PHYSICIANS FIGHT BURNOUT
Six doctors share their strategies

Plus

MONEY
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CHRONIC CONDITIONS
Overcoming barriers to care management

MedicalEconomics.com
Fighting burnout on the front lines

All physicians know that there is a burnout crisis, that the stressors of practicing medicine today is taking its toll on our frontline caregivers. The reasons are myriad: Not enough time with patients, too much paperwork, clunky EHR systems, the list goes on.

The real question, the hard question, is: What should we do about it? There are no easy answers to the challenges facing today’s doctors. So Medical Economics decided that the best way to confront that question is to talk to doctors directly, to ask about how burnout affects them, and what advice they have for their peers on confronting this crisis. So that’s what we did, and the discussions were illuminating and inspiring.

In our cover story, we single out six physicians we spoke with. The physicians we’ve interviewed include practicing, in-the-trenches physicians and leaders who examine the costs of burnout from a wider perspective. We think there will be insight within our coverage that you can put into practice today.

One of the other features in this issue addresses a topic that can also help relieve burnout: How to hire great clinical staff. Building a team around you that can share challenges and accomplishments is one of the keys to not only boosting patient care, but improving career satisfaction.

In addition, this issue features articles on:

- The basics of purchasing malpractice insurance;
- How to boost revenue and reduce compliance risk with proper level of care coding;
- The coming biometrics revolution, and what it means to the practice of medicine; and
- The challenges of chronic care management, and why the program has hit roadblocks since it was created.

Enjoy the issue! And, as always, if you have feedback on our content, story ideas, and would like to contribute to Medical Economics, please reach out to us at medec@mmhgroup.com.

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

Medical Economics
Update on 2020 flu season

The flu season is officially underway and, while an unexpected virus is taking center stage, treatments have been a good match so far for this year’s circulating viruses.

According to the CDC, all regions of the country are now seeing flu activity—typical as the flu season typically peaks between December and March—with the highest level of activity occurring in the southern part of the country. What’s not typical, however, is the predominant circulating virus. CDC reports that most flu activity so far has been caused by Influenza B/Victoria viruses, which typically make an appearance later in the season. However, Influenza A (H1N1) is increasing in proportion in some regions, CDC notes.

"Nationally, flu activity has been elevated ... and continues to increase; this represents somewhat of an early start to the U.S. flu season," said Scott Pauley, a press officer for CDC. "Flu activity is currently being caused mostly by influenza B/Victoria viruses, followed by H1N1 viruses and H3N2 viruses. It is unusual for there to be this much influenza B activity at this time of year."

According to CDC, 4.6 million flu cases have been diagnosed so far this year—up from 2.6 million in early December. This is a high number for so early in the season, but not yet at epidemic proportions. These flu cases have resulted in roughly 39,000 hospitalizations and 2,100 deaths from flu, according to CDC. Data indicates that roughly 70 percent of the current flu cases are Influenza B and about 30 percent have been caused by Influenza A.

Pauley stresses that it’s not too late to be vaccinated against the flu, and adds that antiviral medications have been working well against these circulating strains.
COVER STORY

Fighting burnout
Six physicians share their strategies

ALSO INSIDE

MONEY
12 Level of care coding
Experts discuss how to boost revenue, reduce audit risk

Preventive visits
Clearing up coding and documentation confusion

LEGAL
17 Malpractice buying tips
The basics for doctors purchasing coverage

HIPAA fines
One attorney’s tips to manage liability

PRACTICE MANAGEMENT
20 Hiring clinical staff
How to recruit and retain the best caregivers

24 Real estate mistakes
Three tips to avoid common blunders

25 Management barriers
How to overcome chronic care management program hurdles

27 Biometrics
Is it the next evolution in patient care?

30 Fixing EHRs
Time to give doctors a voice

IN EVERY ISSUE

1 Money
12 Level of care coding
16 Preventive visits
17 Legal
19 HIPAA fines
20 Practice management
24 Real estate mistakes
25 Chronic conditions
27 Technology
30 Practice management

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Burnout has become as much a part of medicine as the stethoscope, with too many doctors feeling overworked, over-regulated, and underappreciated. The result is physicians retiring early, changing careers, or losing their love of medicine at a time when there is already a shortage of primary care physicians.

In the Medical Economics 2019 Physician Burnout Survey, 92 percent of respondents indicated they have felt burned out from practicing medicine at some point in their career, 68 percent said they are burned out right now, and 73 percent said they have thought about quitting medicine. Despite the prevalence and scope of the problem, only 13 percent plan to seek or have sought professional counseling.

Solutions are elusive, because the causes can vary by specialty, location, or practice, and doctors rarely have any control over contributing factors like regulations or EHR design. But that doesn’t mean all doctors have given up or are willing to tolerate the status quo. In fact, as burnout has become increasingly common among physicians, so, too, has the fight against it.

Here are the stories of seven health professionals and what they are doing to battle burnout in the profession.
“We can do better”

Gabe Charbonneau, MD, experienced burnout in 2009 when the demands of practice limited the time he and his wife, also a practicing physician, were able to spend with their new son. When the family grew to three kids, something had to change. His solution was to share a practice with his wife, so that one of them would always be at the practice while the other was with the kids.

“It was super scary, but the best decision we ever made,” says Charbonneau. “We gave up a massive amount of income and had to throw some material things overboard, but our quality of life went way up.”

From there, he began to think about how he could help other doctors fight burnout. “I met so many people who were intelligent, smart, and good doctors, but they were stuck with issues that were insurmountable,” says Charbonneau. “I had an idea that I needed to come up with something symbolic that would give hope to these smart people that they could get to a better place than where we were stuck.”

The result was an image of the Rod of Asclepius being lifted out of the ashes by a phoenix that he printed on a shirt and displayed on his website, fighburnout.org. The American Medical Association wrote an article about his efforts, and interest in the shirts and the cause grew, and now he describes himself as “an accidental person who became an expert on burnout.”

He hopes that his efforts lead to greater awareness of the problem, and that employers will take a hard look at physician workloads and start indexing their burnout so they can measure progress—or lack thereof.

“Leaders often talk about well-being and burnout, but it doesn’t make it onto their financial spreadsheets,” he says. “They offer wellness classes and nice things that are supposed to be helpful, but there is no accountability for physician well-being. They can make a decision in the boardroom that can destroy their doctors, because they are chasing after every dollar.”

“I throw down the challenge that all of us need to start to help unravel this problem before we lose more good physicians and drive them out of medicine. I know we can do better.”

Gabe Charbonneau, MD
Family Medicine, Stevensville, Montana

One proven solution for reducing burnout is to have physicians meet in a social setting outside of work to share experiences, where they can see they are not alone in their feelings and can share coping advice, he says. There is also a doctor-to-doctor peer support group on Facebook if no local group is available.

“I throw down the challenge that all of us need to start to help unravel this problem before we lose more good physicians and drive them out of medicine,” he says. “I know we can do better. As a society, we have to own this problem.”
Tyree Winters, DO, wanted to be a physician since he was five, with a great desire to help others. “But then you get out there and realize it can be a thankless job,” says Winters. “Even though you want to help people, sometimes as much as you do, it’s never enough.”

His loss of interest created an internal conflict: What do you do when you’ve wanted to be a physician your entire life only to achieve your goal and realize that maybe it wasn’t the best choice?

The breaking point came about five years ago. His mother had just passed away, and the next day, while trying to be both an administrator and filling in as a pediatrician, he diagnosed a child with a cold and offered the mother advice on basic care measures that would help. “The mother was furious, telling him, ‘You don’t care about my child. You physicians don’t care about anything.’

“It was the perfect storm,” he says. “I was thinking to myself that I don’t want to do this anymore.” Winters accepted the fact that he was burned out and needed help, not only by seeking counsel, but also in identifying what his passion was. He found a different way to reach his dream of helping people.

“Even if I’m not seeing patients, I’m doing things like teaching and attending community events, using my medical degree to educate people to make an impact in their lives,” says Winters, who is medical director of the Healthstart Pediatric Clinic and associate program director of pediatric residency for Atlantic Health System. “That’s what motivated me to get over the feeling of burnout. I’m not immune to burnout, but I want to get up in the morning.”

Winters says medical students need to be educated on the challenges of being a physician and the risks of burnout. “They need to be able to seek help—not even professional counseling, but just surrounding themselves with individuals who are going through the same thing. There’s an unwritten rule where doctors are taught to believe if you are not able to handle things, then that’s a weakness. So people keep it to themselves and we need to get over that stigma.”

