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*April 2008*

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## Answers to Questions on Consumer-Directed Care

By Richard L. Reece, MD, editor-in-chief

The trouble with innovation in health care is that there are many opportunities for innovation and little time to explore what makes sense and what would be folly to pursue. Physicians want to know where they should focus their attention to get information quickly. This column and this newsletter are designed to help physicians identify opportunities.

Another way is to go online. For this purpose, I prefer [www.sermo.com](http://www.sermo.com), a 2-year-old physician-only website that is free. Doctors post their views anonymously, and other doctors comment. For background reading, I go to [www.google.com](http://www.google.com) and [www.wikipedia.com](http://www.wikipedia.com) to validate the status of new innovations. Physicians should be wary of anything they read online, however, particularly at Wikipedia since anyone can edit the entries.

Also, I have been seeking a way to present material so that readers can grasp quickly the ideas behind significant innovations. I have chosen to use a question and answer approach. The first of these articles addresses short questions and answers on consumer-driven care.

**What?** Consumer-driven health care (CDHC) refers to health plans that pay for coverage with health savings accounts (HSAs) or health reimbursement accounts (HRAs). These and other similar plans pay directly for routine health expenses. Some of these plans feature low premiums, high deductibles, and coverage for preventive-health testing and for catastrophic illness. Often, patients using these plans pay lower premiums than they would for a more traditional preferred provider or health maintenance plan, but the deductibles often are high.

**Why?** Proponents say CDHC offers consumers greater choice and freedom, relies on consumers making more intelligent choices when spending their own money, discourages overuse of services for minor problems, eliminates the middle-man intrusiveness that is common in HMOs, and minimizes administrative costs. Many employers fund HSAs with pre-tax dollars taken from employees' payroll and employees often can carry over unspent money from year to year. Critics say HSAs are simply cost-shifting and are inappropriate for those with chronic disease or low incomes.

**When?** CDHC has been evolving since the late 1990s. Health consumers are encouraged to be engaged in making choices about their health care by getting information about the cost and quality of providers on the Web. Last year, about 4.5 million Americans were HSA holders, about 5% of covered workers. About 25% of HSA holders were previously uninsured.

**Where?** Brokers are marketing high-deductible health plans with HSAs to small and medium-sized businesses in an effort to replace more traditional insurance plans. Employers are attracted to these plans because they allow them to cut the cost of providing coverage to workers.

**Who?** Thought leaders are John Goodman of the National Center for Policy Analysis, Regina Herzlinger of the Harvard Business School, Greg Scandlen of the Center of Health Consumer Choice, Grace Marie Turner of the Galen Institute, and President Bush and members of his administration.

— More information on physician practice strategies is available on our Web site (see page 16). ■

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# PCPs Pursuing Aesthetic Medicine

By Michael Bihari, MD

Seeking new sources of revenue, physicians are entering the medical spa business. The International Spa Association (ISA) estimates that as of the middle of last year, physicians had opened more than 900 medical spas in the United States. In addition, thousands of physicians have left their practices to work for or affiliate with a physician-owned medical spa or have added aesthetic medical services to their practices.

Two complementary trends are fueling the growth of these physician-owned spas. First is growing consumer demand, particularly among baby boomers, for less-invasive and non-surgical procedures to help fight the external manifestations of the aging process. Second is an increasing supply of motivated physicians, who are frustrated with the hassles inherent in the insurance-based reimbursement system.

## Facing the Future

Once considered the domain of dermatologists and facial/plastic surgeons, aesthetic medicine is attracting an increasing number of primary care physicians, ob-gyns, gastroenterologists, and emergency room physicians. While this trend attracts a rising number of clinicians, it is also controversial, especially because of the growing shortage of PCPs. Additionally, there are legal, ethical, and competency issues regarding medical spa ownership.

Some physicians question those who are entering this field for four main reasons. First, critics say that there is lack of professional supervision or oversight of medical spa staff. Second, critics add that the training for this work is brief at best and the manufacturers and vendors of aesthetic medicine equipment and supplies provide what little training

## A Growing Market

The American Society for Aesthetic Plastic Surgery, in Los Alamitos, Calif., said Americans spent \$4.7 billion last year on nonsurgical cosmetic procedures. This amount represented an increase of more than 725% in 10 years.

The top five nonsurgical cosmetic procedures and the number performed last year were:

Botox injections	2,775,176
Hyaluronic acid (Hylaform, Juvederm, Restylane)	1,448,716
Laser hair removal	1,412,657
Microdermabrasion	743,748
Laser skin resurfacing	584,530

—MB

physicians and staff receive. Third, critics question whether it's appropriate for physicians to sell their own self-branded cosmeceuticals. Another criticism comes from those who cite the shortage of PCPs when they charge that these physicians are selfishly leaving primary care in pursuit of more income.

Ignoring such criticism, PCPs are nonetheless attracted to aesthetic medicine for three primary reasons. First, these physicians are frustrated with the current health care reimbursement system, especially for older patients. In some markets, the average reimbursement for a visit is \$50 or less, and most primary care physicians schedule four patients per hour. Along with low reimbursement, PCPs are frustrated with health plan paperwork and approval processes.

Conversely, health insurance does not cover aesthetic medicine services, meaning customers pay cash. Therefore, PCPs who make the transition to an aesthetics practice may be able to increase their net income significantly.

A second attractive factor is the desire for better work-life balance. Aesthetic medicine offers a different pace and practice intensity. There is

no on call or hospital-related duties. Aside from appropriate charting and strict adherence to patient privacy requirements, the only significant paperwork is processing patients' personal checks and credit card payments.

A third issue involves having a different relationship with patients. Patients become clients in an aesthetic medical practice, visiting the practice out of desire rather than need. Although they may be as or more demanding than patients in a typical medical practice, these clients are most often healthy, usually are pleased with the outcomes, and more likely to comply with therapy than the typical medical patient.

## Aesthetic Medicine Options

PCPs considering a move into aesthetic medicine have three chief models to follow. First, they can add the basic aesthetic medical services such as injectables (for example, Botox and hyaluronic acid fillers) into their practice for current patients.

Second, a physician can become a medical spa owner by converting his or her current practice, opening a separate new practice, or purchasing an aesthetic medicine practice and prod-

(Continued on page 4)

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uct line from a medical spa franchisor.

