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Health Systems Will Focus on Chronic Care

Health care managers know that some 20% or less of patients account for 80% or more of total health care spending, according to an article by Gregg Lehman, "When It Makes Cents to Back Into the 80/20 Rule," published by HealthLeaders.com in March 2004. These percentages follow Pareto's Law. In the late 1800s, Vilfredo Pareto, an Italian economist, established that 20% of the population of Italy owned 80% of the land.

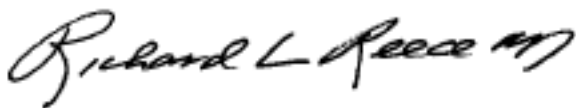
Chronic kidney disease is one of the Pareto Group of diseases, so called because patients with these conditions account for a disproportionate share of costs. Not everyone agrees that the split is 80-20. The UnitedHealth Group, the large managed care organization in Minneapolis, estimates that 7% of chronically ill patients generate 70% of all costs.

Whatever the percentages and conditions, the federal Centers for Disease Control and Prevention in Atlanta says that the medical care costs of people with chronic diseases account for more than 75% of the nation's \$1.4 trillion medical care costs. Those conditions include cardiovascular disease, diabetes, cancer, and other conditions.

Sam Ho, MD, the senior vice president and chief medical officer of PacifiCare, a health plan in Cypress, Calif., says that 5% of diseases generate 67% of PacifiCare's medical costs. PacifiCare is a division of UnitedHealthGroup. Sixteen conditions are associated with about 90% of total health care costs, Ho says. Those conditions are congestive heart failure (29%), coronary artery disease (20%), cancer (11%), end-stage renal disease (9%), chronic obstructive pulmonary disease (7%), diabetes (6%), rare diseases (4%), depression (3%), and asthma (1%).

Given these numbers, it makes sense to concentrate most of the health system's cost control efforts on the patients who generate most of the costs, say health economists. In the coming years, therefore, there will be an increase of private-public partnerships focusing on chronic care management among Medicare and Medicaid patients. Chronic diseases are, by definition, unlikely to be cured, but the costs of caring for these patients can be managed.

Management of these patients will involve monitoring blood sugar and lipid levels and decreasing complications in an effort to cut admissions to hospitals and the use of emergency rooms. Increasingly, patients will be treated at home and other settings outside of high-cost hospitals. The public-private partnerships will ensure that practitioners are using electronic health records and that health systems are using regional health information organizations to gather and store data on costs and outcomes. Doctors will be paid for performance based on their meeting specific standards of quality.



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CAP Vendor Says Company Is Committed to Safety, Service

The specialty pharmacy company chosen to manage the federal Competitive Acquisition Program (CAP) has extensive experience in prescription order fulfillment, company officials say. Before the federal Centers for Medicare & Medicaid services named BioScrip, Inc., as the sole national pharmacy vendor for the program in May, the company was not widely known.

"Even though we might not be well known among specialists who have been obtaining medications from wholesale distributors, we do have a tremendous amount of experience in providing prescription drugs across a multitude of specialty therapeutic areas," says Scott Friedman, BioScrip's vice president of pharmaceutical relations. For years, BioScrip has distributed prescription medications to physicians who have chosen to use a specialty pharmacy to order their in-office administered drugs for their non-Medicare patients, he said.

The Sole Vendor

Based in Elmsford, N.Y., BioScrip is the largest specialty pharmacy in the country not owned by a pharmacy

benefit management company, a chain pharmacy, or a wholesaler. The company (at www.bioscrip.com) will serve as the CAP national vendor for certain Part B drugs and biologicals. Physicians treating Medicare patients will be able to choose to participate in the CAP each year. The first CAP "year" runs from July 1 through Dec. 31, 2006.

As the sole national vendor for the CAP, BioScrip is the only organization that may provide drug distribution and fulfillment services to physicians who enroll in the program. Physicians who elect to participate in the CAP must obtain all drugs on the CAP drug list from BioScrip. There are exceptions related to "furnish as written" and emergencies.

The CAP is separate from the Medicare Prescription Drug Benefit (known as Part D) that went into effect on Jan. 1. The program is for Part B drugs and biologicals and only for injectable and infused drugs currently billed under Part B that are administered in a physician's office and that are "incident to" a physician's service. The CAP drugs that are relevant to nephrology practices

include a selection of anemia management drugs.

