher guarantee, you’ll be paid at a lower RVU rate,” says Joy. “If you want a higher RVU rate, you get a lesser guarantee. You also want to ask about signing bonuses and CME bonuses that are available.”

Flat-rate salaries sometimes are offered, but many practices offer additional pay based on collections in excess of a threshold—usually the new physician’s direct costs divided by the income rate.

Contract stipulations such as restrictive covenants (i.e., contract provisions restricting the future conduct of the doctor, such as competing with the practice for a certain period after leaving it, or soliciting or engaging with patients of that practice after leaving it) and non-compete clauses might seem problematic, but Still says doctors should expect them, and not sign an agreement if they intend to break it later on.

“If you don’t think it’s fair, then don’t sign,” he says. “Work it out or go somewhere else.” And not all such covenants and clauses carry the same legal weight. “Are they really enforceable in your state based upon precedent?” McLean asks.

To find that out, doctors should consult attorneys with specific experience litigating that type of contractual language. Also, enforceability can depend upon factors such as the practice specialty and location, the specific circumstances of a doctor’s termination, and if a court feels that a non-compete clause is unreasonable (e.g., preventing a doctor from practicing in a territory that’s much larger than the area from which a practice derives most of its patients).

Termination clauses can be deceptive, as when doctors negotiate multi-year contracts that they think keep them safely employed for that period.

“What they don’t realize is the contract is only as long as their termination clause, so if the termination clause is 90 days, then your contract is really a 90-day contract,” Parker says. “And then what happens if bonuses are due and the person is terminated?”

While a no-cause notice provision might seem to undermine the value of having a contract, there are other aspects of the relationship that require contract protections for both parties, such as designated responsibilities and salaries.

“With no contract, doctors could be fired at any moment,” Parker cautions.

Both no-cause and for-cause termination clauses can be tricky. Doctors should particularly beware of broad statements like “failure to follow the policies of the practice,” because they might be unaware that they’ve done anything wrong. Ideally, those policies should be spelled out.

Still advises that if there is a vague, unclear or confusing contract clause that could create a misunderstanding, where a doctor could unwittingly violate a policy, the doctor should seek contract language to clarify the meaning of the clause. Otherwise, the doctor is subject to the practice’s interpretation of the provision in question.

To sidestep these potential contractual minefields, doctors should hire a healthcare attorney who is steeped in healthcare law to review the contract and assist with the negotiations, says McLean.
whopping 83 percent of physician practices report that they have experienced some form of a cyber-attack, including phishing, hacking, and even employee theft of electronic protected health information (ePHI), according to a study from the AMA and Accenture.

When attempting to prevent these incidents, practices typically focus on technological tools and interventions. But while protections such as antivirus software and firewalls do play a critical role in cybersecurity, the human element should not be overlooked, says Uday Ali Pabrai, MSEE, CISSP, HITRUST, chairman and chief executive of cyber-defense company ecfirst.

“The journey starts with knowledge acquisition,” he says. Most organizations have not done enough to improve individuals’ cyber-literacy, thus weakening practices’ readiness overall, he says.

Before your practice becomes a cyber-crime statistic, consider the following ways to strengthen your team’s defenses:

1 Explain the dangers
   “Checking boxes’ without thought ultimately defeats the purpose of what cybers-ecurity programs are about,” says Brian Yeaman, MD, a solo primary care physician in Oklahoma and health IT expert. “It’s really so much more significant in terms of protecting our patients’ privacy and protecting our practice because data breaches and their penalties are serious and severe.”

Practices must impress upon employees that training is more than a mandatory exercise that takes up their time; it’s integral to protecting their patients, the practice, and even their jobs.

Even a minor security incident can cause substantial business disruption, notes Yeaman. For example, consider a scenario in which someone gets into a practice’s network with malicious intent and brings down its network or domain. The expense doesn’t end with paying an IT company to rectify the problem, he says. “It’s lost patients, lost revenue, and staff sitting around with nothing to do because without your network, you’re dead in the water.”