Winters says doctors don’t always recognize signs of burnout in themselves, such as apathy, or coping through alcohol or food. “They write it off as just having a bad day or just needing some sleep,” he says.

Physicians need to focus on what brings joy in their lives and find a way to escape from the rigors of their day. He recommends finding a couple of hours to do something that isn’t work-related, whether it’s exercising, binge-watching Netflix, or in his case, dancing.

“Doctors have to be able to step away and just live their life,” he says. “And don’t be afraid to be open and direct with your supervisor or department chair to tell them you are starting to feel burned out and that you are looking for advice. You might be surprised how a lot of institutions respond.”

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Smith leads the ACP’s efforts to demystify and build awareness about burnout, including how physicians can identify warning signs in themselves. "We need to fix the water clinicians are swimming in," says Smith. "We know medical students are more resilient when they start medical school, but their risks increase as they complete their training."

She says it’s important for doctors to recognize burnout in colleagues, because it can be contagious, spreading through an entire staff. "It is part of your responsibility to not only identify and address it when you see colleagues suffering, but to also help intervene and fix the overall culture."

"The overall causes of burnout are a workload where people keep adding more and more things to frontline clinicians, but nothing gets taken away," says Smith.

Physicians should look for sudden changes in behavior in their colleagues as a warning sign that all is not well. "If someone who was outgoing and is now withdrawn, that can be an indicator," says Smith. Missing meetings or conferences, or even not answering pages can also make things better," she says. "They may become more cynical, be quick to anger or have relationship problems or trouble getting along with family or friends."

The ACP has resources on its website for physicians who feel burned out and has trained a cadre of 160 members around the country to fight burnout. "Our message is, don’t worry, you are not alone in this," says Smith. "This is a common issue and a problem that everyone needs help with sometimes. We encourage them to reach out to a friend, a colleague or call their employee assistance line—whatever they feel comfortable with."

Recognizing the signs

"The same things that bother doctors are bothering patients. They want more time together. We think if we join forces with patients and patient advocacy groups to reform healthcare delivery, we might be successful."

Daisy Smith, MD, FACP, ACP vice president for clinical education, Philadelphia

The things you can control

Brown says that many organizations are well intentioned when they set up mindfulness training or yoga classes for physicians, but that while such programs may be helpful in some regards, they can also contribute to burnout.

"Offering classes without fixing the working environment just sends the doctor home an hour later and exacerbates their time away from their family, and takes away time that could be used for exercise or sleep," says Brown. "We also know burned out physicians write more prescriptions, send out more referrals, make more errors, order more tests, and have higher readmission rates. In every other profession, the higher the education level, the more control the person..."
Physicians fight burnout

If you do not have engaged physicians who have a vested interest in being there five years from now, you are not going to be able to provide a good patient experience,” says Adam S. Holzberg, DO, adding that healthcare organizations that want to improve their patient experience must tackle physician burnout. “Every study has shown that if you have engaged providers, the patient has a better experience and that results in better outcomes.”

Healthcare administrators must start by measuring burnout in their organization. They should do this by enlisting an outside company to survey the doctors, says Holzberg. “You have to be willing to then act on it and create an action plan,” he says.

Progress is possible when leaders take the time to listen. In a prior position, Holzberg helped move the physician engagement scores from the 24th percentile compared to the national average to the 73rd percentile in less than five years. “It wasn’t because we gave them

The power of listening

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For example, Brown changed how she prescribes medication for chronically ill patients. It’s common to write a prescription for three months with one refill, so physicians are refilling the same prescription every six months. She suggests changing that to three months plus four refills, so that doctors are writing the prescription once per year. “If you do that, six months from now, the number of refills decreases by half,” says Brown. “With that extra hour, you can stop drowning long enough to see what else you can do.”

Another area to examine is the EHR. Brown says doctors need to look at all the notifications they are receiving. She turned off discharge summaries and notifications about tests that did not include results. “I decreased my inbox by about 50 percent,” she says. “It doesn’t take any resources and doesn’t cost a lot of time. When you are at your wits end, this is something you can do tomorrow.” She also encourages physicians to seek peer-to-peer training on using their EHR more efficiently.

Whenever possible, make sure patients who require lab work have their labs completed before the visit. “That way when you see them, you’ll have everything you need to have a discussion,” says Brown.

“The greatest driver in preventing burnout is being able to deliver quality care, but there are so many obstacles that stop us from delivering it,” says Brown.

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so much more, we just listened to them,” says Holzberg. “We had good methods of communication.”

The organization created a blog to keep physicians up to date on changes. It included a way for doctors to make suggestions on how to improve working conditions. Doctors always got a response to their suggestions, even if they weren’t feasible. “You can say no with a good explanation—you would be surprised at how much they appreciate that compared to no response at all,” Holzberg says.

Listening is a great way to reduce burnout. “There’s not a lot that providers want,” says Holzberg. “They want to take care of patients, have a say in the plan for the organization, and have some recognition for what they do. They want to have the supplies and tools they need to do their jobs and do it without a lot of obstacles. If you pay attention to a lot of that, you will be surprised at how much difference it can make.”

Swamy was a third-year medical resident working nights with two small children at home when burnout hit him. “I became very cynical and laughed about a lot of things—beyond the gallows humor physicians typically use to get by,” he says. “I was falling apart, getting less sleep, and I felt like I was failing with my patients and at home.” He says his work was becoming shoddy and he was being selfish and passing patients off to the next shift.

“It was unprofessional and a really bad spot for me,” he adds. “The big takeaway is, at the time, I could not have told you it was because I was burned out. I couldn’t recognize it in myself, and if I had done so, there were innumerable supports that could have helped.” When he rotated off that shift, his situation improved. Now, he advocates for doctors to look for signs of burnout in each other and to take action when they do.

He advises doctors who suspect a colleague might be heading for burnout to meet with them outside of work to discuss it. “Say, ‘Hey, is everything OK?’ or use other open-ended questions,” says Swamy. “You don’t have to say burnout, because people are often sensitive to that. They might be defensive in the moment, but it lays the groundwork to actually talk to them.”

Speak with them alone, he adds, and not from a position that implies they are unable to do their job. If there is no personal relationship, talk with someone who knows them better and tell them about your concerns. For residents, Swamy advises speaking to the chief resident, but choose your words carefully.

“There’s a big stigma speaking about mental health in medical culture, and burnout relates to that” says Swamy. “If you are in a world where you cannot show weakness and someone is very clearly suffering, the answer is not to go to their seniors and effectively say you think they are weak. You never want to throw people under the bus.”

While he appreciates employers providing yoga or massages for physicians, those do not address the root causes of the problem. “I personally find a lot of wellness in running and doing yoga, but that doesn’t address the root cause of sitting in front of a computer going mad trying to click all the boxes. “Burnout is a symptom of an incredibly broken healthcare system,” says Swamy. “It needs addressing, but the root causes are deep and pervasive.”
After four hours of pushing, I was utterly exhausted. "Nicole, you can’t keep pushing. We can try a forceps delivery and if it doesn’t work we will have to do a c-section. We would have to take you to the operating room just in case. What do you want us to do?" My obstetrician needed an answer. My eyes began to well up with tears. Tears rooted in fear and born from exhaustion.

In that moment I wasn’t a physician, I was a patient and I had no control over the situation I was in. I was incapable of using my years of medical education and knowledge to make a coherent decision about my own care. This was one of the most important decisions I ever needed to make. I looked at my obstetrician and asked her what she would do if she were me. She raised my bedrails in answer, preparing to move me to the OR. I made her promise the baby and I would be OK.

We made our way to the operating room in preparation for delivery. I was met by my medical team—dozens of faces in light blue scrubs and surgical masks. As a doctor, I see people like this every day. But as a patient, I was scared. My nurse held my hand as the anesthesiologist hooked me up to sensors and monitor leads. My husband sat nervously by my side, awaiting our new arrival.

Thirty minutes later I held my newborn boy for the first time. My joy was overwhelming as I shared the incredible moment with my husband and nearly 30 other medical personnel in the operating room. After Owen was delivered, my medical team worked diligently on us both. They attended to Owen, assessing him and providing support for his breathing. Hours of pitocin and magnesium resulted in postpartum hemorrhage and my obstetric team worked to stop the bleeding. My nurse continued to comfort me as anesthesiologists stood watch, helping with my resuscitation. I felt weak and powerless, but I was also humbled and grateful.