Physicians in the CAP can get more than 180 drugs and biologicals for their patients. The full list is available at (www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/CAP_Drugs_List.pdf). Physicians who have elected to participate in CAP must obtain all drugs on the CAP drug list from BioScrip. Physicians must still continue to purchase and bill Medicare under the average sale price (ASP) system for those drugs that BioScrip will not provide.

Supplier's Responsibilities

"As CMS's contracted CAP vendor, BioScrip is responsible for accepting physician orders for drugs, verifying each physician's eligibility to order under CAP, dispensing the drug orders, and shipping these orders to the physicians' offices for administration to their patients," Friedman says.

CMS has designated Noridian Administrative Services (at www.noridianmedicare.com) of Fargo, N.D., to serve as the claims administrator for the CAP. "Noridian and BioScrip will essentially have a PBM-pharmacy relationship in which Noridian serves as the PBM and BioScrip serves as the network pharmacy," Friedman says.

When a CAP-enrolled physician submits a drug order, BioScrip will verify the physician's CAP enrollment and the patient's Medicare status, Friedman says. Once these verifications are obtained, BioScrip will process the order. "We will confirm the prescription and schedule delivery to the physician's office such that we meet the physician's specified

(Continued on page 4)

BioScrip at a Glance

BioScrip, Inc., of Elmsford, N.Y., is the sole national pharmacy vendor for CMS's Competitive Acquisition Program. The company is the largest specialty pharmacy in the United States that is not owned by a pharmacy benefit management company, a chain pharmacy, or a wholesaler. Physicians can get more information from the company's Web site or can call or send questions to the company by e-mail.

Web site: www.bioscrip.com

Customer service phone: 866-366-7915

E-mail address: CAP@bioscrip.com

Noridian Administrative Services (at www.noridianmedicare.com) of Fargo, N.D., will work closely with BioScrip and serve as the program's claims administrator.

(Continued from page 3)

administration date,” he says. “We will also contact the patient to ensure their understanding of the therapy and identify their out-of-pocket responsibilities, though we will not be asking the patient for payment until after the drug administration has taken place and authorization has been provided by Noridian.”

The Qualification Process

As part of CMS’s vendor qualification process, BioScrip had to meet certain basic requirements. “Of course, competitive pricing was one component of the CAP vendor selection process,” Friedman says. “But BioScrip also had to meet specific CMS requirements. The company had to prove its financial stability as an organization and had to demonstrate that it maintains processes in place to distribute drugs to physician offices, and to submit and process drug specific claims.”

BioScrip has had 20 years of experience in providing patient-specific drugs to physician practices across the United States and is licensed as a pharmacy in all 50 states.

“Our belief that we will be able to consistently provide high levels of service to any physician who chooses to enroll in CAP is based on the fact that we are an experienced provider of pharmacy products and services,” Friedman says. “We believe CAP is a good fit for BioScrip because our business model has centered on patient-specific pharmacy fulfillment rather than wholesale pharmacy distribution. We are well positioned to offer physicians an alternative to buying and billing their medications.”

Safety and Timeliness

BioScrip is the result of a March 2005 merger between two large specialty pharmacy organizations: Chronimed Inc., founded in the mid-1980s, and MIM Corporation, founded in the early 1990s.

For physicians who have expressed

Key Facts About the CAP

Here are some facts physicians may want to know about the federal Competitive Acquisition Program (CAP). These facts come from the federal Centers for Medicare & Medicaid Services.

- The 2006 CAP physician election period began May 8 and ended on June 2. The second phase of physician election began on June 3 and ended on June 30. Physicians who return completed election forms by June 30, can begin participating in the CAP starting Aug. 1.
- The first CAP “year” will run from July 1, through Dec. 31.
- For 2007 and subsequent years, the CAP program will run from Jan. 1 through Dec. 31. A 45-day physician election period will occur in the fall.

If a physician chooses to participate in the CAP, he or she must agree to:

- Share information with the approved CAP vendor to facilitate the collection of applicable deductible and co-insurance.
- File CAP drug administration claims within 14 days of administering the drug.
- Pursue appeals for CAP claims denied because of medical necessity issues in a timely and appropriate fashion.