And, third, a PCP or other specialist can develop a relationship with an existing spa that is expanding into medical aesthetics. In such arrangements, the physician rents space from the spa to provide aesthetic services requiring a licensed physician such as injections and some types of laser therapy. Additionally, the spa owner will pay the physician a consulting fee to provide oversight for the spa's medical aestheticians and share in the proceeds from the distribution of spa-branded cosmeceuticals.

An example of the collaborative model is the Bellezza Day Spa in Falmouth, Mass. Melissa Mason, co-owner of the spa and director of marketing and sales, spent more than two years researching the industry before expanding to include medical aesthetic services. Although several PCPs expressed interest in working with Mason, she decided to work only with physicians who were board certified in dermatology, ENT, or plastic surgery.

"I'm concerned about primary care physicians who get trained only by representatives of pharmaceutical companies or medical device companies," Mason explains. "And, some doctors are sucked in at medical conferences where they're offered laser therapy training along with a line of skin products and medical spa business planning, all in one weekend," she adds.

"Plus, some companies will not sell certain products to physicians who are not dermatologists, ENTs, or plastic surgeons," Mason adds.

Noting the rapid advancements and increasing complexity of aesthetic procedures in the past three years, Mason elected to collaborate with a local, respected otolaryngologist who is a board certified facial plastic surgeon.

### More Regulation Predicted

Fueling the controversy about which physicians are most appropriate to perform aesthetic procedures and manage medical spa businesses is a rising number of states considering pro-

posals to define and regulate aesthetic medicine. In response to consumer complaints, states such as Florida and California may limit the number of medical spa offices that a physician can supervise, and which professionals can perform certain procedures.

Some of these proposals differentiate between supervision by dermatologists and plastic surgeons and that of primary care physicians. This move may reflect a concern among traditional providers of aesthetic services that PCPs are cutting into their patient base.

Eric Light, president of the International Medical Spa Association, an industry trade group in Union City, N.J., opposes any legislation that regulates the type of specialist who can perform or oversee medical spa procedures. "Why are dermatologists or plastic surgeons better qualified to supervise offsite procedures than any other physician?" he asks. "After all, it is possible for either class of physicians to get their board certification without taking a single course in medical spa treatments. A case could be made that a board certified family practitioner would be better positioned to take a holistic approach to aesthetic care."

### A Mixed Experience

Interestingly, most of the aesthetic medicine PCPs we asked to comment about their experiences for this article declined to be interviewed. Two PCPs agreed to talk briefly about their experiences as long as their names and practice locations were omitted. These physicians cited "personal reasons" most often as the basis for their refusal to be quoted on the record.

The physicians who did agree to talk had different experiences both in satisfaction with the move and the financial rewards. The first PCP, a board certified internist in the Northeast, entered the field by slowly converting his primary care practice to aesthetic medicine. He found that combining the two practice models did not work because patients

## Cosmeceuticals: A Continuing Controversy

Albert M. Kligman, MD, PhD, emeritus professor of dermatology at the University of Pennsylvania in Philadelphia, coined the term "cosmeceuticals" by combining "cosmetic" and "pharmaceuticals." It refers to nonprescription cosmetic products applied to the skin that are claimed to have drug-like benefits.

Melissa Mason, owner of the Bellezza Day Spa in Falmouth, Mass., has an expanding medical spa business, and says, "The sale of cosmeceuticals is one of the fastest-growing segments of the aesthetic medicine industry." Significant multimedia advertising drives sales along with physician branding of cosmeceuticals purchased from manufacturers and sold directly to patients within their practices.

Some physicians and consumers are concerned that the designation "cosmeceuticals" may be misleading and infers that the product has been tested and scrutinized in a manner similar to prescription medications. The Food, Drug, and Cosmetic Act, however, "does not recognize any such category as 'cosmeceuticals,' the FDA says. "A product can be a drug, a cosmetic, or a combination of both, but the term 'cosmeceutical' has no meaning under the law." Since cosmeceuticals are not considered drugs, they are not regulated as such, and independent clinical studies subjected to peer review are few.

—MB

interested in aesthetic procedures did not want to come to a traditional doctor's office. He then eliminated primary care and found the cost of advertising and managing the practice too expensive. He closed the practice and rented space in three day spas that were adding medical services. He found this "riding the circuit" approach to be unrewarding and became a fulltime hospitalist.

The second PCP, a board certified family physician in the Southeast, first worked with an aesthetic medicine consulting firm and then teamed with an internist and an emergency room physician to open a free-standing medical spa. Located in an upscale community with a large retiree population, the business is thriving. After several years, the physician closed his primary care practice and acknowledges that his primary care patients needed to find a new doctor in an area that has a shortage of PCPs. He understands the problems patients face when they lose their PCP, but adds, "I just couldn't stomach it anymore."

### Challenges for PCPs

PCPs and staff face numerous challenges when adding aesthetic medicine. These challenges include:

- Compared with a traditional medical business model, the technical training, type of business plan, and the implementation of a marketing plan may be foreign to PCPs.
- The physician-owner may be ill-prepared to manage what is essentially a retail, cash-based business based on a different style of patient interaction.
- As opposed to primary care practice, a medical spa requires an ongoing investment in expensive technology and products acquired from manufacturers and vendors that may not provide training or support. Additionally, the field is growing so rapidly that patients are demanding the latest procedures and products

## Aesthetic Medicine: Scope of Practice

The unique dual status of the skin as both a vital functioning organ and a means of physical and tactile communication is reflected in the practice of aesthetic medicine, a rapidly growing field in which the aesthetic and the medical intersect. Currently the American Board of Medical Specialties does not recognize aesthetic medicine and there are no board certification procedures for the field.

The International Association for Physicians in Aesthetic Medicine (IAPAM), a trade organization for physicians providing medical spa services, defines the field as, "A branch of medicine focused on satisfying the aesthetic desires and goals of patients. This specialty is primarily focused on the pathophysiology of aging skin, and adheres to scientific based procedures. Physicians practicing aesthetic medicine are trained in both invasive and non-invasive treatment modalities, and typically utilize a combination to meet the needs of the patient."

Typical anti-aging treatments include injectable soft tissue fillers, botulinum toxin treatments, laser surgery, vein therapy, and skin-product applications.

—MB

that are heavily advertised.

- There is a considerable change from a traditional medical practice to an aesthetic medicine practice in which patients are customers or clients and have different expectations toward staff, the physical design of the office, and the practice's level of customer service and attention to detail.
- Legal issues abound, especially regarding spa ownership and supervision of new staff such as medical aestheticians.