And it’s not unheard of for disgruntled patients to make privacy or security complaints without merit, says Kate Borten, CISSP, CISM, a Massachusetts-based security and privacy consultant. “I worked with one office in which a patient angry about his bill made a privacy complaint as a means of wigging out of financial responsibility,” she says.
HEALTHCARE-RELATED CYBERCRIMES WILL COST AN ESTIMATED $6 TRILLION IN DAMAGES IN THE NEXT THREE YEARS.*

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*Source: https://phoenixnap.com/blog/healthcare-cybersecurity-statistics
Because there was a complaint, HHS investigated and therefore required the practice to provide copies of all of its policies, procedures, and evidence of staff training. “Through no fault of its own, the practice was really on the spot [to prove compliance],” Borten says. “Practices have to convey to employees that it doesn’t take much to become involved in an investigation and they need to be prepared.”

2 Select a security officer
Success starts at the top. Therefore, it’s crucial that practice leadership and security officials be devoted to protecting the organization from cyber-threats, says Borten.

First, practices of all sizes should recognize that they are required to have a privacy official and a security official. “I’ve seen some backsliding on compliance with this point,” Borten says.

She advises appointing practice privacy and security officers (who can be the same or separate individuals, according to HIPAA regulations) who welcome the role. Physician owners shouldn’t “just automatically appoint the practice manager, for example,” Borten says. “You really want somebody who cares, who will go out and actually seek information to understand his or her responsibilities.”

Security personnel should be provided with some work time to fulfill those responsibilities, Borten notes. Those duties include developing training content, which may be in the form of slides, paper handouts, or other media that can be shown to HHS in the case of an audit or complaint.

“It should be the officer’s responsibility to make sure that training is adequate and meets [patients’ and regulators’] expectations—and hopefully he or she will become the eternal go-to person for questions, complaints, and education.”

3 Make training stimulating
The frequency and content of security training are not spelled out explicitly in federal regulations, says Borten. She recommends that all employees, including physicians, receive comprehensive training upon hire and annually thereafter, with short refreshers on specific topics at least monthly. One way to carve out the time is to include some cyber-training on the agenda of existing staff meetings, she says.

To keep employees engaged, conduct the training using a variety of formats. For example, hold a brief roundtable discussion about ransomware, suggests Pabrai. Or develop a handout focused on a particular area, such as how to report a potential breach of ePHI. “Keep trainings short, fast-paced, and relevant to current events,” he says.

In addition to keeping training content relevant to current risks, employees must be able to connect the information to their day-to-day work, says Borten.

“Make it personal and directly related to people’s work processes and behavior,” she says. In other words, rather than regurgitating regulatory language, use training to explain what employees should do when they encounter specific situations.

She also recommends practices take advantage of the numerous training modules available online at little or no cost, many of which are geared toward physicians.

4 Reduce internal risks
Especially in small practices, the trustworthiness of employees can be easily taken for granted. However, a 2018 survey from Accenture found that 18 percent of healthcare employees said they would be willing to sell confidential data to unauthorized individuals. Furthermore, about a quarter of those surveyed said they knew someone in their organization who had sold their login credentials or similar information.

“We’d all like to think our employees are perfect and would never do that, but the reality is they would and they will at some point in time—so you have to create an environment that protects you,” says Yeaman.

Yeaman recommends, for example, shutting down USB ports on all equipment to prevent individuals from downloading data onto a thumb drive or other device. Network activity monitors should also be set to track any aberrant patterns.

And while anonymous reporting of suspected data misuse or noncompliance with security policies can be challenging in a small practice, it’s essential that leadership try its best to support reporting without retaliation, says Borten. What’s more, she says, HIPAA requires written processes for discovering and reporting suspected misuse or breach of patient information. For that reason, reporting procedures should be included in training, she adds.
PRACTICAL MATTERS

5 mistakes doctors make that can cause big practice problems

NOT CONDUCTING BACKGROUND CHECKS DURING HIRING
Reduce your risk by conducting background checks for all final candidates. Trusted Employees is one company that provides this service at reasonable rates.