Physicians who agree to participate also agree to support BioScrip (the CAP vendor) on administrative appeals of drug administration claim denials, including supplying medical records and written statements. They also must:

- Accept assignment for CAP drug administration claims
- Notify the approved CAP vendor when a CAP drug is not administered
- Agree to comply with emergency drug replacement rules
- Agree to the requirements of the “furnish as written” provision
- Maintain an inventory for each CAP drug obtained.

The CAP rules state that physicians choose to participate in the program for a calendar year and cannot withdraw from the program except under the following circumstances:

- A CAP vendor terminates its participation in the program
- A physician leaves a group practice and establishes a new practice
- A physician is no longer able to obtain drugs for a beneficiary from the approved CAP vendor because of the beneficiary’s failure to pay applicable cost sharing.

concern about drug safety and the timelines of deliveries under the CAP, Friedman addressed these two issues. “Certainly, it is understandable that physicians who have until now maintained relationships with certain wholesalers, purchased their own medications and managed their own inventory, want to ensure the stability and integrity of the medications they administer,” Friedman acknowledges. “But they should be assured that BioScrip is a licensed pharmacy and as such, the company must comply with state pharmacy laws. Accordingly, for

each and every mediation we carry, we must follow the storage, handling, and stability requirements as indicated on the package labeling.

“We are absolutely aware of these requirements, and satisfying them is already part of our business process,” he continues. “We are experienced in shipping drugs in a way that protects their integrity. Therefore, while Medicare Part B is a new prescription market segment for us to service and we will have new physicians as clients, our core business processes are already in place.”

BioScrip also will continue to focus on customer service, Friedman says. "We want physicians to thoroughly examine whether CAP is right for them and what to expect if they enroll in CAP," he adds. Physicians who have questions about the CAP program or BioScrip's services can call BioScrip's CAP customer service center or send an inquiry by e-mail (see sidebar on page 3).

"Part of our mission is to ensure that physicians are educated about the CAP process," Friedman says. "For example, we are available to explain how to place an order and walk them through the completion of a drug order form. If they are unsure of our turnaround times, how far in advance they need to order, or what they can expect from us once we receive an order, they are encouraged to call us. We will communicate with physicians proactively as well. For example, every time physicians place an order, whether by fax or phone, they will hear back from us regarding the status of that order. The bottom line is that we want physicians to have confidence in the services we provide."

Benefits to Physicians

Friedman and other proponents of the CAP program say it can help alleviate the administrative and financial burden on physicians as a result of the buying and billing for medications for Medicare patients.

"Constricting Medicare drug reimbursement rates have understandably made it tougher for physician's to be profitable," Friedman says. "CAP offers physicians a solution. Physicians who elect to participate in CAP will no longer have to purchase and carry an expensive drug inventory in order to service the Medicare population."

Physicians participating in the CAP would still have to buy and bill for drugs that are not covered under the CAP and for drugs for patients

How the CAP Works

Under the competitive acquisition program (CAP), physicians should be aware that the local carrier will continue to pay drug administration claims and that all local coverage determinations (LCDs) will continue to apply to CAP drug administration and CAP drug claims.

When physicians acquire drugs, BioScrip will submit claims for the drug to the designated carrier, which is Noridian Administrative Services (NAS), CMS says. Also, BioScrip will collect the deductible and co-insurance from the beneficiary. These amounts may not be collected until BioScrip has received Medicare payment for the drug (unless BioScrip has entered into an agreement with the physician to collect the deductible and co-insurance on his or her behalf at the time the drug is administered). Also, if the beneficiary has a supplemental insurance policy, BioScrip must wait to bill the beneficiary until it receives payment from the supplementary insurer.

—DJN

who are not on Medicare.

"However, if commercial payers follow Medicare's lead in reducing reimbursement rates for drugs, many physicians may be looking to exit the buy and bill arena," Friedman says. "We can meet their medication fulfillment needs for their commercial patients who are covered by payers with whom we are a participating pharmacy."

But the CAP may not be right for everyone, Friedman adds. "Some practices may remain strong under the current Medicare reimbursement rates," he says. "Those physicians who are comfortable with how their practices are operating in this changed environment under MMA are likely to continue to buy and bill for medications. Practices that can make a marginal profit on drugs or that must buy and bill drugs for a large number of commercial patients may not see the value in CAP."