### An Internist's View

Many states are facing a severe shortage of primary care physicians, especially in areas where the population is growing rapidly and aging, a situation familiar to Lisa Taylor, MD, medical director of the Community Health Center of Cape Cod, in Mashpee, Mass. A board-certified internist, Taylor is concerned about PCPs leaving primary care to join or start medical spas.

Each week, Taylor trashes the mail she gets from aesthetic medicine vendors and medical spa franchisors offer-

ing supplies, equipment, and training.

Several of her colleagues from residency have switched to aesthetic medicine because of "low reimbursement for cognitive services, the need to pay back large medical student loans, and general dissatisfaction with the practice of medicine," she explains. Although she is committed to primary care, its disadvantages are troubling.

"It's not as rewarding to be a PCP as it was when I started out," Taylor comments. "As reimbursement drops compared to costs, I have less time to take care of people with chronic diseases, negotiating the health care system is often difficult for my patients, affordability erodes many of my patients' compliance with therapy, and I'm faced with a growing population of patients who are depressed and addicted to pain medications."

Although sometimes frustrated, Taylor is committed to primary care and still finds rewards in problem solving and caring for sick patients.

—Michael Bihari, MD, is a writer and editor in Falmouth, Mass. More information on physician practice strategies is available on our Web site (see page 16).

# Two Views on EHRs for Physicians

By Richard L. Reece, MD, editor-in-chief

**M**any physicians have found that electronic health record (EHR) systems have improved the quality of care they deliver to patients while also helping to cut costs. But other physicians find that EMRs slow them down and require that they enter patient information during the exam.

Almost all physicians have opinions on both sides of this topic. For this article, we asked Douglas E. Henley, MD, executive vice president and CEO of the American Academy of Family Physicians (at [www.aafp.org](http://www.aafp.org)), to discuss the advantages of EHRs. Previously, Henley worked as a family physician in North Carolina and encourages the 93,000 AAFP members to adopt EHRs. Next, we asked Walker Ray, MD, vice-president of the Physicians' Foundation for Health Systems Excellence, in Boston (at [www.physiciansfoundations.org](http://www.physiciansfoundations.org)), to discuss the challenges to more widespread adoption of EHRs. Ray has practiced pediatrics in Atlanta for 38 years and is a former president of the Medical Association of Georgia.

## AAFP's Efforts

Two years ago, Henley was seeking to encourage at least 50% of the members of AAFP to install electronic records in their practices. The group is well on its way to reaching that goal.

"I'm happy to say our members have about twice the adoption rate of the rest of the physician community," Henley reports. "Our most recent EHR survey, done six months ago, showed 37% of our members had adopted and implemented EHRs, 13% had written the checks to begin to adopt a system, and 25% indicated they would implement EHRs within 12 to 18 months.

"This effort has been a strategic

focus of AAFP since the late 1990s," Henley continues. "Five or six years ago, we created the Center for Health Information Technology and hired excellent people with the right skills to give our members the ability to move to EHRs. Our staff made several live presentations and prepared printed materials. Their efforts have persuaded members to adopt EHRs to improve quality and cost efficiency."

## Advice from Peers

The full-time staff includes family physicians with strong IT backgrounds who are experts in educating other physicians and discussing the ins and outs of EHRs. They communicate electronically, person to person, and at meetings around the country with our members and our chapters.

"In addition, the AAFP journal, *Family Practice Management*, has included many articles on EHR use and implementation as well. Also, we identified members who installed EHRs and have seen benefits following the initial challenges of adoption and implementation," he adds. "There is nothing like family physicians who have gone through it to speak to their peers about EHR implementation. We have found that a strong strategic focus is important in moving a population of family physicians to adoption. But it's also vital for doctors to understand the value of the technology.

"Implementing EHR systems is a challenge in part because most of our members practice in small or medium-sized groups of two to five doctors," he explains. "Roughly 18% of our members are in solo practice. In larger groups, physicians have the resources to help them implement EHRs, but smaller groups find it a challenge to do the initial selection of a vendor and meet the start-up costs. Usually, those are their two largest concerns.

## Readiness Assessment

"To assist our members, we have a Web site at our Center for Health Information Technology to help practices evaluate what we call their readiness assessment," Henley says. "This assessment determines if practice workflow is ready for implementation and it can identify potential vendor options appropriate for the work environment and practice size. Through this assessment, a practice can learn how to select the right software and EHR vendor. We also have a customer feedback mechanism members use to comment on various EHR vendors. All of this information helps physicians choose vendors and select, adopt, and implement an EHR.

"For all physicians, cost is vitally important," he continues. "Next is making sure there is not a single champion in the practice, but rather getting all of those who work in the

**"After the initial investment and the required ongoing maintenance costs, we know from articles in the literature that physicians often recoup the initial investment in three to six years. That ROI occurs through enhanced documentation and improved coding and efficiency."**

**—Douglas E. Henley, MD, AAFP**

practice committed to implementing and understanding that during the installation, there will be downsides to workflow and productivity, but eventually the EHR will help the practice provide better patient care.

"Through peer-to-peer networking, we provide information on the return of investment (ROI) physicians can expect from using EHRs," Henley explains. "After the initial investment and the required ongoing maintenance costs, we know from articles in the literature that physicians often recoup the initial investment in three to six years. That ROI occurs through enhanced documentation, improved coding, and improved efficiency.

"From our latest survey, we learned that clinicians are not using the software to maximum capability to improve quality," he adds. "That's understandable because it was hard enough to go through the adoption phase. Now we're educating physicians to turn on all the switches to manage their systems more efficiently and improve care, particularly for populations of patients.

### **Steadfast Resistors**

"From where we were two years ago, we have made remarkable progress," Henley continues. "In the same recent survey, 25% of our members said they would never adopt an EHR. So, while we have some physicians who see the value of EHRs for their practices, we also have some steadfast resistors. Thus, we don't expect EHRs to be in universal use in the immediate future.

"One other point worth making about EHRs involves certified systems," he concludes. "Initially I was a member of the Certification Commission for Health Information Technology (CCHIT) and later moved to the American Health Information Community. As a result of my experience with these organizations, I believe it's important for physicians to use certified EHR systems. Certification will ensure that

## Do Patients Expect Physicians to Use EHRs?

Just in the past two or three years, consumers have become more interested in using personal health records (PHRs), says Douglas E. Henley, MD, CEO of the American Academy of Family Physicians, in Leawood, Kan. When the use of PHRs rises, it is likely that patients will be interested in linking them with electronic health record systems, he adds.