IGNORING VITAL INFORMATION
The practice could be at risk if physician leaders don’t understand essential business functions and review vital reports. For example, if you take the time to review the adjustments report at least quarterly, you’ll be more apt to ask questions about why so much is being written off to categories you don’t recognize.

SLOPPY CASH CONTROLS
Make sure the practice’s “daily close procedure” balances changes and collected amounts with the totals shown on computer reports. Reconcile patient encounter forms and electronic numbers daily to be sure each has been “closed out.” Make sure the month-end bank balance matches the practice-management system report of total collections. Don’t allow the person who opens the mail to post payments or write refund checks.

BEING TOO CASUAL ABOUT ELECTRONIC SAFETY
Start with simple steps, such as insisting that staff use strong passwords and not share them. Hire an IT consultant to conduct a data security assessment.

UNDER-CODING E&M SERVICES
Consistent under-coding can draw unwanted payer attention to the practice. For example, CMS analyzes coding patterns of physicians in the same specialty and state, as well as national averages. Falling outside the norm of your peers’ coding patterns can make you a potential audit target.

Karen Zupko is president of Karen Zupko & Associates, Inc., a consulting and education firm that has been advising physicians to succeed in the business of medicine for more than 30 years. Send your practice management questions to medec@mmhgroup.com.
VS Pharmacy is stepping up its healthcare offerings by rolling out 1,500 “HealthHUBs” by the end of 2021. While its 1,100 MinuteClinics focus on low-acuity services, these “HealthHUBs” will provide for more everyday needs with a focus on chronic disease management while offering services like blood draws and sleep testing.

Then there are nearly 9,000 U.S. urgent care centers, according to the Urgent Care Association, and more than 550 freestanding emergency rooms, according to a report from UnitedHealth Group.

For traditional primary care clinics, these increased services from these clinics shouldn’t dampen the financial bottom line much—after all, primary care physician shortages lead to many clinics being understaffed and overbooked—although rural clinics in small towns may feel a pinch.

But the impact is being felt in other ways: The increased access to healthcare service is changing the role of the traditional primary care physician, and it can too easily lead to fragmented care. “People who have colds, flu-like symptoms, ear infection, sinus infections, maybe even need basic immunizations, may just decide it’s easier to go to their local CVS or equivalent in-store healthcare provider because they can seek care without an appointment and potentially get in more quickly,” says Andrew Hajde, assistant director of association con-
tent at the Medical Group Management Association (MGMA). “In most cases, though, traditional clinics are going to see a lot more chronic patients who need ongoing care or have more complex issues where they need the constant attention of a physician on an ongoing basis. “You might see a slight, slight decrease in encounters over the next few years. But it’ll probably be balanced out in terms of overall productivity just because they’re higher complexity patients with higher-acuity illnesses.”

THE EVOLVING ROLE OF PRIMARY CARE PHYSICIANS

The big separator between traditional primary clinics and retail and urgent care clinics is going to be how acute the patient’s health is, Hadje says. That offers a differentiation for traditional primary care clinics.

According to MGMA data, the median total number of encounters in family medicine clinics without obstetrics services decreased 9.9 percent between 2015 and 2018. The median relative value units (RVUs), though, decreased just 0.3 percent. Those numbers indicate that while doctors are seeing fewer patients, they’re seeing more complex patients and cases. “I think most people want a relationship with a physician who will really manage their care closely,” Hajde says. “When you go to a MinuteClinic or someplace like that, you probably won’t have a relationship with those providers, and you might see a different person every time you go. “It’s not to say that you’re going to have a bad experience, but they may not be able to treat you in the same way as somebody who you have built a longstanding relationship with,” he adds.

THE PROBLEM WITH INCREASED ACCESS POINTS

Increased access points for consumers can be a good thing, particularly in rural areas where there is a shortage of primary care providers, says Gary LeRoy, MD, a family physician in Dayton, Ohio and president of that American Academy of Family Physicians (AAFP). “The ultimate goal would be to provide comprehensive longitudinal coordinated care for patients from coast to coast, east to west, north to south. But in some of those underserved areas, sometimes we have to get creative in how to fill those voids. And these retail health-type centers can sometimes provide the needed immunizations and healthcare information that underserved areas are in desperate need of.”