The days and weeks following my son’s arrival continued to humble me. Profound anemia made climbing a flight of stairs or doing a load of laundry exhausting tasks. I made biweekly follow-up appointments to my OB’s office to check my blood pressure and lab work. The walk from my car to the office felt miles long and I always arrived weary and short of breath. At home I tried to keep up with simple household chores, and spent hours nursing or hooked up to my hospital-grade breast pump. I was an anemic, sleep-deprived milk-making zombie fueled by Doritos, Oreos, and iron supplements.
A week after my delivery, my baby blues morphed into overwhelming anxiety and depression. I struggled to find balance in my new life and feel like myself. My medical training did not prepare me for my postpartum experience and I found myself continually struggling to navigate simple daily decisions.

In the emergency department, I was a decision-making expert, tasked with making thousands of decisions during an average shift. I had lost my edge. At a postpartum visit to see how things were going, my OB listened carefully as I tearfully recounted how I had been feeling. "I think you should go see one of our psychiatry colleagues," she softly urged.

I had postpartum depression and anxiety—something I knew very little about, despite being a physician. Postpartum depression is common and it affects one in seven women. This statistic likely underestimates the prevalence of the condition due to lack of recognition and underreporting. Most women do not see their medical provider until six weeks after their delivery, making postpartum mood disorders even more difficult to recognize and treat. Additionally, studies put rates of postpartum anxiety at 9 percent and postpartum OCD at between 3 and 5 percent.

I was home for three months before I went back to work. Three weeks after returning, I took care of a new mom in my emergency department. She had come in with psychiatric concerns and I needed to provide a medical screening before the psychiatrist would see her. I pulled up a chair and listened to her describe how she was struggling at home. She described thoughts of inadequacy, feelings of anxiety and at times bizarre thoughts bordering on paranoia.

I told her I understood; just a few months ago I had been feeling the same things. I told her there was a path back to the person she used to be, to someone she actually recognized. I was grateful for the opportunity to connect with her—more grateful than I had felt in my profession in a long while.

I encounter many new parents in the emergency department. They bring their new loved ones in for concerns that physicians often find easy to address. Their faces are weary and full of concern. I now see these new parents in a new light. They are more than just the stewards of my patient—they need my attention too. I have an opportunity to ask them about the subtle signs and symptoms of postpartum fear, anxiety and depression.

I can show incredible love and compassion by asking them, "How are you sleeping? When did you last eat something healthy?" I can make a human connection even though the stress and sleep deprivation may make them feel less than human. Most importantly, I can show empathy: I care about them and their family more than just the little one I am tasked to examine and treat.

In many ways my son made me a better physician. I am more patient and more empathetic. The line separating doctors from patients is thin, and it is not something we should be afraid of. Our shared experiences and humanity can make our practice stronger. Through my time of complete vulnerability and powerlessness I became a better physician.

Nicole Battaglioli, MD, is an assistant professor of emergency medicine at the University of Kentucky. Her interests are in medical education, physician resilience and wellness and workplace diversity and inclusion.
The clock is ticking, and you’re trying to select the right E/M level from a drop-down menu in the EHR. Choose a level that’s too high, and you run the risk of post-payment audits and recoupments. Choose one that’s too low, and you may lose revenue to which you’re entitled. You decide to just trust your instincts and go with a code that feels right so you can move on to the next patient.

Choosing an E/M code based on a gut feeling is one of the biggest mistakes a physician can make, says Sonal Patel, CPMA, CPC, a healthcare coder and compliance consultant with Nexsen Pruet LLC, a business law firm in Charleston, S.C. Payers and auditors use a quantitative scoring process that requires specific elements (i.e., history, exam, and medical decision-making [MDM]—or time spent counseling and coordinating care) for each E/M level.

If physicians don’t document these elements adequately—or the elements they document don’t make sense given the patient’s presenting problem (for example,
performing a comprehensive exam for a patient with a sinus infection)—payers and auditors may down-code the service or even conduct a more in-depth audit that could expose additional documentation vulnerabilities, she adds.

It’s equally risky to report the same E/M level for all patients with the same diagnoses (e.g., diabetes or congestive heart failure) without first considering medical necessity—a trap into which many physicians fall because they assume all patients with the same diagnoses generally require the same work, says Toni Elhoms, CCS, CPC, director of coding and compliance at RT Welter & Associates Inc., a healthcare consulting company in Arvada, Colo. “In reality, every single visit could be a different level based on the documentation and circumstances of the encounter,” she says.

**FOCUS ON QUALITY E/M DOCUMENTATION—AND THE DOLLARS WILL FOLLOW**

Knowing what documentation is required for each E/M level is paramount. For example, the history, exam, and MDM must meet or exceed certain requirements for all new patients. The only exception is when the physician selects the E/M level using time as the controlling factor. In this case, documentation must indicate that the physician spent more than 50 percent of the encounter face-to-face with the patient and/or family providing counseling and/or coordination of care. The physician must also explain the specific services they rendered and why.

Only two of three key components must meet or exceed certain requirements for established patients unless the physician bills based on time. Elhoms provides an E/M scoring guide that includes a visual depiction of documentation requirements for each specific E/M level based on whether the patient is new or established.

Sound confusing? Experts agree that even the most experienced medical coders find it hard to translate physician documentation into an accurate E/M code. They cite several reasons why E/M coding is so difficult for physicians—lack of formal training on E/M guidelines, complex documentation requirements that don’t align with clinical practices, and the subjective nature of the MDM component.

We asked our experts to share their best documentation tips to ensure accurate E/M reporting. Here’s what they said.

**HISTORY**

✓ When billing a level 4 or 5 new patient E/M code (i.e., 99204 or 99205), remember to document one specific item from the past medical history (i.e., illness, operations, injuries, treatments, medications, or allergies), one specific item from the family history (i.e., medical events or hereditary diseases that place the patient at risk), and one item from the social history (e.g., use of tobacco, drugs, or alcohol).

✓ Also document a review of systems that relates directly to the problem identified in the history of the present illness (HPI) in addition to a review of all additional body systems, says Elhoms. Physicians frequently forget to include all of these elements, often leading payers to down-code these services to a level 2 or 3 on post-payment review, she adds. That means physicians could lose as much as $133 per encounter.

✓ Similarly, when billing a level 3 new patient E/M code (i.e., 99203), don’t forget to document one specific item from either the past, family, and/or social history that’s directly related to the problem in the HPI. Omitting one or more of these details usually prompts payers and auditors to down-code the service to a level 1 or level 2 on post-payment review, says Patel. Revenue loss in this case could be as much as $64 per encounter.

✓ Be as descriptive as possible when documenting the HPI. Specify the location, quality, severity, timing, context, modifying factors, and associated signs and symptoms that are significantly related to the presenting problem, says Patel.
These descriptors help physicians gain points when choosing an E/M level, she adds.

✓ Don’t repeat the same HPI for every visit. This is true even for follow-up appointments related to chronic conditions. Payers want to see what’s new with the patient—for example, new pain, new flare-ups, new concerns, or new lab results—or acknowledgement that the patient has been stable and symptoms are controlled, says Patel. Repeating the HPI could be a red flag that a physician is cloning their documentation, she adds.

**EXAM**

✓ Only review body areas or organ systems that affect MDM for the current encounter, says Michael Miscoe, JD, CPC, founding partner of Miscoe Health Law LLC in Central City, Pa. Most subsequent visits, for example, don’t require a multi-system exam even though it’s very easy in an EHR to pull this information forward from the initial visit. Doing so inflates the E/M level and could expose a physician to audit risk, says Miscoe. “More isn’t necessarily better,” he adds. “Because many docs either don’t understand this or let their EHR system flood the record with irrelevant content, we see skewed E/M profiles that lead to post-payment liability.”

✓ Explain negative findings. Miscoe says documentation should reflect the following: For example, what did the physician specifically ask the patient about each body system, and how did they respond? How did this contribute to the physician’s overall assessment and evaluation? In the examination, what element of the organ system did the physician evaluate, and why? Physicians who don’t explain their analysis in the context of the patient’s complaints often end up with what Miscoe terms “healthy sick people records” (i.e., level 4s and 5s with mostly negative findings and no explanation of why the physician performed certain services) that tend to raise a red flag with payers and auditors.