"PHRs clearly need to be interoperable with EHRs, and there are certification efforts underway to achieve that goal," Henley explains. "Sooner or later, and probably sooner, patients will demand to have personal health information in an electronic format that they can transport from doctor to doctor, from doctor to hospital, and back again, and to various other health care entities in any part of the country.

"Patients will no longer be satisfied with filling out the old clipboard information over and over again when they enter a physician's office," he says. "The day is coming when the patient will walk into the office and say, 'Here's my personal health record. Please import this information into your records and also update your information into my personal health record.' For those physicians who don't have an EHR, fulfilling that patient request will be difficult. The EHR is not necessarily a prerequisite for entering data into a PHR, but it would certainly make it much easier and efficient.

"We're moving into an era that will support the wider use of health information technology," he adds. "HIT includes not only EHRs, but PHRs, regional health information organizations (RHIOs), pay for performance, disease registries, physician Web sites, and e-mail communication between physicians and patients. But also HIT means fostering the ability to have EHRs communicate with systems in other practices, hospitals, laboratories, pharmacies, radiology centers, and surgicenters. In addition, HIT will make it easier for physicians to comply with evidence-based and clinical protocols and to enter codes and submit claims electronically.

"The health care enterprise is moving in a direction in which someday in the not too distant future, it will be necessary to have an EHR to remain in practice and communicate electronically," Henley predicts. "While one can practice very good care in a paper-based environment, the untapped future potential for primary care is to have robust clinical decision support software tied to the EHR. The EHR and clinical decision support software must be adaptable to the workflow, available at the point of care, and capable of providing the best knowledge and evidence when and where that care is delivered.

"The EHR not only will help to improve care, but it will help reduce duplicate testing, adverse drug interactions, and unanticipated allergies," he concludes. "The future for family medicine and primary care will include an electronic environment which can foster better and safer care than a paper-based environment can."

—RLR

what they are hearing from the vendor is just not vendor-speak but that it reflects the true functionalities of the EHR system. CCHIT uses a rigorous process to ensure that the systems it certifies can accomplish the tasks that physicians seek in these systems."

### **A Cautionary View**

Not all physicians share Henley's enthusiasm for EHRs. Ray, for example, says, "I have a cautionary view toward EHRs. I do not, however, have a negative view of the potential value

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of health information technology (HIT). In fact, the Physicians' Foundation for Health Systems Excellence, which is a nonprofit charitable foundation formed as the result of litigation against managed care organizations by 19 state and local medical associations, is dedicated to helping physicians adopt HIT, develop chronic care models in their practices, and improve patient safety and practice efficiency. Toward those goals we awarded grants to 26 health care related organizations in 2005 totaling \$16 million. In 2006, we awarded \$5.6 million to 14 other such grantees.

"There's no doubt that HIT will come, and it will improve care," Ray says. "Here's why. Our foundation estimates that health care costs, which are currently at \$2.2 trillion annually in the United States and 17% of the gross domestic product, will double by 2015. Such an increase is unsustainable and will require information technologies to reduce costs.

"And, an aging population will have greater health care needs than we have currently," Ray adds. "It's estimated that 75% of our health care spending today is for patients with chronic diseases. Coordinating care for patients with chronic disease will require HIT use. We know from the Institute of Medicine, for example, that only 55% of insured patients are receiving all the care that is recommended for them. There are many reasons for this deficiency in care delivery, but one of the most important is lack of information for physicians at the point of care.

"It's no secret that doctors are stressed and hassled," Ray explains. "Working harder to be more productive is no longer an option. Greater

efficiency and effectiveness will require HIT. So, if EHRs help ease their concerns, why have physicians been slow to adopt them in clinical practices? EHR adoption is costly, time consuming, and challenging. EHR systems cost about \$40,000 per doctor in addition to the annual cost of maintenance, which can be about \$10,000 a year for each doctor in a practice.

### Assessing ROI

"Primary care practices have suffered payment declines for years now," he continues. "Costs of this magnitude threaten their survival. Already primary care practices are disappearing, and primary care residencies are not being filled adequately.

"In addition, return on investment for EHRs is low," Ray estimates. "It's only about 10% per year. And, much of the ROI accrues to others, mostly to payers, either public or private.

"But even if we take the economics out of the equation, EHR implementation would still be difficult," he adds. "A study by Charles Kilo, MD, who leads GreenField Health, a primary care group in Portland, Oregon, and Mark Leavitt, MD, who chairs the CCHIT, estimate that only 15% of practices with EHRs succeed in improving care and having a satisfactory ROI the first year. About 65% have mediocre results, 15% fail and are degenerating, and 5% fail utterly.

"There are many reasons that practices fail to be successful with implementing EHRs," Ray explains. "For one, there is often incompatibility among systems. A physician's EHR may not be able to communicate with the system the hospital uses, for example. Or it may not have a link to the free-standing surgical

clinic, local laboratories, radiology centers, or pharmacies.

### Vendor Continuity

"For another, there are high risks in choosing systems from certain vendors if those vendors are not going to be in business in three years," he explains. "All of these problems show that the complexities of installing, maintaining, and using EHRs are formidable. But even once a physician practice installs a new system, the EHR may slow down productivity for up to six months, which may be a critical make or break period for marginal practices.

"In addition, there are privacy and confidentiality issues, which have not been adequately addressed either from the physicians' or patients' points of view," he says. "Physician practices may have adequate ways to keep paper records secure, but securing electronic data adds another level of complexity to the problem.

"We know from experience that EHR vendors often lack interest in small practices," Ray adds. "That's understandable in that larger practices have more resources for EHR systems. But we could argue that smaller practices are the ones that need more help in terms of increasing efficiency. For example, when a small practice adopts an EHR, it is likely to face significant data entry problems involved with moving its historical data from paper records to electronic charts. This effort could create a significant burden on the office staff, requiring that they invest additional time, money, and energy to resolve these problems.