This increased access can cause fragmented care, though, because retail clinics...
don’t have a system for sharing records and patients don’t always remember what took place during a visit or consultation.

“If you get a vaccine at a CVS or some other freestanding facility, and you don’t provide a copy of the documentation they give to you to your primary care physician, it can create a gap in care,” Hadje says. “I have seen patients say they saw a cardiologist or other physician, but they don’t remember the physician’s name, they don’t remember the name of the practice, or where it was. You ask somebody what medications they’re on, they don’t know. They say they take one blue pill, one red pill, one white pill.

“Probably one of the things that frustrates physicians more than anything else is when they have to see patients and they don’t have a complete copy of their medical record for all the facilities they’ve been to. Then they’re trying to piece meal how to treat a patient without complete information.”

Ann Abraham, MD, a retired family practice physician in Austin, Texas who now works per diem, recounts the story of a patient who went to several urgent care clinics about a persistent cough. She was initially told it was allergies, then bronchitis. They put her on multiple medications. But Abraham diagnosed a knew from her records that the patient had had breast cancer more than 20 years previous and diagnosed her with a pulmonary embolism. If she’d come to Abraham sooner, the embolism could have been discovered earlier.

Or someone goes to a retail clinic and gets referred to a specialist when their primary care physician could handle the treatment. Instead they go to the specialist and the PCP falls out of the loop of care.

“We don’t want to create a situation like with relay races, where people lose because they drop the baton handoff,” LeRoy says. “That’s basically what’s happening here. You put more runners in the race, there are more opportunities to hand off the baton—and more opportunities to drop the baton because they’re not effectively practiced in handoffs.”

**HOW CAN PHYSICIANS COMPETE?**

Healthcare consumers have become used to getting the products and services they want where and when they want them; they expect the same from their healthcare providers.

“Healthcare delivery in traditional clinics really is going to have to evolve to be quicker, better, cheaper and faster in order for people to be satisfied with it. That’s our new expectation,” Hajde says.

Primary care physicians need to listen to their patients and look at ways to meet consumers’ needs within traditional practices, says Michael Munger, MD, with St. Luke’s Health System in Kansas City.

“The onus is on primary care physicians to deliver what our patients need,” he says. “How can I make sure I’m available to patients? Sometimes that could be as straightforward as making sure you have someone on call for your practice 24 hours a day, seven days a week. That

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“[Retail clinics] need to understand what we do and understanding that just because it is called primary care, doesn’t mean that it’s easy care, because there’s nothing easy about what we do.”

— GARY LEROY, MD, FAMILY PHYSICIAN, DAYTON, OHIO
way, you can tell patients that if they need help, they can call you first, so you’ll know what’s going on. Perhaps you’ll just tell them they need to be seen in urgent care, but if they’ve communicated with you before they go, you know that you have something to follow up with. You know you need to close the loop.”

Primary care clinics need to create ways for patients with acute illnesses to be seen that same day. Offering extended hours or technology options, such as televisits and online support, can help with that. Munger notes that many family physicians nationwide have already instituted some form of advanced access, extended hours or capability for walk-in and same-day availability.

Strong relationships with patients and exceptional overall patient service can form the bonds that bring them back to your practice for all their needs. That means making sure your clinic is competing on a technological level. Traditional clinics need online scheduling, text message reminders, same-day access for appointments and price transparency, Hajde says. “Those are all things that if they can’t meet that need, it’s going to be really difficult for traditional clinics to compete with these retail and urgent care clinics.”

“If I’m a family physician and I have an independent practice, I would be reaching out to the retail clinics around me and making sure I let them know I’m here if my patient shows up,” Munger says. “I ask them, ‘How can we communicate with each other? Can you send me a report? Can I at least know that they were here?’ You want to establish some way that you can coordinate the care.”