For certain practices, the CAP may be ideal, Friedman says. Physicians who do not want to carry drug inventory, those in smaller practices, or those physicians in practices that treat a large number of Medicare patients might be most interested in the CAP.

"The practices that do not have the patient volume or purchasing power

to continue to obtain discounts are likely to find CAP to be an appealing option," Friedman notes. "Other practices that do not have strong cash flow may find it difficult to finance drug inventory or to carry receivables while they await Medicare reimbursement. Still other practices may never have wanted to purchase drugs, but had no choice. CAP is a way for practices that do not want to be in the drug business to eliminate the cash concerns and administrative hassles associated with managing drug purchasing and billing."

When evaluating whether to participate in the CAP, each practice must evaluate its payer mix, drug fulfillment requirements, patient volume, and ability to function in the current reimbursement environment. "We want to provide physicians who need an alternative to buy and bill with the information they need to decide on CAP participation," Friedman says. "And for those physicians who do enroll, we intend to offer them an excellent service that will help them ensure the continued viability of their practices."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

Hospitalists Enhance Care Quality

Hospitalist care has gained widespread recognition among primary care physicians and specialists such as cardiologists, orthopedists and gastroenterologists. Now, a growing number of nephrologists also are working with hospitalists to co-manage their inpatients. Also, nephrologists are touting hospitalist care as a valued strategy for both improving quality and enhancing practice efficiency.

“Certain specialties very quickly welcomed hospitalist involvement in patient care,” says Ronald Greeno, MD. For nephrologists, the strategy holds some untapped potential.

Significant Advantages

“Nephrologists may not have adopted the hospitalist model as quickly because they are used to taking care of their patients’ general medical problems,” says Greeno. “But the advantages of hospitalist care can be significant for nephrologists.” A pulmonologist, Greeno is a founder and chief medical officer of Cogent Healthcare Inc., a professional hospitalist organization in Irvine, Calif., that provides comprehensive hospitalist programs to hospitals nationwide. Since 1993, Greeno has served as a practicing hospitalist at Good Samaritan Hospital in Los Angeles, where he also serves as co-medical director of the ICU and respiratory medicine.

Edward T. Casey, a hospitalist and

an instructor of medicine in the Department of Hospital Medicine at the Mayo Clinic in Rochester, Minn., says hospitalists have a unique perspective on the care of hospitalized patients. “Because they focus on inpatient care, they are very knowledgeable about hospital processes and know how to get things accomplished quickly and efficiently. They also ensure that a patient’s needs are met at discharge,” he says. Board certified in both internal medicine and nephrology, Casey spends 70% of his time serving as a hospitalist and 30% of his time treating nephrology inpatients.

Kim Le, MD, a nephrologist with Premier Nephrology in Los Angeles, says hospitalists manage patients’ overall medical problems and address all issues. The three nephrologists in Premier Nephrology have worked with the hospitalists at Good Samaritan Hospital for six years. “Hospitalists help ensure the continuity, coordination, and timeliness of care,” Le says. “The hospitalist is already there in the hospital and is always available and responsive, whatever the patient needs.”

Hospitalist care may be particularly attractive to nephrologists because their patients tend to have multiple medical problems. “Hospitalists are used to treating patients with all common comorbidities in a nephrology patient population such as coronary artery disease, obstructive pul-

monary disease, and diabetes,” Casey comments.

Managing Comorbidities

Greeno agrees that comorbidities make it important to delegate care to others. “For example, most ESRD patients have multiple comorbidities, possibly including diabetes, peripheral vascular disease, coronary disease, hypertension, or lupus,” he notes. “The opportunity to delegate the management of these complex medical problems to a hospitalist during a patient’s hospital stay makes the hospitalist model particularly attractive to nephrologists.”

No specific training programs for hospitalists currently exist. Rather, most hospitalists have been trained as internal medicine physicians.

“This training enables hospitalists to provide care to a wide variety of patients, beyond those with internal medicine diagnoses,” says Greeno, explaining that hospitalists co-manage patients with surgeons and other specialists. Hospitalists provide general medical care to patients and prevent complications while those patients are hospitalized.