### Improving Work Flow

"And, finally, there needs to be a culture change, a behavioral change in

**"EHR adoption is costly, time consuming, and challenging. EHR systems cost about \$40,000 per doctor in addition to the annual cost of maintenance, which can be about \$10,000 a year for each doctor."**

**—Walker Ray, MD, Physicians' Foundation for Health Systems Excellence**

the medical profession,” he explains. “Such a change would entail a redesign of work flow so that the EHR can do what it is supposed to do. Some people insinuate that you can simply plug in an EHR and all will be fine. That’s not the case at all. You have to redesign work flow even before you get the EHR. Otherwise you will simply have an electronic version of the paper chart and that will limit data gathering and decision support.

“I’m talking about how a medical practice does its business and sees its patients,” he adds. “To suddenly change established practice patterns isn’t easy. It isn’t the same as a technical fix, like getting your car repaired at the local garage. In other words, fixing a practice culture does not lend itself to a specific external intervention. Fixing a practice, however, requires changing minds, behaviors, and even hearts. Behavioral changes can’t be managed. They must be confronted and dealt with honestly. Physicians and staff must be willing to work in a whole new way than they have worked in the past and they need to be comfortable working with new systems than they have in the past.

“Also, behavioral changes must occur among patients too,” Ray adds. “If patients are not willing to work with practices that are going through a transition from paper to electronic charts, then the practice will have a difficult time delivering care.

### **Closing the Technology Gap**

“Given all of these barriers, it’s clear that a gap exists between our aspirations for EHRs and the outcomes that we can accomplish with them,” he explains. “What we hope to do with them will take a while. So how do we accomplish this goal of more widespread use of EHRs in physician practice? We know it doesn’t work to place blame on physicians as being either perverse mavericks or stubborn technophobes.

“The solution will require statesmanship and leadership, not just with-

## Will EHRs Reduce Health Costs?

Some experts have predicted that when more physicians use electronic health records, the cost of health care will decline because EHRs will increase efficiency dramatically. “There’s the premise that health information technology will enhance quality and outcomes and costs will come down. That’s the premise,” explains Walker Ray, MD, of the Physicians’ Foundation for Health Systems Excellence, in Boston.

“But there were two important studies recently, one in the *Annals of Family Medicine* in May 2007 (Jesse Crosson, et al, “Electronic Medical Records and Diabetic Quality of Life: Results in a Sample of Family Medicine Practices”) and one in the *Archives of Internal Medicine* in July 2007 (Jeffrey Linder, et al, “No Quality Benefits Seen with Electronic Medical Records”) that cast doubt on that assumption. Neither study showed a positive relationship between the use of electronic medical records (EMRs) and care outcomes. One looked at 55,000 patient records from 2,500 ambulatory practices in 2003 and 2004. The researchers concluded that there was no positive correlation between EMR use and quality of care.

“My point is this: We have significant questions about effectiveness of EMR adoption,” Walker says. “There may be a significant payoff down the road, but it will not occur quickly, and we don’t have all the answers to clearing the path for smooth adoption. Better outcomes will not occur unless patients take their doctors’ advice, which may require a change in lifestyle, a better diet, smoking cessation, more exercise, or filling the prescription and following its instructions. All of these patient actions have no bearing on whether a physician has an EHR or not.

“We’ve all seen the pie chart of health determinants,” he concludes. “Medical care is 10%, the environment is 20%, our DNA is 20%, and lifestyle is 50%. So that brings us back to patient adaptive behavior, which ultimately determines most health outcomes.”

—RLR

in the physician community but by a collaboration of doctors, public and private payers, purchasers, vendors, and consumers. Frankly, developing such a collaboration could be difficult considering the animosity that exists between physicians and public and private insurers. Certainly engaging physicians in health information technology will take time and a number of success stories from physicians who have experience using these systems.

“The financial incentives will come from public and private insurers and possibly from employers. But even if you take finances out of this, it will still not be easy to engage medical practices.

“A Massachusetts Blues study reported in March (“Insurers Find EMRs Won’t Pay Off for its Doctors,”

*American Medical News*) showed that EMRs return only 11 cents on the dollar,” he adds. “Consequently, the plan no longer uses EHRs as a criteria for awarding bonuses for quality. This and other similar studies show that we need to be cautious before we accept EHRs as the Holy Grail for improving care. That said, we’ve still got to move forward. HIT is going to happen, just as happened with personal computers. Over time, they will become a necessity in everyday practice. My strongest cautionary point is this: If we don’t get it right for doctors the first time, they will be even more reluctant to adopt EMRs than they are now, and the whole process could lose momentum,” Ray concludes.

—More information on physician practice strategies is available on our Web site (see page 16).

# The One Contract Every Practice Needs

By David B. Mandell, JD, MBA, and Jason M. O'Dell, CWM

As owners of a professional practice, doctors can spend 10 to 12 hours each day building their practices to the point where it provides a measure of security for their families. But those who ignore one fundamental legal contract jeopardize all of their hard work.

This important legal contract is the buy-sell agreement. It is one that all owners sign and explains their concurrence about how the practice will be valued if a partner dies or becomes disabled. Without a buy-sell agreement, partners and remaining families have no document about how a practice will deal with the death or disability of a physician-owner.

In too many cases, the absence of a buy-sell agreement at the time of death or disability can cause bankruptcies of the families or all of the partners.

Consider some of the questions that doctors should ask themselves:

- What would happen to my family if

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## The buy-sell agreement may perform the role of a succession plan by providing for continuity of practice management.

I died or was permanently disabled?

- Is it true that all my family will get is my outstanding accounts receivable?
- What happens if a partner dies or becomes permanently disabled?
- Do I want the surviving family members as new partners?
- If not, how do I buy them out?
- What happens to my share of the practice if I decide I want to leave the practice or retire?

There are various types of buy-sell agreements and some basic facts regarding all buy-sell agreements that apply to any type of business. Both S and C corporations, partnerships, limited partnerships, limited liability companies, and others can use buy-sell agreements. For these discussions, the words "business owner" can mean any type of business owner, including shareholders in a corporation, partners in a partnership, or members of an LLC.

From the standpoint of a healthy practice owner, the buy-sell agreement can provide the individual partner with an opportunity to negotiate and obtain the fairest or best price for his or her share of the practice. In the case of retirement or disability, the agreement can be an additional source of funds for each owner.

### Benefits for Practices

For both the practice and its remaining owners, buy-sell agreements can provide continuation and control and liquidity to buy out surviving family members. They also can keep out unwanted owners.

**Continuation and control.** For the practice and its remaining partners, a properly planned buy-sell agreement will provide for the orderly continuation of the ownership and control of the practice. This continuation should survive the death, disability, divorce, or bankruptcy of any owner and should provide for a seamless transition in the event any owner wants to retire and sell his or her ownership share.