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**Five E/M best practices**

1. **Invest in training.**
   This includes annual E/M refresher training for all physicians and staff.

2. **Hire an external consultant.**
   Ask the consultant to audit E/M documentation and ensure it supports the level of codes assigned.

3. **Be mindful of time-saving functionality.**
   The Office of Inspector General (OIG) monitors copy-paste functionality (often referred to as cloned documentation) as well as auto-populated fields within E/M templates. Experts suggest turning off this functionality to avoid inappropriately upcoding E/M services. They also suggest turning off the automatic E/M calculator. This calculator is often based on a vendor-proprietary algorithm that may not accurately correlate with E/M scoring guidelines. The calculator also isn’t able to consider the medical decision-making or complexity of care that’s provided.

4. **Always consider medical necessity.**
   Is it medically necessary to bill a higher-level E/M code when a lower level of service is warranted? For example, even though CPT guidelines permit physicians to report a level 5 E/M code when performing a comprehensive history and exam, it may be appropriate to report a level 3 if the medical decision-making is straightforward (i.e., minimal risk of complications, morbidity, or mortality; minimal or no data reviewed; and minimal number of diagnoses or management options considered). Per the Medicare Claims Processing Manual, CMS considers medical necessity the overarching criterion in selecting an E/M code.

5. **Partner with a certified coder to validate codes prior to claim submission.**
   Certified coders are well-versed in E/M guidelines and documentation requirements and can help increase compliance and minimize post-payment audit risk.
component of the E/M level, says Patel. More specifically, the 1997 guidelines provide additional options for single organ system exams, allowing providers to report higher-level services for intensive, problem-specific examinations. Once you know which guideline your MAC uses, ensure that your EHR vendor incorporates them into any templates you use, she adds.

**MDM**

✔ Know how payers calculate the MDM. "MDM is all about the cognitive labor a physician puts into the encounter," says Elhoms. This includes the number of diagnoses and management options considered, the amount and/or complexity of data reviewed (e.g., urinalysis, EKG, lab results, or additional workup planned), and the risk of complications, morbidity, or mortality. Therefore, documenting each of these elements is critical because it can help justify a higher-level E/M code, she adds.

✔ Know how your MAC interprets MDM. Contractors publish frequently-asked questions and other guidance describing what they look for in all E/M documentation, including MDM. For example, some MACs define ‘additional workup’ as any service that’s performed outside of the current encounter while others state it’s any work that goes beyond the E/M service—even when the physician performs it during the current encounter, says Shannon O. Deconda, CPC, CPMA, founder and president of the National Alliance of Medical Auditing Specialists in Knoxville, Tenn.

**TIME**

✔ Document the total time (in minutes) spent face-to-face with the patient and/or family during the visit, and specify how much time (in minutes) was spent counseling the patient and/or family or coordinating care, says Miscoe.

✔ Summarize specific details of the conversation with the patient and/or family (i.e., what was discussed with patient and/or family and why), says Elhoms.

**“Every single visit could be a different level based on the documentation and circumstances of the encounter.”**

—TONI ELHOMS, CCS, DIRECTOR OF CODING AND COMPLIANCE, RT WELTER & ASSOCIATES, INC.

**WATCH OUT FOR UNDERPAYMENTS**

Experts agree that with all the buzz about upcoding, it’s easy to forget that under-coding is also problematic because it results in revenue loss. Though less common, under-coding occurs when physicians report a lower than necessary E/M level out of fear they will be targeted by a payer for an audit. It can also happen when physicians don’t document all the services they render or the complexity of their MDM.

Most physicians become aware of a trend of underpayments after hiring a consultant to perform an internal audit, says Elhoms. The good news is that physicians can submit corrected claims to try and recoup some of the revenue to which they’re entitled. Medicare allows providers to submit corrected claims up to a year from the date of service, while many commercial payers require resubmissions within 120 days or sooner.

Is it worth the time and effort of resubmitting a claim? Elhoms provides this hypothetical example: A provider sees 100 patients per month, 50 of whom receive level 4 E/M services based on the documentation. However, the provider bills a level 3 for these 50 patients out of fear of being audited or because they don’t understand documentation requirements for each E/M code. The difference in payment between a level 3 and level 4 established patient is $35, equating to a $21,000 revenue loss over the course of a year.
Clearing up preventive visit confusion

Q: I’m confused about the various Medicare preventive visits. The Initial Preventive Physical Examination (IPPE) and annual wellness visit (AWV) list depression screening (G0444) & alcohol screening (G0442) in the CMS documents online, but doesn’t CMS forbid the use of these codes during welcome to Medicare and initial wellness visits?

A: There are several documents on the CMS website outlining the IPPE and AWV service and the required components of those. Some just list all the potential “other Medicare Part B Preventive Services.” But you are correct about the G0444 that is bundled into both the G0402 and the G0438.

You can bill G0444 with a G0439, the subsequent AWV, which does not list depression screening as a required element.

But none of the AWVs or the IPPE specifically name alcohol screening or counseling—and neither the G0442 or the G0443 is currently bundled with these codes, suggesting that they can be billed along with the G0402, G0438 and G0439. The IPPE does mention alcohol, tobacco and other drugs under “Review the patient’s history,” but that’s not the same as counseling.

However, the health risk assessment (HRA) that is required for the G0438 and G0439 includes a review of Psychosocial and Behavioral risks—which would surely include alcohol. And the questions in the standard HRA are enough to score a patient’s risk. If taken out of the HRA—and set up as a discrete screening section in the chart with some actual detail and, of course, time documented—this could support a G0442 in addition to any of these codes.

You would likely only do this with patients that scored positive, and not make this a routine part of IPPE or AWVs.

Q: I was wondering if you could provide guidance on using time for coding when the time is 20 minutes since that is exactly between the 15 minute/99213 and the 25 minute 99214? I am running into this quite often because they have changed most of my appointments to 20 minutes.

A: Thanks for reaching out. It would appear that based on your comment about “insurance” that you are at least vaguely aware that governmental and commercial payers may do this differently.

The bad news is that Medicare has pretty clearly said that the “midpoint” rule (meaning more than halfway between two time listed as below qualifies you for the higher code) does not apply to evaluation and management (E/M) codes.

The AMA and the CPT manual do endorse the midpoint rule. Medicare specifically doesn’t for E/M codes.

At least for Medicare/Medicaid and TRICARE, if you are between two typical times you have to use the lower. For commercial payers you could go with the midpoint, i.e., 21 minutes being enough for a 99214.

But providers rarely have perfect knowledge of a patient’s insurance, so the safe play is to stick with 25 to 39 minutes for a 99214 based on time, for everyone.

This is changing for everyone in 2021. The AMA is redefining some time parameters for the office visit codes 99202–99215. This would appear to eliminate the “midpoint” rule for commercial payers.

So stay tuned.

Bill Dacey, MHA/MBA, CPC is principal in The Dacey Group, Inc., a consulting firm dedicated to coding, billing, documentation, and compliance concerns for physicians. Send your coding questions to medec@mmhgroup.com.
Legal

The ABCs of malpractice insurance

by JEFFREY BENDIX, Senior editor

For doctors in independent practice, decisions about malpractice insurance may be among the most important they will make. That’s because in addition to the significant financial commitment, doctors need an insurance carrier whose judgment, expertise and financial resources they can count on if they are ever faced with a lawsuit.

With that in mind, here are some of the basics doctors need to know when purchasing malpractice insurance.

TYPES OF POLICIES
Malpractice insurance policies come in two flavors: “occurrence” and “claims-made.” They differ in that an occurrence policy provides coverage for any action brought against a doctor during the time the policy was in effect, regardless of when the lawsuit is brought. The coverage applies even if the doctor is sued at a point in the future when the policy is no longer in effect, says Patricia Lawrence, assistant vice president of business development at The Doctors Company, a national malpractice insurance provider.

By contrast, says Lawrence, a claims-made policy provides coverage only so long as the policy is in effect, and under the terms of the policy in effect at the time the suit is brought. “If you have a claims-made policy and are sued for an event that occurred in 2016, the claim will be attached to the policy as it exists today,” Lawrence explains.