If traditional practices and retail and urgent care clinics are going to co-exist, they need to find common ground so they can create a patient-centered medical community, LeRoy says.

“We need to figure out ways to talk with each other and communicate with each other so we are working as a team to create a community of health. They can be part of that community, but we have to talk with each other.”

PATIENTS PLAY A ROLE
Greater collaboration between providers would help address the fragmented care. But the universal technology isn’t there yet. So the burden for quality, continuous care also falls to patients.

“Pushing consumers to become more responsible for their own personal health and care will be huge moving into the future,” Hajde says. “It’s a matter of how physicians, practices, payers, and other people can encourage people to do that through their social determinants of health and other factors.”

“Healthcare delivery in traditional clinics really is going to have to evolve to be quicker, better, cheaper and faster in order for people to be satisfied with it. That’s our new expectation.”

—ANDREW HAJDE, MGMA

Patients need to understand their primary care physician, their medical home, should be the hub of all their care, Munger says. To help that happen, primary care physicians should talk to their patients about when to visit a retail or urgent care clinic, and they should emphasize the importance of accurately and fully communicating what took place during those visits to their primary care physician.

“That’s the best way to ensure care is coordinated,” he says.

LIVING WITH RETAIL CARE
Physicians need to recognize that retail clinics and urgent care are not going away.

“It’s important we educate our members, physicians and the medical community about the capacity of the retail clinics as opposed to just bemoaning the fact that they’re in your community,” LeRoy says. “But it’s a two-way street. [Retail clinics] need to understand what we do and understanding that just because it is called primary care, doesn’t mean that it’s easy care, because there’s nothing easy about what we do.”
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Physicians plan and insure against the possibility of a medical malpractice suit. However, they often overlook another serious threat to their livelihood: a medical board complaint. Here are some common causes of complaints and the risks and process involved.

While most doctors are primarily concerned about a medical malpractice suit, a medical board complaint on its own can significantly disrupt your income — and even end a career. It is vital to have the right coverage at the right limits before a complaint is filed against you.

Unlike an actual medical malpractice suit, a patient can easily file a board complaint at little or no cost. The Federation of State Medical Boards (FSMB) provides significant guidance to physicians and medical boards in all 50 states. It also provides some very specific guidance to patients on when, and how, to file complaints against physicians.

Complaints can result in fines, reputational damage, license suspension or limitations and even complete license revocation. So, while the results may not be as devastating as a seven-figure lawsuit judgment against the wealth you have already amassed, it can take away your future ability to earn more. For many physicians, this is their biggest asset.

A medical board complaint may accompany or precede a more onerous medical malpractice lawsuit. Medical board complaint legal defense costs are not always covered by your medical malpractice insurance. It’s a policy specific question, and I advise physicians to make sure they know, at a minimum, the following important details about their coverage:

- If they are actually covered for board complaint defense.
- What the dollar limits of that coverage are. It may be a rider that only covers $50,000, for example.
- If they have stand-alone coverage or if that coverage shares limits with another policy, thereby potentially reducing the coverage available for a resulting medical malpractice claim.

CAUSES OF MEDICAL BOARD COMPLAINTS

According to the FMSB, medical boards
sort and prioritize complaints, fast-tracking adjudication of those complaints that present the possibility of imminent patient harm. Such claims logically include instances of physicians allegedly engaging in sexual misconduct with patients, deviation from the accepted standard of medical care in a state and practicing under the influence of drugs or alcohol.

Some causes common standard-of care complaints include:
- Failure to diagnose, also a leading cause of medical malpractice claims;
- Inappropriately prescribing and monitoring opioids or other controlled substances;
- Incorrectly prescribing medication;
- Actionable violations of physician-patient confidentiality;
- Inappropriate behavior that interferes with patient care, including interactions with others in the chain of care;
- Failure to provide appropriate postoperative care; and
- Failure to respond to a call from a hospital to help a patient in a traumatic situation.

Ike Devji, JD, has practiced law exclusively in the areas of asset protection, risk management and wealth preservation for the last 16 years.