“In the presence of a hospitalist program that can deliver high quality care and a high level of service to patients, there are significant advantages for specialists and sub-specialists to having a hospitalist oversee their cases in the hospital,” Greeno says.

“Hospitalist care frees up specialists to practice their specialty, because they have a primary care physician taking care of the general medical problems of their patients while they are in the hospital. The specialist does not have to be accountable for all the small, general medical decisions that must be made during a hospitalization.”

—Ronald Greeno, MD, Cogent Healthcare Inc.

Benefits for Nephrologists

Maintaining a specialty-specific focus is one such advantage. "Physicians train in a specialty in order to practice specialty medicine," asserts Greeno. "Hospitalist care frees up specialists to practice their specialty, because they have a primary care physician taking care of the general medical problems of their patients while they are in the hospital. The specialist does not have to be accountable for all the small, general medical decisions that must be made during a hospitalization."

Greeno offers as an example a diabetic patient who has experienced worsening renal failure, needs to be started on dialysis, and is admitted to the hospital for placement of access. "If there is a hospitalist on staff, the nephrologist will see the patient on the day of admission and will continue to supervise daily care from a renal standpoint, while the hospitalist will manage all of the other care needs of the patient," Greeno says. "In the absence of a hospitalist, the nephrologist manages all the care of the patient, including relatively minor issues and addressing more complex issues related to the patient's diabetes and other co-morbidities. For example, the nephrologist will get the call at night when the patient needs a sleeping pill or when the patient wants a pain reliever, and will have to write the sliding scale for insulin."

Improving Quality

Casey agrees, saying, "Working with a hospitalist allows nephrologists to manage only renal issues, be it the treatment of acute glomerular nephritis or, more commonly, the dialysis portion of patient care. They can focus their practice on where their level of expertise allows them to offer the greatest benefit."

Another important benefit is high quality care, says Jeff M. Sands, MD, professor of medicine at the Emory University School of Medicine and

Studies Show Link to Quality

While no studies have specifically addressed the link between hospitalist care and nephrology outcomes, many studies show that hospitalists enhance quality.

In a study of 5,300 patients published in the *Annals of Internal Medicine*, Dec. 3, 2002, researchers reported that over two years, patients of hospitalists exhibited lower in-hospital mortality rates and lower mortality rates at 30 and 60 days following discharge. A second study of 6,500 patients published in the same issue reported that hospitalist care was associated with lower short-term mortality, and that disease-specific hospitalist experience may reduce resource use and improve patient outcomes. —DJN

chief of the renal division at the Emory University Hospital in Atlanta. Sands and other nephrologists at Emory University Hospital have been working with hospitalists since Emory instituted its hospitalist program in the mid-1990s.

"We provide care to dialysis inpatients, who often develop non-renal conditions such as pneumonia, lacerations, or cellulitis," Sands says out. "Hospitalists are expert in treating such general medicine problems. And, they have a team approach in which nephrologists provide the renal care. Therefore, the patient gets the best of both worlds. Furthermore, continuity of care is facilitated when a patient is admitted to a hospitalist, because there is always a physician on-site who has direct knowledge of that patient's needs." Hospitalists also add considerable value in the ICU, Sands adds.

An additional benefit is that, by limiting their hospital involvement to renal care, community nephrologists can practice more efficiently. "Nephrologists do not receive higher reimbursement for the care of a hospitalized patient when handling the totality of care than they would if they were just seeing the patient in the role of consultant, and in most cases, they will be paid less," Greeno observes.

A consulting physician is reimbursed more for a specialist consult

than he or she would be for a history and physical (H&P) and other services provided as a primary care physician. "On the day of admission, if the hospitalist performs the H&P and the nephrologist dictates a note that indicates the nephrologist is a consultant, the nephrologist will be paid more (and spend less time) than if the nephrologist functions as the primary care physician and codes the initial dictation as an H&P," Greeno explains. "Financially, the nephrologist is better off continuing to function and bill as a specialist while the hospitalist co-manages the patient during the course of the hospitalization."