Another difference between the two is that the premiums for claims-made policies usually are lower, at least in the first years of the policy, says David Zetter, CHBC, president of the practice consulting firm Zetter HealthCare in Mechanicsburg, Penn. That’s because when a claims-made policy lapses—either because the doctor retires or leaves a job where the employer provided insurance—the doctor has to buy a “tail policy” for coverage in the event they are sued over something that happened at their previous job or before they retired.

Tail coverage is usually available from the doctor’s previous insurance carrier, Zetter says, but often at a substantially higher cost—in part to make up for the lower premiums in the first years of the policy.
“Basically, an occurrence policy is going to be a full premium payment from day one and covers any claim, regardless of when it’s brought, while claims-made allows a doctor to go in at a lower premium that they make up with the cost of tail coverage. So no matter what, the insurance company gets the full premium for their coverage,” Zetter says.

Lawrence says many insurance carriers, including The Doctors Company, provide free post-retirement tail coverage as a benefit to long-time policyholders.

WHERE TO BUY INSURANCE
Doctors and practices can buy malpractice coverage either directly from a carrier or through an insurance broker. If going the direct route, experts advise researching the carrier’s financial strength rating from A.M. Best—and to buy from a company with an “A” rating or better—as well as its reputation for customer service.

And while comparative shopping is always useful, getting more than a handful of quotes can be counterproductive, Zetter says. That’s because other carriers could perceive a wide search as meaning the doctor is having difficulty getting coverage, and price their own quotes accordingly. For the same reason, it could also harm a doctor’s credit rating.

“ That’s not to say you shouldn’t shop your malpractice every few years to make sure there aren’t better deals out there. You just don’t want to do it with more than two or three carriers at a time,” he says.

LEGAL REPRESENTATION
Legal representation is probably the most important service malpractice carriers offer to their policyholders. And while that system works well most of the time, there are circumstances where a doctor may want to hire their own attorney, says Fred Cummings, JD, a healthcare attorney with Dickinson Wright in Phoenix, Ariz.

Cummings cites examples such as if the insurer doesn’t think a plaintiff’s claim in a lawsuit is covered by the doctor’s policy, or if the company loses a case at trial it could have settled out of court, and the amount awarded the plaintiff exceeds the limits of the doctor’s policy, thereby leaving the company on the hook for the entire amount of the settlement.

Conversely, there may be times when the insurer wants to settle a case out of court but the doctor doesn’t. Cummings says most policies now include a “consent to settle” provision, which requires the carrier to get the doctor’s permission before seeking an out-of-court settlement.

“A doctor giving consent to an insurance carrier will pretty much guarantee some money gets offered because every case has some value. But whether it’s sufficient to settle the case is another matter. And that’s where the physician may need another lawyer, to pressure the company to enforce [the doctor’s] rights under the contract.”

— FRED CUMMINGS, JD, HEALTHCARE ATTORNEY, DICKINSON WRIGHT, PHOENIX, ARIZ.

COST
In addition to the type of policy, malpractice insurance premiums are determined largely by the physician’s specialty and location. Some specialties, especially those that involve surgery, carry higher risks and thus more potential liability for the insurance carrier, Lawrence explains.

Similarly, carriers have to take into account the wide variation in malpractice payouts among and even within individual states. Other factors used to set premiums, Lawrence says, include any previous claims history, number of hours worked per week, how long a doctor has practiced, and whether they perform procedures outside their specialty.
Don’t get fined by HIPAA in 2020

The trend continues as the Department of Health and Human Services Office for Civil Rights (OCR) has issued more enforcement actions. Failure to provide patient records can result in a HIPAA fine. Earlier this year, I wrote an article that addressed one of 2019’s many enforcement actions – Bayfront Health’s failure to provide a pregnant woman with a complete copy of her medical record by omitting the fetal heart rate monitor records of her unborn child. As a result, the hospital agreed to pay $85,000 and implement a corrective action plan.

In December, OCR continued to focus on Privacy Rule violations for failing to comply with HIPAA’s Right of Access. This time, Korunda Medical, a Florida-based provider, agreed to pay $85,000 to settle potential violations of the HIPAA Right of Access, adopt a corrective action plan and revise its policies and procedures to bring them into compliance with the Right of Access.

The HIPAA Right of Access Initiative has been identified as an enforcement drive to ensure HIPAA-covered entities are providing patients with copies of their medical records in a manner that comports with the law. It is also important to read state laws, which often have shorter time periods for providing medical records to patients.

As OCR Director Roger Severino stated, “For too long, healthcare providers have slow-walked their duty to provide patients their medical records out of a sleepy bureaucratic inertia. We hope our shift to the imposition of corrective actions and settlements under our Right of Access Initiative will finally wake up healthcare providers to their obligations under the law.”

In Korunda Medical’s case, an initial complaint was filed with OCR on March 6, 2019. Subsequently, on March 18, 2019, OCR provided technical assistance to Korunda Medical on the HIPAA Right of Access and the complaint was closed. Four days later, a second complaint was received and on May 8, 2019, OCR advised Korunda Medical that a compliance investigation had been launched. And as stated above, a monetary settlement was paid and corrective action plan was implemented.

Two issues come to mind with this most recent fine. First, why weren’t policies and procedures reviewed more closely and on an annual basis to ensure that the content was adequate? Second, how was this missed during the requisite, annual risk analysis?

As 2020 gets underway and compliance preparations are reviewed, covered entities, business associates and subcontractors should evaluate the quality of their policies and procedures, training and risk analysis. Doing so could lead to a year without worry about an enforcement action coming your way.

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In a small Kansas town, an independent medical practice is taking an innovative step to attract talent.

The practice owner and his team of six clinicians believe they need at least one more physician but expect the position will be part-time, at least at first.

The owner developed a training program with a local hospital that allows newly-hired physicians to get hours at the hospital, thereby creating the equivalent of a full-time position attractive enough to draw high-quality applicants, says Jillian Schneider, MHA, manager of practice support at the American College of Physicians, who has worked with the practice.

Many practices have difficulty recruiting and retaining clinical staff, but small and independent practices often face the biggest challenges as they try to compete for talent against larger entities that are better able to promote all they can offer. Small, independent and rural practices don’t have as many recruitment and retention resources.

They typically aren’t able to offer compensation packages as generous as larger or system-owned practices, or offer the high-profile work environments found in urban research healthcare centers. They might not even have a full-time schedule to offer to start, as the Kansas example illustrates.

Management experts stress that a well-crafted plan can help these practices be more successful in hiring the right people, ensuring the longevity of their practices, and ultimately serving their patients in the most efficient and effective manner.

“At a small practice, there’s only so much money that can be spent on compensation, so they have to consider the types of benefits they can offer, like flexibility and work-life balance. Those are big perks that money can’t buy,” Schneider says.

TARGET THE TALENT

Smaller, rural, and independent practices can be particularly hard-pressed to attract qualified candidates, says Travis Singleton, executive vice president of Merritt Hawkins.

These practices sometimes struggle to attract physicians and other clinicians because prospective employees are often unfamiliar with smaller practices, how they operate, and why they can be good places to work. Singleton says younger physicians typically train at hospitals or in larger practices affiliated with healthcare systems, so they’re only familiar with practicing in such settings.

To attract physicians, Singleton says independent practices should search for candidates who come from rural areas and are...
therefore likely familiar with life in those areas, the sense of community they can offer and perhaps even how healthcare practices in those areas operate. Practices should use professional networks, medical schools, or physician associations to identify clinicians who fit that profile.

That’s just the first step, however. Independent practices also should work with medical schools or regional medical associates to attract potential candidates. “Physicians in small and rural practices should be reaching out to schools, saying, ‘We want students to come to us. We want them to learn about small-practice medicine, rural medicine, so let’s form programs so they can be exposed to this kind of environment,’” she says.

Russell Kohl, MD, had a solo family practice in rural Oklahoma from 2006 to 2012. He relied on networking to help attract candidates when he had positions to fill. But he also worked with his local vocational high school and area colleges, offering to be a preceptor for nursing students. “Some physicians say they don’t want to be a training center. Some might think it slows down the practice. But if you think about it as an on-the-job interview for both—you get to see these people, they get to see the culture of your practice—then you realize you both really get a feel for whether it’s the right fit,” Singleton says.

Indeed, Kohl, who now practices in Stilwell, Kan., and is a director of the American Academy of Family Physicians, had hired a nurse practitioner and two licensed practical nurses from the training programs he had established with area schools when he was still with his previous practice in Oklahoma.