**What the complaint process looks like**

This can be a long and complex process and often involves legal representation. How long a particular case takes depends on how many of the following steps are required to resolve it. Watch the dates carefully, as you have a specific and limited amount of time to respond. Here is a step by step guide to the process of a complaint:

1. **The complaint is assessed for jurisdiction.**
2. **The case is prioritized, and the investigation begins.** Any indication of risk to patients may allow the board to immediately suspend or otherwise limit the physician out of concern for patient safety.
3. **The state medical board identifies individuals and intuitions with relevant information.** Individuals involved in the case are asked to provide statements.
4. **The complainant receives formal notification.** The physician also receives formal notice of the complaint as well as any record requests.
5. **The board conducts a medical review to determine if a patient’s medical care has been impacted as a result of the complaint.** Same specialty experts may be called to comment on the standard of care provided.
6. **If not settled by the board ruling, the case is set for an informal hearing.** It may be formally settled at this stage. If not, the matter proceeds to a formal hearing.
7. **Cases go to a full hearing for adjudication, similar to a civil lawsuit.** There is a formal proceeding, with presentation of evidence and witnesses. The board rules on the evidence presented.
8. **Any disciplinary action imposed by the board is entered into public record.** It is then part of the physician’s permanent professional record and is available nationally through the FSMB Physician Data Center. Patients can access this info through their state’s medical board or by accessing docinfo.org.

The board rules. Minor or inaccurate complaints may be resolved at this level with the board providing sanctions or conditions.
Medicare and Medicaid make up 38 percent of medical payments in the United States. Whether working in a private practice or a health network, a large number of patients will be receiving benefits from these programs run through the Centers for Medicare and Medicaid Services (CMS).

By accepting payments through federal payers and contracted Medicare Advantage (MA) plans, physicians are held to the quality standards set by CMS and the National Center for Quality Assurance (NCQA). These standards were established in 1991 and are updated yearly to reflect changes in value-based care goals and standard of care guidelines. With an increasing focus on value-based care, physicians can expect a larger focus on these quality measures.

The Healthcare Effectiveness Data Information Set (HEDIS) is divided into six domains of care:
- Effectiveness of Care,
- Access/Availability of Care,
- Experience of Care,
- Utilization and Relative Resource Use,
- Health Plan Descriptive Information, and

HEDIS defines how these quality measures are to be collected by payers for evaluation of both providers and insurance plans. Collection methods can include billing claims, surveys or clinical documentation from offices or labs. Once collected, measures are tallied into a 5-Star rating for private payers using pre-determined Core Quality Measures stratified for different medical specialties.

As these ratings are tied to CMS reimbursement bonuses, there are incentives at multiple levels to reach either the 4- or 5-star rating tiers. Many insurance companies have their own programs designed to help providers meet these measures through education, tools and bonuses. Pay-for-performance programs include flat-fee bonuses for each patient meeting a measure or a percentage bonus for a practice if it meets a certain rating threshold.

Working with payers to meet these goals helps increase effectiveness of care and can be an important source of revenue for healthcare providers.
**PREVENTIVE SCREENINGS**

CMS has selected several HEDIS measures as indicators of care of the elderly population. Working on these measures, including preventative screenings, diabetic management and medication adherence is an important step to improving a practice’s quality ratings.

HEDIS measures related to preventative screenings were designed with United States Preventative Services Taskforce guidelines in mind. For MA patients, these are colon cancer and breast cancer screening. The quality measure is a percentage determined by the number of patients with completed tests over a denominator of total applicable patients.

Thus, it is important to identify all patients who should be recommended testing and to help remove barriers to testing. The National Colorectal Cancer Roundtable offers several tips for practices that are applicable to any screening measure. Physicians should evaluate their resources to determine which screening methods are best suited for their patients based on demographics or location.

While Annual Medicare Wellness visits are an excellent opportunity to discuss and order preventative interventions, often it is necessary to order screenings during regular visits. Therefore, physicians should develop action plans such as screening policies so that staff members can provide order recommendations. Electronic health records can also help by providing automatic notifications for testing.