Boosting Patient Volume

Hospitalists can also help nephrologists improve their practice efficiency and see more outpatients. "Hospitalist care allows community physicians to spend less time at the hospital, freeing more time in their schedules to treat patients in the office," Greeno notes. As a hospitalist, Greeno performs H&Ps, follows patients every day, writes the post-operative orders, and provides the discharge summaries. "This is all work that the specialists do not have to perform," he says.

Casey agrees that nephrologists can increase the number of outpatients they see if hospitalists help provide care to inpatients. "Hospitalist care

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frees nephrologists to treat more patients in the outpatient arena, because they do not need to spend as much time at the hospital," he says. "Additionally, hospitalist care considerably reduces interruptions due to patient-related calls from the hospital. In my experience, most of those calls are not specialty-specific, but rather involve general medical questions that a hospitalist can easily handle."

Le finds that working with hospitalists increases efficiency. "They allow me to manage renal problems only, while they manage all other care needs for my patients while they are in the hospital," he says. "This enhances my ability to see more patients in my office because I am not needed in the hospital as much."

Increased Focus

"By using hospitalists, we no longer divert our focus away from purely renal issues to deal with the other aspects of patient care," Sands comments. In the past, Sands and his colleagues spent time on non-renal issues. Now, that time is spent caring for additional renal patients or on teaching. "Our time is more directed at the missions we are supposed to accomplish," he comments.

Since hospitalists are on-site, they can respond to a patient's needs quickly, enhancing quality and patient satisfaction. "Patients who receive hospitalist care tend to have shorter lengths of stay, and generally are more satisfied with the care they receive," Casey observes. "This is because hospitalists are on site every day, all day. So, they are available to quickly respond to problems and questions."

Sites of Care

Nephrologists are well trained in

Society Says Number of Hospitalists is Rising

The Society of Hospital Medicine (SHM), in Philadelphia, defines hospitalists as physicians whose primary professional focus is the general medical care of hospitalized patients.

"Hospitalists are not yet a defined specialty," says Ron Greeno, MD, a hospitalist who serves on the society's leadership committee. "There is no board certification, and there are few formal training programs. The role of the hospitalist is evolving over time as the number of hospitalists grows.

SHM data show that 10,000 to 12,000 hospitalists are currently practicing in the United States, making hospital medicine the fastest growing field in the history of American medicine, says Greeno. "About 50% of hospitals in this country with more than 100 beds have hospitalists who practice there," he adds.

The term "hospitalist" was coined in an article published in 1996 in the *New England Journal of Medicine*, although hospital-based specialists have long existed in Europe and Canada. The SHM was founded in 1997 to promote high quality in the practice of hospital medicine. —DJN

general medicine, and provide excellent care to critically ill patients, Greeno comments. "Therefore, they may not want to give up the care of their patients while they are in the hospital," he acknowledges. "But for nephrologists who want to focus only on nephrology care and improve their practice efficiency on both the inpatient and outpatient sides of their practice, the hospitalist model will be very attractive."

Given that nephrologists are well trained to provide a broad base of care, would nephrologists be reluctant to relinquish control of that care to hospitalists? "In my experience, most nephrologists are more than happy to have in-hospital care provided by hospitalists and solely concentrate on the nephrology portion of patient care," Casey says.

Furthermore, Casey believes that providing hospitalist care is a good

strategy for nephrology practices to consider. "Adding a hospitalist to a nephrology group could benefit the practice as a whole, because it would allow the nephrologists to see more patients in the outpatient area and perform more consultative work. It could cut down on the number of inpatient-related interruptions during the day, and may actually improve the care of their patients' comorbidities."

Several large nephrology groups have hired full-time hospitalists to care for their hospitalized patients, Casey adds. "Groups with significant patient volume generally dialyze so many patients and are in charge of so many dialysis centers that it becomes overwhelming to take care of these patients while they are in the hospital," he says. —Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

By adding a hospitalist, a nephrology group could cut the number of inpatient-related interruptions each day and improve the care of patients' comorbidities, Casey says.

Groups Boost Efficiency With EMRs

Recognizing that EMRs help increase efficiency and improve the quality of care they deliver to patients, nephrology practices are investing in electronic medical record (EMR) systems.