OFFER COMPETITIVE COMPENSATION
An attractive compensation package includes a competitive salary and standard benefits, such as health and dental insurance as well as paid time off for vacations, sick days, and bereavement. Schneider acknowledges that small and independent practices often don’t have the money to fund a new position as soon as they recognize the need for more staff, so she advises practices to plan strategically so they can start budgeting for new positions a year or two in advance of recruiting and hiring.

To ascertain the compensation that other practices in their region offer, practice owners can look at compensation surveys, such as those done by the Medical Group Management Association (MGMA), and talk to colleagues, says Nick Fabrizio, Ph.D., FACMPE, an MGMA principal consultant.

“One of the best strategies is to talk with others. People will share what they’re paying, or share a range. That gives the hiring physicians the best benchmark,” Fabrizio says.

He notes that physicians don’t have to offer the exact same compensation package that others in their region do, particularly because small practices generally can’t afford to match the benefits packages offered by the largest healthcare systems. Still, Fabrizio says the practice must be close to what others in their area are offering. That could mean a higher salary but a less generous benefits package, or vice versa.

“"One of the benefits of having a small practice is you have the flexibility to meet [employees’] needs. That’s a big selling point, particularly for younger physicians who are raising kids or still going to school.”

—RUSSELL KOHL, MD, FAMILY PHYSICIAN, STILWELL, KAN.

HAVE OPTIONS ON EMPLOYMENT, OWNERSHIP ARRANGEMENTS
While salary is important, small practices also can attract and retain staff by structuring compensation to reward hard work or finding other ways to boost the total compensation package.

“Even more important than competitive pay is providing employees a sense of how they can earn more,” says Laurie Morgan, MBA, a practice management consultant and partner at the practice management consulting firm Capko & Morgan.

She suggests creating bonuses for clinicians who meet productivity goals. “Creating that type of job structure, and then communicating it clearly, can be a powerful way to compete against larger organizations with more cookie-cutter employment policies for doctors,” she says.
With the physician shortage remaining a large concern for healthcare providers, a 2018 study from medical employment firm CompHealth identified ways young physicians find their first positions, what they want in a job, and why they leave.

Not surprisingly, the survey found that young physicians are looking for good compensation. But money’s not all that motivates them. Lisa Grabl, president of CompHealth, says employers should be aware that young physicians also want to work in a place that has a great culture and offers a good work/life balance.

“If you’re not strong in these areas, look for ways to improve, or you’re going to lose out on attracting the best talent,” Grabl says.

For many years, physicians were willing to work long hours and make their career the center of their lives. Millennial physicians still care about their patients and career, but they also want to have time for family, friends, and interests outside of medicine. That’s why many healthcare facilities have adjusted their recruiting tactics to show how they can meet all of the physicians’ needs—not just their at-work requirements.

Jennifer Moody, an associate principal at ECG Management Consultants, a Dallas, Texas-based medical staffing company, says physicians in their first job are looking to build upon the clinical expertise they’ve been developing in residency/fellowship.

“It is important to many that they find a practice opportunity that allows them an interesting case mix,” she says.

Also important, she notes, is any opportunity for improved financial stability—such as loan forgiveness, net income guarantees or a signing bonus, as new physicians quite often have a great deal of educational debt.

Chris Borasz, manager of physician and provider recruitment for OhioHealth in Columbus, Ohio, says when recruiting, it’s important to think about the total family, not just the physician, and consider what the community can offer the spouse or partner.

“It’s finding things that are helping to engage that person in connectivity to community,” Borasz says. “The development and support as they ramp up is important, but also think about that long-term development.”

Finding work
According to the survey, 40 percent of placements come from referrals and networking. Only 12 percent of young doctors use social media to find work, despite spending between five and 19 hours a week online for personal reasons.

Moody says that millennials will often use social media to look for practice opportunities, confer with peers about salary norms or contract requirements on social media-based message boards, and research potential employment locations on the internet.

Therefore, if practices are only advertising in specialty journals or hoping to network at society meetings, they will miss out on many candidates.

The key to retention
The survey found that physicians are generally quite satisfied in their jobs but are also willing to change employers if they can find a better fit. The key to retention, Grabl notes, is listening to physicians to ensure their needs are being met.

She suggests holding interviews at intervals after the physician has been recruited—at three months, six months and a year—to monitor how the physician and his or her family are integrating into the practice and community.

Grabl says this is important because young physicians today want more than just a good working opportunity.

“They are still willing to work, and work hard, but they also want more in their lives,” she says.
Kohl established a profit-sharing program for employees, which became an effective tool for retaining staff and boosting practice efficiency. "It made my employees very creative in getting work done. They were very focused on being effective and efficient, so we could do all the procedures we needed to do," he says.

Similarly, Singleton advises practice owners to be open to various types of employment arrangements. He points out that many physicians don’t want to be practice owners, so there should be a career path for them, as well as an option for those who want to become partners.

Practices should also determine ways for their clinicians and members of the support staff to grow professionally, Morgan says. "Not all employees are interested in doing the same job forever; many people are aiming to progress. Enabling employees to pursue more education conveys that your practice is investing in your staff," she says, adding that investing in continuing education can also save the practice money over time.

"The cost of the training plus a raise and promotion for the employee could be less than the salary you’d wind up paying an external hire. And you likely foster more loyalty in that employee you invested in," she says.

Kohl says he used professional development opportunities as a recruitment tool. He encouraged members of his clinical team to pursue further education, and he worked with those who continued their studies to create schedules that gave them time to take classes while still having the practice adequately covered. As a result, he retained top talent and his practice gained more skilled employees.

OFFER UNIQUE BENEFITS, PERKS
During his years running his small practice, Kohl says he learned that staff members often didn’t use the benefits he expected them to need, but did want some degree of individualized benefits.

For example, he found that most of his staff didn’t need health insurance because they were covered by their spouses. Some, however, were more interested in flexible hours or more vacation time. Kohl says he sought to learn what his staff members valued most and tailored what he offered to each as a way to help retain them.

"One of the benefits of having a small practice is you have the flexibility to meet [employees’] needs. That’s a big selling point, particularly for younger physicians who are raising kids or still going to school," he adds.

Practice owners should determine what benefits or perks they can offer, such as flexible schedules, and highlight those to prospective employees.

“Even more important than competitive pay is providing employees a sense of how they can earn more.”

—LAURIE MORGAN, MBA, PRACTICE MANAGEMENT CONSULTANT AND PARTNER, CAPKO & MORGAN

For example, practice owners could allow new physicians to hire their own care teams, determine how broad to make the scope of their practice coverage, and even set their office hours, Singleton says.

“That control goes a long, long way in recruiting and retaining physicians," he says, citing a group of physicians that decided to join an independent practice where they’d make less money but could have more say in the way they provided care for their patients.

Management consultants say practice owners also should emphasize the unique qualities or professional opportunities that their practice offers as a way to attract clinicians seeking professional experiences different than those offered in larger settings.

For example, Schneider says, rural practices can sell the fact that their physicians generally practice a broader range of medicine and that they’re often a bigger part of these communities than their suburban and urban counterparts.

FORMAL POLICIES NEEDED
While management consultants say small and independent practices should use individualized employment packages as a way to recruit and retain top talent, they advise practice owners to establish policies and procedures regarding available benefits so that even if employment packages are individualized they won’t seem capricious.

Fabrizio says practice owners who want to recruit and retain skilled professionals need to focus on being good employers—not just good healthcare providers. He adds: "Be the best employer you can be. Respect your staff, be responsive to your staff."
PRACTICAL MATTERS

Three common real estate mistakes physicians make

Real estate is the second-highest expense behind payroll for most physician practices. The benefits of capitalizing during lease negotiations can include increased profitability, reduced debt, a nicer office and more. On the other hand, if negotiations are not handled properly, the results can be decreased profitability; resulting in the need to produce tens to hundreds of thousands of additional dollars just to maintain the practice’s financial position.

While there are many key concepts and strategies to be aware of prior to and during any lease or purchase negotiation, there are an equal or greater number of mistakes to avoid. Having represented thousands of healthcare professionals over the last decade, we have gathered some of the most common mistakes healthcare professionals make during lease and purchase negotiations with the goal of helping others avoid the same miscues.