Once patients are identified, the final step is ensuring they are tested. This includes patient education on the importance of screenings, help with test scheduling, and providing reminders for appointments or test-kit submissions via mailings or text messages.

HEDIS measures are automatically captured using billed CPT codes for completed screenings. However, proper documentation of prior testing can help simplify the process of identifying patients who need future screening.

Supplemental data may be submitted to close care gaps for patients who do not require testing in the current year, such as someone who isn’t due for a colonoscopy for three years. This can be accomplished by submitting the medical record to insurance providers. Exclusions such as previous mastectomy patients who don’t need biannual mammograms can also be submitted in this manner.

**THE IMPORTANCE OF DIABETES**

The single medical condition that takes the most weight in the CMS 5-Star ratings system is diabetes. These measures fall into a category called Comprehensive Diabetes Care and include HbA1c >9.0%, annual retinal eye exam, blood pressure control <140/90 mmHg and annual nephropathy screening.

Percentage of patients with HbA1c >9.0% is one of several triple-weighted measures CMS uses for ratings calculation and physicians will want to ensure that this data is being accurately reported to payers. The HbA1C measure is captured using CPT-II codes, and when charting for completed HbA1c tests, physicians should use the following codes to denote these results:

- **3044F**: signifies <7% whereas **3045F** denotes a result between 7.9% and **3046F** denotes >9%. It is important to follow up with patients with poor control throughout the year because only the last test result of the calendar year is included in the measure.

- **3044F** signifies <7% whereas **3045F** denotes a result between 7.9% and **3046F** denotes >9%. It is important to follow up with patients with poor control throughout the year because only the last test result of the calendar year is included in the measure.

**PREVENTIVE SCREENING CODES**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Coding</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Percentage of patients ages 50-75 who have had appropriate screening for colorectal cancer</td>
<td>3 FOBT claims (82270, 82274), FIT claim (82270, 82274, G0328), FIT-DNA claim (85128, G0464), sigmoidoscopy (45330-45350), colonoscopy (45378-45398) or CT colonography (74261-74263) within recommended timeframes</td>
<td>Personal History of Other Malignant Neoplasm of the Large Intestines (Z85.038) or Personal History of Other Malignant Neoplasm of the rectum, rectosigmoid junction and anus (Z85.048)</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Percentage of women ages 50-74 who had a mammogram in the last two years</td>
<td>Mammogram claim (77055-77057) from Oct 1st 2 years ago to 12/31 of measurement year</td>
<td>Bilateral Mastectomy (Z90.13) or (Z90.11) and (Z90.12)</td>
</tr>
</tbody>
</table>
year is captured. Additionally, appropriate preventative interventions should be performed each year to prevent chronic complications.

Blood pressure should be assessed at every visit and annual retinal exams ordered unless results were normal in the previous year. Nephropathy screening should be performed by urinalysis or micro-albumin screen because a spot dipstick test is insufficient.

Because insurance companies are held to the same standards as physicians, they will often have resources that providers can recommend to patients for self-management, such as house calls, telehealth case management, education resources or financial incentives for annual testing.

Chronic care coordination, diet education, or lifestyle counseling are also resources that physicians can recommend to these patients to help with diabetes management.

**MEDICATION ADHERENCE**

Medication adherence is another important category in the HEDIS quality measures. Two measures for Medicare patients are statin therapy for ASCVD (SPC) and diabetic (SUPD) patients. To meet requirements, patients will need to be on at least one approved medication for 80% of the year. Continuous medication adherence is tracked by billing claims from pharmacies and is calculated on the assumption that patients take their medications every day and pick up refills as soon as they run out.

Each day that an unfilled prescription is left at the pharmacy is counted against the measure. Physicians can try to simplify prescriptions for patients by giving three-month refills. They can also avoid directions to pill-split, advise patients to show their insurance card at the pharmacy and educate patients on medication adherence. For elderly patients this could mean acquiring a pill organizer or finding assistance such as a mail-order pharmacy with shrink wrap services.