Southwest Kidney Institute, a 23-physician kidney disease management company with six locations in the Phoenix metropolitan area, provides high-quality kidney disease care through a model built on providing a continuum of care. To enhance its ability to improve clinical quality and the efficiency of its research efforts, Southwest Kidney Institute adopted the GE Centricity EMR (from GE Healthcare in Hillsboro, Ore.) in the spring of 2005.

"An EMR can be hugely valuable to any nephrology practice," says Jeff Weintraub, the CEO of Southwest Kidney Institute. "It allows the nephrologists to access patient records anywhere at any time, enhancing both physician efficiency and quality of care. An EMR also enables the practice to track outcomes, allowing for the formation of evidence-based protocols for care."

Monitoring Care

An EMR is particularly useful for an organization such as Southwest Kidney Institute, which provides nephrology services along the whole continuum of care. "This technology is mission-critical to us because of how we are structured," Weintraub says. "Using the EMR, we can monitor clinical trends electronically and ensure that patients receive proactive care. The EMR makes care more efficient and ensures that no patients fall through the cracks."

The organization includes a clinical nephrology practice, dialysis facilities, an interventional nephrology program, and a chronic kidney dis-

ease clinic, called Arizona Disease Education, Prevention, and Treatment (ADEPT). Through ADEPT, physicians and nurses address all the major comorbidities associated with kidney disease, including anemia, dyslipidemia, bone disease, diabetes and hypertension.

"Thanks to the EMR, we are now using non-claims-based data analysis and guideline-based protocol-driven digital prompts to enhance quality of patient care," says Vijay Kumar, MD, a nephrologist at Southwest Kidney.

No Lost Charts

Northwest Renal Clinic, a 13-physician nephrology practice with four full-time locations and five outreach clinics in Portland, Ore., adopted the GE Centricity EMR in 2000. "One factor prompting EMR adoption was our need to access information at a variety of locations. With so many locations, we found the use of paper charts to be quite unwieldy," says administrator Caryl Scharpf. "In addition, we risked losing patient charts every time they left the office."

The practice also wanted to analyze laboratory and other data in a more systematic way. "The EMR is extremely helpful, especially for CKD staging," Scharpf explains. "We analyze patient data to determine progression of disease and then attempt to delay that progression through timely intervention. We also track clinical data on a practice-wide basis so that we can pinpoint trends and develop protocols to manage the population as a whole."

Both Weintraub and Scharpf note that the EMR was sufficiently flexible to allow the practices to establish nephrology-specific functionality, including guidelines, protocols, templates, and checklists.

Furthermore, the EMR automati-

cally alerts physicians and staff when patients need to be referred externally and to other departments within the group. "All referrals are triggered by the EMR so physicians do not have to manually request scheduling," Weintraub says. "For example, a stage 3 CKD patient is automatically referred to our ADEPT program."

Also, the EMR is integrated with Southwest Kidney's practice management system. "As we continue to build functions and templates, the EMR will facilitate billing and help us ensure full charge capture and appropriate coding," Weintraub says.

This summer, the group is implementing Patient Keeper, a clinical and billing software system that uses a PDA device. The Patient Keeper will work in conjunction with the EMR. "Because it is interfaced with our EMR, the device has a real-time patient list that physicians can reference when entering services, diagnostic tests, and charges," Weintraub says. "New information can then be downloaded to the EMR. This system facilitates the sharing of patient care duties and will get charges into the system more quickly."

The group is working on additional add-ons, including appointment reminders, secure messaging, and online health information. "We are testing voice recognition software, image visualization, and patient portals," says Kumar. "We are striving to bring cutting-edge technology to real world practice."

Improving Care

Improved quality of care is the most significant benefit of the EMR, Scharpf says. "By looking at trends and comparing them to protocols including K-DOQI guidelines, we can easily pinpoint outliers," she adds. "Then we contact those

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patients and ensure they are given appropriate care.” Data analysis revealed that the practice slowed the progression from CKD stage 4 to stage 5 over the last year.

Weintraub agrees that clinical quality improvement has been substantial. “We can gather large quantities of data and perform detailed analyses,” he says. “For example, looking at our population of CKD patients, how many are getting appropriate follow up? How many are receiving anemia management? How many have hemoglobin levels of 11 or greater? By establishing physician-developed, nurse-driven protocols for care, our practice manages our patients much more efficiently and effectively, allowing physicians to focus on the more subjective areas of care and patients in need.”