Here are three of the most common mistakes:

Mistake 1: Believing the landlord/seller will simply offer the best terms
Landlords and sellers are in business to make money. They are no more likely to voluntarily reduce lease rates or give up any extra money through concessions than you would be to reduce your reimbursement from an insurance company or cut your patient fees if you didn’t have to. While it sounds pleasant to hear a landlord talk about giving a fair deal or reasonable price, your odds of getting either are bleak without truly understanding the market, entering the negotiation process with multiple other options and having capable guidance. Trusting a landlord or seller without the help of professional representation will most likely result in the loss of tens to hundreds of thousands of dollars that could have stayed in your checking account.

Mistake 2: Determining market value by asking what your neighbors pay
Several years ago, we were reviewing the lease terms for a doctor who had been in a building for 20 years. In looking at his lease, we saw he was paying $30 per square foot (SF), and had not received any free rent or tenant improvement allowance in his last negotiation.

When we posed the question, “Do you believe $30 per SF with no concessions is a good deal?” His response was: “I believe so.” When we asked why, he responded: “There are four other healthcare practices on this floor. We all know each other and talk about our leases. We are all paying $30 per SF and the landlord has told all of us they don’t give free rent or tenant improvement allowances.”

We told him, “We understand the logic behind that approach, but what if we told you we just did a lease with a new tenant at $21 per SF and the landlord has told all of us they don’t give free rent or tenant improvement allowances.”

We told him, “We understand the logic behind that approach, but what if we told you we just did a lease with a new tenant at $21 per SF, while also obtaining three months of free rent and over $100,000 in tenant improvement allowance?”

The bottom line is that landlord got away with convincing five different practices the market was far stronger than it really was and that he couldn’t provide any concessions. This scenario happens every day to uneducated tenants who consult with other uneducated tenants and compare terms that were the result of having no posture, no knowledge of the market and not applying leverage through representation.

Mistake 3: Not knowing market availability and comps
The foundation of any successful negotiation starts with understanding what your other viable options are, how they compare to each other and how to execute on them. When dealing with landlords or sellers, many doctors try to bluff their way into and through negotiations. A savvy landlord or seller can often read a bluff from a mile away.

If you are going to be successful in your next negotiation, understanding market availability and comps is the first place to start.

Leon Dayries is a real estate agent in Louisiana for CARR. Send your practice management questions to medec@mmhgroup.com.
Managing patients with multiple chronic conditions—who, according to the RAND Corp., account for about a quarter of the U.S. population but more than two-thirds of healthcare costs—is critical to success in value-based models.

The only problem? The health system was purpose-built for episodic care rather than the ongoing, community-based care this population typically needs.

To learn more about the challenges of managing chronic care, Sage Growth Partners conducted a survey of over 100 healthcare leaders in early 2019. Respondents were roughly equally divided between health system executives and leaders of physician practices.

What we found is a large gap between need and ability. While virtually all (98 percent) respondents believe chronic care management is very important, only about half (53 percent) say they’re doing it very well.

**TOP THREE BARRIERS**

What’s getting in the way? Respondents say their main barrier is insufficient human resources (61 percent), followed by inadequate reimbursement (52 percent), and capital constraints (35 percent).

It’s not surprising that managing the care of those with chronic conditions is difficult. Nor is it surprising that—despite the emergence of thousands of new technology solutions—respondents think people are essential to managing care:

- 71 percent of respondents say that an even mix of people and technology is needed to drive care management success, while 19 percent think staffing is more important than technology.
- Over two-thirds (69 percent) of respondents believe a trusted relationship with a nurse or other clinicians is central to managing chronic conditions, and 76 percent say these relationships are extremely likely to improve patient loyalty.

Overall, the industry is sober about its ability to manage chronic care and readmissions, and hospital executives are less sanguine about their abilities than are leaders of physician practices.
Chronic Conditions

Avoid common CCM denials

by Lisa A. Eramo, MA  Contributing author

Even though physicians have been able to bill CCM since 2015, they still run into problems in terms of getting paid, says Kim Garner Huey, CPC, owner of KGG Coding and Reimbursement Consulting in Birmingham, Ala. Here are some common reasons for denials and how to avoid them:

Reason for denial: Multiple providers bill CCM for the same patient during the same 30 days.
How to avoid it: Communicate with specialists regarding who will bill for the CCM. “This code was really intended for primary care, but it’s not restricted to primary care,” says Huey.

Reason for denial: Physician bills CCM more than once every 30 days.
How to avoid it: Set up an alert in the practice management system that prevents physicians from reporting CCM before 30 days have elapsed, says Huey.

Reason for denial: Insufficient documentation.
How to avoid it: This problem often surfaces during post-payment audits, says Huey. Avoid recoupments by ensuring that documentation reflects the intent of the code—i.e. to manage all of the patient’s chronic conditions. “CMS intended a very personalized, hands-on type of medical management,” she adds. Documentation such as ‘Patient is taking medications as prescribed’ is not sufficient. Instead, she says to document the following:

- List of all of the patient’s conditions with as much specificity as possible
- Why these conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan—What the physician is doing to manage the diagnoses. If a specialist is managing a condition, the primary care physician should note the specialist’s name, the date of the last appointment, and a brief summary of the visit.

For more information about CCM, including patient and practitioner eligibility as well as the service elements included in the code, visit the CMS web site.

Why is there such a big gap? The survey findings reveal that only 20% of hospital executives believe office-based care is most important, compared with 75 percent of those running physician practices. That indicates that physician leaders view office-based care as key to managing chronic conditions, while hospital executives appear to place a greater value on home-based care. Or, perhaps, physicians feel more in control of care delivered outside the hospital than do hospital leaders.

Where both groups agree: telephonic nurse outreach is the second most important type of care.

MAKING CCM WORK

The CMS Chronic Care Management (CCM) program has been available since 2015, when CMS established new reimbursement codes to cover the cost of managing chronic care remotely. While this was a step in the right direction, it appears that only a small percentage of Medicare patients are actually receiving care under these codes.

The survey findings indicate that CCM reimbursement isn’t sufficient to cover the costs of delivering care in this program. Many providers struggle to enroll enough patients in this program to cover their staffing and technology time and costs. And even a number of chronic care management companies have folded because they couldn’t make the model work.

Creating a pool of experienced nurses that can work closely with physicians’ staff to give the higher acuity patients the extra support they need—to catch problems early so they don’t become crises—is key. It’s also important to have technology that can readily integrate with the EHR so that physicians don’t waste precious time getting the program up and running.

When programs are implemented effectively, health systems with 1,000 enrolled Medicare patients can generate an additional $500,000 in annual revenues, without spending a dime up front.

The challenges of delivering chronic care are multiple and significant. But for those who can operationalize this care model with the right combo of people and technology to make a program work, the rewards can be great.

Drew Kearney is co-founder and CEO of Signallamp Health, Inc.
Why biometrics are the future of patient care

Patient identification is in desperate need of an overhaul—and biometrics could be the answer.

by DONNA MARBURY Contributing author

Most consumers are accustomed to using their fingerprint to unlock their phones. That’s just one of the uses for biometric technology, which includes: fingerprint, iris, and facial recognition, as well as palm-vein readers, to reduce the authorization fraud and security breaches common with passwords.

Government, financial, travel/logistics and consumer electronic industries have all increased their use of biometric technology in recent years and use in the healthcare industry also continues to grow.

Estimates are that the healthcare biometrics market will be worth $14.5 billion by 2025, due to the increase in healthcare information exchanges and the demand for technology that decreases data corruption and fraud, according to an analysis by Grand View Research. That represents a growth of 23% from 2017, and Grand View predicts the growth of consumerism in healthcare will push many organizations to consider biometrics as it becomes the standard in other industries.

Kerry Pillon, director of corporate communication for biometrics technology company Imprivata, says the company works with 1,700 global healthcare customers in 39 countries and has seen increased uses for the technology in healthcare settings.

“We have seen an increased investment in biometrics by our healthcare customers as a way to accurately identify people in their ecosystems, including patients and clinicians, maintain secure access to protected health information, and secure high-risk work flows such as electronic prescribing for controlled substances,” Pillon says.

Michael Trader, co-founder of RightPatient, Inc., says that his company has seen growing interest in its biometrics technology among hospitals and clinics. Currently, RightPatient supports six forms of biometric patient identification—fingerprint, finger vein, palm vein, iris, facial, and voice recognition—at 70 hospitals and hundreds of clinics.
Compared to manual methods of identification that lead to an 18% average duplicate record, $1.5 million annual losses in claim denials, and a significant impact on patient safety, health systems should not see any limitations in implementing biometrics to address these issues, Trader says.