**Liquidity.** The buy-sell agreement is often used in conjunction with life and disability insurance policies to provide liquidity for the practice to purchase the outstanding ownership interests of the disabled or deceased partner.

**Keeping out unwanted owners.** The buy-sell agreement also can prevent unwanted outsiders from becoming owners and can eliminate the need for negotiation with remaining spouses and children. The agreement may also perform the role of a succession plan by providing for continuity or orderly succession of practice management. This aspect of the agreement may not apply to professional practices, but it would apply if the partners own a surgery center and other medically related businesses that non-doctors can own.

### Family Member Benefits

The buy-sell agreement benefits the family members of disabled or deceased partners in two significant ways. First, it provides liquidity to surviving family members and second, it eliminates practice risks for surviving family members.

**Liquidity.** For a deceased or disabled owner's family, the existence of a properly funded buy-sell agreement can ensure that the family will have a liquid asset rather than an illiquid minority interest in a privately held practice that would be extremely difficult, if not practically impossible, to sell. This factor can be important as the remaining family may be burdened with estate tax payments or additional expenses to care for a disabled family member. The agreement itself may provide a valuation of the practice interest which can be used for estate tax filing purposes.

**Eliminating practice risks.** If one owner becomes disabled or dies, the buy-sell contract guarantees that the disabled owner's family does not have to become involved in the practice to protect the total family's interest.

### **Funding the Agreement**

Given that the buy-sell agreement assumes a buy-sell transaction at the time of an owner's death or disability, insurance policies are generally recommended to fund the transaction. There are many reasons for insurance policies being used for this purpose. For one, insurance policies pay a pre-determined amount with proceeds that are available when needed. Second, the proceeds will be available regardless of the financial state of the practice as long as premiums have been paid. Third, the practice leverages the cost of insurance premiums to create the proceeds. Therefore, it costs the practice less to buy insurance than it would cost to save money in a special buy-out side fund. And, fourth, the economic

risks of early death or premature disability of any owner are shifted from the medical practice to the insurer. One other aspect that makes insurance policies attractive for family members is that proceeds are paid to the owner or owner's family income-tax free.

### **Disability Needs**

Buy-sell agreements receive a lot of attention when used to address a practice's needs upon the death of a business owner. But they are equally important if a physician owner becomes permanently disabled.

Business owners may need two-way protection in the event of disability. First, they must consider providing for adequate income to meet routine personal expenses, including increased medical expenses, through a disability income program. Then, they must protect the value of their ownership interests, which can most easily be accomplished by expanding a buy-sell agreement to cover the risk of total disability. An owner's disability may jeopardize the continued existence of the business. Similar to a death or retirement that has not been adequately provided for, the loss of an owner of a business because of total disability could impair the practice's credit standing, which could cause a forced sale at a distressed price. It could also necessitate a sale to parties not compatible with the interests or philosophies of management.

In addition, a disability could cause economic hardships to the business if a totally and permanently disabled owner continues as an employee or retains a decision-making position.

### **Coordination Required**

Creating a buy-sell agreement that fits a practice's circumstances requires expertise in insurance; practice valuation; and in corporate, practice, and tax law. Drafting such an agreement also requires experience in dealing with different owners and being able to draft an agreement that meets all parties' needs. Too often practice owners make one of two key mistakes in deciding who should oversee the creation of a buy-sell arrangement.

These include choosing a friend who is a lawyer, instead of an expert with experience in this area, to create the strategy and draft the document. A second mistake is failing to work with a coordinated team to implement the plan. The team members will prepare and administer the buy-sell agreement and will include an attorney who has experience creating these types of arrangements; a life and disability insurance professional who has worked on these issues many times; and a practice appraisal firm, whose expertise may be needed continually in the future for annual practice valuations.

As with any legal or insurance planning, the economic benefits of developing a buy-sell agreement are obvious for the practice and each owner's family. But there are political benefits as well. If the planning is done before any owner is close to a disability, divorce, retirement, or death, all owners are in the same position relative to each other, a factor that facilitates the negotiations.

—More information on *physician practice strategies* is available on our Web site (see page 16).

**Business owners may need two-way protection in the event of disability. First, they must consider providing for adequate income to meet routine personal expenses. Second, they must protect the value of their ownership interests by covering the risk of total disability.**

# Why Physicians Should Learn to Code

By Terry A. Fletcher, BS, CPC

One question coding and billing professionals ask when attending coding seminars is, “Where are the physicians?” Coders, billers, and administrators attend these specialty coding workshops but few physicians do so, even though more physicians are coding than ever before.

Without a coding education, physicians who assign codes and submit them without verification from certified professional coders may expose their practices to audits and charges of fraud and abuse. In addition, physicians who know little about coding risk denials from payers. Whether using professional coders or performing the coding themselves, physicians are liable when medical coding does not accurately reflect the services rendered.

## Serious Consequences

Consider this excerpt from the federal Office of Inspector General Compliance Program for Individual and Small Group Physician Practices, published in *The Federal Register*, Volume 65, No. 194, Oct. 5, 2000, page 59,442: “The OIG understands that most physician practices do not employ a professional coder and that the physician is often primarily responsible for all coding and billing. However, it is in the practice’s best interest to ensure that individuals who are directly involved with billing, coding, or other aspects

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**Many physicians code any endoscopic diagnostic procedure they perform in addition to the major endoscopic procedure. But the CPT book has instructions for using endoscopic codes that contradict this practice.**

of the federal health care programs receive extensive education specific to that individual’s responsibilities.”

Since coding is such a complex endeavor, physician coding errors are commonly found in audits. Coding for orthopedics can be particularly problematic. Many physicians code any arthroscopic diagnostic procedure they perform in addition to the major arthroscopic procedure. They believe that since they performed both procedures, they should be able to code and be reimbursed for both. But the CPT book has instructions for using arthroscopic codes that contradict this practice. *CPT 2008, Professional Edition*, says: “Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy. When an arthroscopy is performed in conjunction with arthrotomy, add modifier -51.”

Many orthopedic surgeons want to use modifier -59 to indicate a distinct, separate service when coding open procedures with arthroscopic procedures, and again, per CPT, using modifier -59 is inappropriate. Most payer editing systems will bundle these noncompliant billings, and pay only for the one procedure. If the payer mistakenly pays for both, it could ask the provider to refund the overpayment in the future.