A representative from UnitedHealthcare Regional Operations says a common misconception is that documenting non-adherence can help close care gaps such as refusal to take medication or perform screening tests. Only a few specific exclusions, such as intolerance to the listed drugs or end-stage renal disease are usually accepted.

Exclusions such as these need to be accurately documented and coded. Physicians also should discuss the reason for refusal with patients or consider other appropriate medication options. Patient education on the importance of the intervention and a proper system for reminders can help improve adherence.

To get a better understanding of the quality measures payer track, physicians can refer to resources published by major Medicare Advantage providers showing the HEDIS measure collection method exclusions and tips on improvement. These guides can educate office staff on proper documentation and billing coding protocol. Examples of these guides include the UnitedHealthcare PATH guide or the BCBS Provider Quality Pocket Guide that include quick summaries of important exclusions, such as intolerance to the listed drugs or end-stage renal disease are usually accepted.

Closing care gaps

<table>
<thead>
<tr>
<th>COMPREHENSIVE DIABETES MANAGEMENT CODES</th>
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<tbody>
<tr>
<td><strong>Measure</strong></td>
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<tr>
<td>HbA1C</td>
</tr>
<tr>
<td>Annual Eye Exam</td>
</tr>
<tr>
<td>Blood Pressure Control</td>
</tr>
<tr>
<td>Medical Attention for Nephropathy</td>
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</tbody>
</table>
Chronic Conditions

Closing care gaps

uled care meetings with staff and insurance providers are useful tools to gauge performance in various quality metrics for the clinic. Quality Improvement projects can either be based on HEDIS measures or internal benchmarks, and they should be developed with clear goals in mind. Other potential areas for improvement could be assessed by looking for barriers of care in your care population or soliciting feedback from patients. These can be used to determine future QI projects.

Quality Assurance measures are here to stay, and with the current shift to value-based care and how private payers are modeled on Medicare, it can be expected that increased weight will be placed on these measures going forward. Changes are to be expected and it can be hard for providers to keep up to date on what measures they’re responsible for as well as how they are being tracked. CMS is holding multiple parties responsible for the best coordinated healthcare management of Medicare patients so physicians do not have to bear this burden alone. Insurance payers with MA programs often put out references and tools for private physicians to quickly digest and make appropriate changes in their practices. Physicians can reach out to the largest MA payers in their network to enroll in incentive programs geared towards improving on quality measures and learn about the resources being offered their patients outside of the clinic. Focusing on developing office protocols towards meeting these measures can be an important part of increasing revenue for the office and improving appropriate care for your patients.

Jesse Zheng is a third-year medical student at the Medical College of Georgia in Augusta, Ga., and Janis Coffin, DO, is the chief transformation officer at Augusta University Health in Augusta, Ga.

References:


<table>
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<tr>
<th>Measure</th>
<th>Description</th>
<th>Coding</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease (SPC)</td>
<td>Percentage of patients with ASCVD (Males ages 21-75 and Females ages 40-75) who have 80% adherence on a statin medication</td>
<td>Pharmacy claim of high or moderate intensity statin with &gt;80% compliance</td>
<td>Intolerance to statins: Myalgia, myopathy, myositis or rhabdomyolysis (G72.0, G72.2, G72.9, M62.82, M79.1), End Stage Renal Disease (N18.5, N18.6, Z91.15, Z99.2), Cirrhosis (K70.30, K70.31, K71.7, K74.3 - K74.5, K74.60, K74.69, P78.81), Pregnancy (O00-O9A), In-vitro Fertilization (S8321, S8322) or clomiphene prescription. Patients in Hospice are excluded.</td>
</tr>
<tr>
<td>Statin Therapy for Patients with Diabetes (SUPD)</td>
<td>Percentage of patients ages 40-75 who have diabetes who have 80% adherence on a statin medication</td>
<td>Pharmacy claim of any intensity statin with &gt;80% compliance</td>
<td>Patients with diabetes and ASCVD are counted in the SPC measure. All other exclusions are the same</td>
</tr>
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