**HOW HEALTHCARE IS USING BIOMETRICS**

Generally, healthcare organizations are using biometric tools for two-factor or multi-factor identification and single sign-in for staff and patient identification. Because electronic prescribing for controlled substances is highly regulated, Pillion says, biometrics is ideal for the required two-factor authentication. The U.S. Drug Enforcement Agency requires biometrics to meet criteria for false match rates and other regulatory specifications. According to Imprivata, fingerprint biometric identification has a false match rate of less than .1 percent.

“Many organizations adopting electronic prescribing for controlled substances have selected biometrics, and specifically fingerprint biometrics, as one method of authentication for compliance,” Pillion says. “It is an easy, fast, and highly secure way for prescribers to complete two-factor authentication.”

Patient identification is also a valuable use case for biometrics throughout the care continuum, including at point of care. One such case is radiation oncology, where healthcare providers want to be certain that they are treating the correct patient, Pillion says.

“Patients may see this most at the point of registration, when the registration or patient access staff uses biometrics to make sure they are checking in the correct patient and bringing up the patient’s correct medical record.”

**ROLLING OUT BIOMETRICS ACROSS A HEALTH SYSTEM**

Keely Aarnes, PMP, assistant vice president of business operations for Northwell Health, says the health system is planning to rollout iris recognition for patient identification across more than 600 practices through the next 18 months. Working with

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**Three considerations before Investing in biometrics**

1. **Start small before scaling to enterprise-wide deployment.**
   
   It’s okay to start small and learn, says Keely Aarnes, PMP, assistant vice president of business operations for Northwell Health. “We initially did a proof of concept in September 2018, and we went live with our first site. Looking back, that was a great way to do it, because what we thought would work as far as workflow was completely different than that works in a live environment, Aarnes says. The health system deployed across 11 more practices in December 2018, with another 40 practices slated for February 2019.

   “After that we’re going to take off very rapidly. We have 600-plus practices, so we envision this will take about 18 months to roll across our organization” Aarnes says. “Also, we will be implementing our first hospital acute site in June or July 2019. So that will be a whole new workflow that need to be defined and understood.”

2. **Think long-term when choosing biometric capabilities.**

   Healthcare organizations should be paying attention to regulations that are coming out around telehealth as well as areas such as interoperability, Pillion says.

   “More and more health systems are offering telehealth options, and to do that successfully, they need to be sure that they are correctly identifying the patient who is not physically in front of them,” Pillion says. “Investing in biometrics may help organizations be ahead of the curve when it comes to positively identifying patients and being able to successful treat them in person and remotely.”

3. **Consider more robust technology expansion to complement biometric solutions.**

   “Health systems should consider much more than just the biometric technology. While important, it is one part of a much larger value proposition that the right platform and partner can deliver,” says Michael Trader, cofounder of RightPatient, Inc.
RightPatient, Aarnes says the organization was able to pilot the technology at 11 practices before planning to expand the use across the organization.

“We strategically went with iris recognition, because it takes a high-resolution photo of the patient’s face, which then uses the iris identification and that pattern to create an identifier,” Aarnes says. “That picture can be used for multiple use cases. One, we take that picture and send it through our EHR, which is a better level of identification for the clinician.”

Second, Aarnes says the health system would like to use facial recognition in the future to identify patients as they enter facilities and create a more concierge patient experience or warn staff of security risks.

Aarnes says high-resolution photos provide multiple use cases. “If we know that a patient has arrived, we can welcome them and send them messaging and way finding so that they know where to go. It also has a use case in the hospital where we can identify patients that we know we want to intervene early, such as central fraud or drug seeking.”

Aarnes believes the initial rollout of the iris recognition technology will allow the health system to solve security and patient experience challenges in the future.

“We need to really start thinking outside the box so we’re not just solving our immediate registration problems in a silo. We need to start thinking about what healthcare looks like in 10 years from now with telehealth services, online scheduling, filling out documents, and registration intake forms,” Aarnes says. “That process has to start with identification. That’s why we chose something that has the ability to be portable and not something that is tied to our registration station.”

**OVERCOMING PATIENT AND PROVIDER SKEPTICISM**

Though consumers are using biometric technology more often, patients and healthcare staff still need to be educated on how it works and why the organization is using these solutions, says Pillion.

“Healthcare organizations that are implementing biometrics will want to be prepared to overcome any stigma associated with this type of technology,” Pillion says. “Some providers or patients may be concerned that the government will get access to their information. However, the data is never shared outside the health system, and with some forms of biometrics such as palm vein recognition, there is no forensic value.”

According to a 2018 survey of 1,000 people by the Center for Identity at the University of Texas, Austin, 58% of respondents feel very comfortable with fingerprint recognition technology and about 33% are comfortable with other forms of biometrics technology.

“Many organizations adopting electronic prescribing for controlled substances have selected biometrics, and specifically fingerprint biometrics, as one method of authentication for compliance.”

— KERRY PILLION, IMPRIVATA

Trader says that the biggest barrier that health organizations face when implementing biometrics is overcoming a culture that resists innovation.

“Patients are becoming increasingly tech savvy and they expect an experience like hospitality or retail,” Trader says. “If health systems acknowledge and embrace this fact, then moving forward with biometrics should not be a difficult process. There will always be skeptics but they are in the vast minority and many of them are typically won over when they see the technology in action and witness first-hand the impact that it delivers.”

Aarnes says it was important to develop on “elevator speech” for staff to explain to patients how the technology would be used and data would be stored.

“With our first launch, we really learned to stay away from using the verbiage, ‘scanning your iris’ because people have a negative connotation with the word ‘scan,’” Aarnes said. “A lot of our staff training was educating them on how to speak to a patient about the technology. The technology in itself is pretty easy. It’s really just finding that sweet spot of informing and educating our patients that this is for their benefit in safety and ease of registration.”

So far, the health system has had 10,000 patients enrolled using iris recognition.
Electronic health records are among doctors’ major frustrations, yet their objections are rarely heard where they can make a difference. At the Health Information Technology Advisory Committee (HITAC) meetings, which take place a few times a year in Washington, independent doctors are conspicuously absent.

While several hospital-employed doctors sit on this high-octane panel, they and most of the other HITAC members primarily represent corporate healthcare: hospital systems, large insurers and big IT companies (Sutter Health, Anthem Blue Cross, Accenture, Epic, to name a few.)

A Washington-based organization, HITAC makes recommendations to the National Coordinator for Health Information Technology about what health IT should be implemented, how and when. In short, it directs the future of EHRs.

What strikes me, however, is that the very committee largely responsible for shaping how independent doctors spend their time is missing that group’s voice at the table.

“The very committee largely responsible for shaping how independent doctors spend their time is missing that group’s voice at the table.”

I hear from doctors like this pediatrician who recently lamented, “Electronic health records was pitched to doctors as the panacea, the way to integrate and share health information across systems for the benefit of patients and doctors. No longer were doctors going to have to search for paper charts or transfer information between offices and hospitals and clinics, or run duplicate tests. Electronic health records would be easily accessible.”

Except, that didn’t happen. Instead, EHRs “became the bane of our livelihoods: time-consuming, exorbitantly expensive, and without interoperability. They don’t enhance, but rather degrade patient interactions, serving only as a data source to help insurance companies with their coding and billing.”

And I hear from doctors like this cardiologist who called my office at 5:30 pm, a time when many workers are winding up their days. Although he was done seeing patients, he said in a voice of resignation, “I’m surrounded by 45 dictations I need to do to please the bureaucrats before I go home, eat, see my family, sleep and do it all over again tomorrow.”

Currently, the committee has two open seats. I have been nominated for one. It’s a long shot, and whether I get appointed or not isn’t what matters. What does matter is that someone who represents independent doctors and their patients does get a seat at that table.

Marni Jameson Carey is executive director of the Association of Independent Doctors, a national nonprofit trade association that works to support doctors who want to remain independent. You may reach her at marni@aid-us.org. To become an AID member, go to www.aid-us.org/join.
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COMING NEXT ISSUE

You’ve been sued for malpractice. Now what?
Data shows that most physicians will face the prospect of a malpractice lawsuit at some point during their career. So what should a physician do when they are sued? We talked to legal experts about how physicians should respond, what questions they should ask their attorney and, just as important, what they should not do.
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