## The Folly of Cheat Sheets

In an attempt to make coding easier for physicians, many practices allow

physicians to code from a pick-list or cheat sheet rather than meticulously follow guidelines and read code definitions. According to one software pick-list, selective renal angiography, for example, is reported with 75724. Typically a physician will first perform a flush aortogram to assess the renal arteries before engaging them selectively. A flush is also known as an abdominal aortogram, and the pick-list says this service is reported with code 75625. However, the full description for 75724 is Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation. So the coder should know that one would not code these two codes together. The flush aortogram is bundled or included in the bilateral selective renal angiography. It is nonetheless common to see coders who incorrectly code these services together, hoping to get paid. Occasionally, they do get paid and later have to send a refund.

Another example of miscoding involves placing a stent in a coronary artery. This procedure usually includes a balloon angioplasty performed on the same vessel. Physicians unfamiliar with coding guidelines do not understand the full meaning of code 92980 Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel. In stating “with or without other therapeutic intervention,” the description is indicating that PTCA (angioplasty)

on the same vessel is included in the code. It is understandable that the physician wants to get reimbursed for all services performed, but these inclusive codes are valued to include everything in the code description.

### **Loss of Revenue**

Coding for evaluation and management (E/M) may seem easy to a physician, but the actual rules show there is more to E/M coding than simply choosing a level of service. Physicians who work for multiphysician groups often overlook the basic wording in guidelines. Take, for example, codes 99233-99231 reporting subsequent hospital visits. In multiphysician groups, patients may receive care from many physicians on a single day, and sometimes, each physician submits a claim for service. However, the first two words following the subsequent hospital care description are “per day.” Multiple visits from the same clinic (meaning the same tax identification number) qualify as a single visit if all are treating the same patient with the same condition.

The nuances of codes and their guidelines not only lead to situations in which physicians over code, but also to a loss of revenue when additional charges remain uncaptured.

When a gastroenterologist, for example, performs an ERCP, code 43268 represents an insertion of a tube or stent into the bile or pancreatic duct. This code description represents one duct, yet some physicians do not use 43268x2 when a tube or stent is placed into both the bile duct and pancreatic duct. Missing that lack of plural can lead to missed revenue.

A common mistake in cardiology

occurs when a physician fails to read the entire pretext of a section before coding for services. An example of this type of error happens when the cardiologist changes a patient’s pulse generator (battery) in a pacemaker. Replacing a pulse generator should be reported with two codes: One for removing a pulse generator (33233) and one for inserting a pulse generator (33212 or 33213).

This error is commonly found during electrophysiology audits, and can cost the practice several hundred dollars per error in lost charges. Physicians reported thinking that they would be committing fraud to code for both, despite CPT 2008 instructions on pacemaker coding: “When the ‘battery’ of a pacemaker or pacing cardioverter-defibrillator is changed, it is actually the pulse generator that is changed. Replacement of a pulse generator should be reported with a code for removal of the pulse generator and another code for insertion of a pulse generator.”

### **ICD-9-CM Errors**

Coding errors are common when using CPT codes, and inappropriate use of ICD-9-CM codes can create problems as well. Guidelines prohibit the use of rule-out diagnoses from being reported when the diagnosis is unfounded, for example. To use a rule-out diagnosis can create future unwarranted insurance problems for the patient, especially if the rule-out is for a disorder with high utilization costs such as cancer, hepatitis, or diabetes.

Some seemingly simple code decisions are anything but. Many payers’ medical necessity edits for drugs darbepoetin alpha and epoetin alpha, for example, can result in denials if the

drugs are linked to ICD-9-CM codes for anemia in neoplastic disease (285.22), but are paid when linked to codes for chemotherapy-induced anemia (284.4 with E933.1). This small nuance of etiology can make a difference in whether the claim is paid or denied.

### **Coding Sequences**

Even something as simple as the sequencing of codes can affect payment. For surgical procedures, the first code is paid at 100% and subsequent procedures are paid at 50% of the relative value. This progression makes it imperative that the coder knows the values of all codes so that he or she can list the highest paying code first. For ICD-9-CM, erroneous sequencing will result in claims denial. While the office can resubmit the claim, time and money is wasted in the added effort.

There is more at stake with correct coding than reimbursement. The OIG now seeks punitive damages when officials believe coding errors are committed with indifference. Sloppy coding can jeopardize a physician’s ability to continue to practice medicine. For this reason, many physicians who do their own coding have a certified professional coder validate their work before filing the claim. In this way, a coding expert involved in continuing education is overseeing the process.

Physicians who want to tackle coding should first educate themselves not only on the rules of the coding systems, but the rules of Medicare and other payers, and be familiar with what their specialty societies have said about coding issues. Clearly, the OIG is directly addressing physicians who code when it recommends that individuals directly involved with billing, coding or other aspects of the federal health care programs receive extensive education specific to that individual’s responsibilities.

—More information on physician practice strategies is available on our Web site (see page 16).

**There is more at stake with correct coding than reimbursement. The OIG now seeks punitive damages when coding errors are committed with indifference.**

# OIG Begins HIPAA Compliance Audits

By John W. McDaniel

The federal Department of Health and Human Services (HHS) Office of Inspector General (OIG) has initiated patient-information security compliance audits of health care organizations. Compliance revolves around a broad set of security requirements that took effect in 2005 under the federal Health Insurance Portability and Accountability Act (HIPAA). Although hospitals have been the early targets of these audits, medical practices could be next.

In light of a possible OIG audit, and given the potentially disastrous financial consequences of a major security breach, practices should review their internal policies and procedures regarding security compliance. Protecting the security of patients' clinical, administrative, and financial data also protects the group's ability to see patients and conduct business. To do so, practices must limit the availability of these data only to those in the practice who need to see the information.

## Protecting Patient Records

The foundation of any security initiative is the risk assessment and analysis. A risk assessment is a required element of sound security procedures. It allows a medical practice to identify potential threats and vulnerabilities. CMS has included a matrix at the back of the HIPAA security regulation ([www.cms.hhs.gov/SecurityStandard/02\\_Regulations.asp](http://www.cms.hhs.gov/SecurityStandard/02_Regulations.asp)) that lists the

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## More Information on Compliance

For practices seeking additional information on the Health Insurance Portability and Accountability Act (HIPAA), the federal Centers for Medicare & Medicaid Services (CMS) offers documents practices can download on its Web site ([www.cms.hhs.gov](http://www.cms.hhs.gov)).

The following documents (in pdf format) are available from CMS on HIPAA compliance steps for physicians

- Security 101 for Covered Entities
- Security Standards Administrative Safeguards
- Security Standards Physical Safeguards
- Security Standards Technical Safeguards
- Security Standards Organizational Policies
- Basics of Risk Analysis and Risk Management
- Security Standards Implementation for the Small Provider
- Security Final Rule
- HIPAA Security Guidance for Remote Use of and Access to Electronic Protected Health Information.

Source: [www.cms.hhs.gov/EducationMaterials/04\\_SecurityMaterials.asp](http://www.cms.hhs.gov/EducationMaterials/04_SecurityMaterials.asp)

Practices seeking guidance to reinforce some of the ways they can protect e-PHI when it is accessed or used outside of the practice can download a document, *Security Guidance for Remote Use*. Here's the link: [www.cms.hhs.gov/SecurityStandard?Downloads/Security-GuidanceforRemoteUseFinal122806.pdf](http://www.cms.hhs.gov/SecurityStandard?Downloads/Security-GuidanceforRemoteUseFinal122806.pdf).

—JM

requirements. It is likely that the OIG would use this same list for any audit of a hospital or physician practice.

OIG auditors are expected to concentrate on an organization's administrative, physical, and technical safeguards, which are the core requirements under the security regulation. These safeguards could include policies and procedures relating to:

- Access to electronically protected health information (e-PHI)
- Electronically transmitting e-PHI
- Preventing, detecting, containing, and correcting security violations
- Monitoring systems
- Remote access
- Wireless security
- Antivirus mechanisms
- Firewalls

- Other e-PHI security requirements.

The security regulations provide a number of implementation specifications for each provision. There are two kinds of implementation specifications: required and addressable. Required specifications mandate what a practice must do; addressable specifications allow for more flexibility and can be tailored to the requirements of each group.

Documentation is critical for each type of implementation specification. If a practice is audited, it will help the group's case if it has a written account of the practice's security risk assessment and a set of written policies and procedures. Two factors are making it imperative that practices complete and document their HIPAA security

processes: the risk of OIG security compliance audits, and the increasing use of electronic patient data.

CMS has also said in its work plan for 2008 that it will be looking closely at what it calls place of service errors and evaluation and management services during global surgery periods.

**Place of service errors.** CMS said it will review physician coding of place of service on claims for services performed in ambulatory surgery centers (ASCs) and hospital outpatient departments. Federal regulations provide for different levels of payments to physicians depending on where the services are performed. Medicare pays a physician a higher amount when a service is performed in a non-facility setting, such as a physician's office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ASC. CMS will determine whether physicians properly coded the places of service on claims for services provided in ASCs and hospital outpatient departments.

**Evaluation and management services during global surgery periods.** CMS also will review industry practices related to the number of evaluation and management (E&M) services physicians provide and get reimbursement for as part of the global surgery fee. CMS's *Medicare Claims Processing Manual*, Chapter 12, section 40, contains the criteria for the global surgery policy. Under the global surgery fee concept, physicians bill a single fee for all of their services usually associated with a surgical procedure and related E&M services provided during the global surgery period. The global surgery fee includes payment for a certain number of E&M services provided during the global surgery period. CMS said it will determine whether practices related to the number of E&M services provided during the global surgery period have changed since the global surgery fee concept was developed in 1992.

## Increases Don't Keep Pace

Physicians who have been tracking their practice's financial data for the past decade know that income from Medicare has not kept pace with medical practice costs. In fact, new data from the federal Centers for Medicare & Medicaid Services for expenditures since 1999, show that the Medicare conversion factor (which Medicare uses when setting physician payment rates) has declined 1.9% (including the projected 10.1% reduction scheduled for July) when compared with an overall increase in the consumer price index of 25.1%. Also, CMS reports that total operating costs per full-time physician rose 43.8% in the same period.

Indeed, since Medicare payment levels have fallen substantially behind the cost of providing services, medical practices have few options for action. Some practices have chosen to limit the number of new Medicare patients they see while others have stopped accepting new Medicare patients. But aside from a few selected practices that specialize in surgery or similarly focused services, few physicians are willing to opt out of Medicare altogether.

—JM

### Coding Compliance

To ensure that practices do not violate rules concerning the use of E&M codes, place of service errors, and over-coding, every practice should have a coding compliance program. These programs address auditing and monitoring, by specifically reviewing coding practices and periodically auditing medical records, to ensure coding accuracy and compliance with billing and documentation guidelines.

The best consultants will offer coding compliance programs that involve at least these four steps:

1. Analyze levels of service utilization. This service helps ensure physician's compliance with CMS' audit standards and finds areas of potential undercoding or overcoding.
2. Document chart audits. Each physician's charts should be audited in order to ensure appropriate documentation and proper coding for medical necessity.
3. Conduct educational sessions. An auditor will conduct individual education sessions with physicians to review the outcome of the assessment and establish steps the physician or group can follow to comply with CMS' requirements.
4. Allow unlimited access to reimbursement specialists. A practice

should be able to get any question answered by a specialist available by telephone, facsimile, or e-mail consultation.

Physicians should expect at least the following four deliverables as a part of a top of the line coding compliance program:

1. An initial comprehensive report regarding levels of service utilization analysis by individual physician.
2. A comprehensive report of findings from the chart audits.
3. Educational information presented to each physician to improve coding proficiency and serve as documentation for coding compliance.
4. Quarterly progress reports of levels of service utilization analysis by individual physician.

Physician consultants perform thousands of coding reviews and still find that most physicians tend to undercode. That means that after a coding compliance program the practice may expect to see an increase in reimbursement levels. For those physicians who tend to overcode, however, the coding compliance initiative will provide evidence that the practice is making an effort to improve its coding proficiency in the event of a government audit.

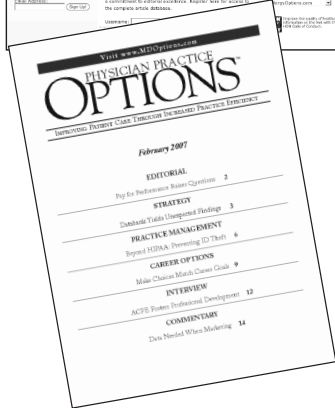
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