Northwest Renal Clinic’s EMR also has facilitated quality reporting. “Several of our contracts are quality-based,” Scharpf observes. “For example, each month we submit data on ESRD patients’ hemoglobin levels and other parameters to an IPA. With the EMR, we simply touch a button to submit the data. There’s no need for individual chart reviews.”

Ease of research is another benefit. “We can enter the parameters for inclusion and exclusion criteria for studies and come up with a list of eligible patients,” Scharpf states.

“Manually searching records for patient data was very labor intensive and not very practical,” Weintraub notes. “With an EMR, we can easily mine our data and obtain statistics.”

The EMR facilitates computerized physician order entry and e-prescrib-

Look for These EMR Features

When purchasing an electronic medical record (EMR) system, it is best to look for one that has some of the following features, say administrators who have installed these systems.

Customization. “Nephrologists should purchase an EMR that can be customized so it has nephrology-specific functionality and can fit into the nephrologists’ work flow,” says Jeff Weintraub, CEO of Southwest Kidney Institute in Phoenix.

Caryl Scharpf, administrator of the Northwest Renal Clinic, in Portland, Ore., notes that when evaluating an EMR for purchase, nephrologists should ensure that templates can be adapted to mirror physician work flow and address the specific needs of the nephrology patient population. “Managing ESRD, CKD, and transplant patients involves certain requirements that differ substantially from the standard set-up of most EMRs,” she says. Another feature to have is lab value trending, which is important for nephrology practices.

Interface. It is best to find a system that can be linked to, and preferably integrated with, the practice management or billing system, Weintraub suggests. “Ideally, demographic and insurance information should be entered only once and then will populate all relevant areas,” he says. That way, if a patient’s insurance information changes, the updated information is automatically carried throughout the system.”

Intuition. Also consider whether the EMR is intuitive. “The user interface should be laid out so that physicians can review a summary, medications, problems, and flow sheets of lab values in the same way they looked at paper charts,” Scharpf says. “Nephrologists should ensure that the EMR makes it easy to find information within the chart by sorting by type of document, such as lab reports.”

—DJN

ing with formulary verification and crosschecking for side effects. “These functions, which have been endorsed by the Institute of Medicine and the Joint Commission on Accreditation of Healthcare Organizations, have enhanced the safety of patient care,” observes Kumar.

Increasing Efficiency

In addition, timeliness of care has improved due to easy access to clinical information. “Prior to EMR adop-

tion, lab reports would be waiting for the physicians to return to the office and review them,” explains Scharpf. “Now, physicians can view documents from their homes or the hospital, so patient care progresses even when doctors’ offices are empty. Physicians constantly send notes to the office staff regarding appointments to schedule, patients or referring physicians to contact, or follow-up lab tests to order.”

Northwest Renal Clinic also has

“With the EMR, we have increased the volume of work without an increase in front office staff. We no longer have to dedicate square footage to chart storage. We have reduced the time and effort required for documentation and reporting to payers.”

—Caryl Scharpf, Northwest Renal Clinic

increased efficiency with regard to staff time and effort in pulling charts. "The EMR makes it much faster to take phone notes or refill prescriptions," Scharpf says. "As a result, the staff can handle more work."

Southwest Kidney Institute has had similar benefits. "The EMR has improved physician and staff morale and satisfaction because information can be accessed efficiently at the point of care," Kumar says. "We no longer have to look for charts and then dig through stacks of papers."

The EMR facilitates treatment discussions and patient education. "During office visits, the physicians review long-term trends in lab results, such as creatinine levels, and show this information to patients," Scharpf notes. "If physicians discuss a particular topic, such as a specific diet, they can click a tab so that a handout is printed for the patient. The handout distribution is then documented in the chart."

All G-code documentation is noted in the EMR, Scharpf says. "The EMR is interfaced with our billing system so that demographic information is automatically transmitted," she says. "By 2007, we are planning to add an interface that will allow us to transmit charge information to the billing system at the end of each visit." Orders for lab tests and prescription orders are generated automatically and faxed electronically, and the practice can electronically fax documents to other physicians.

Cutting Costs

Weintraub also notes that practice costs have dropped. "Our annual transcription costs fell from \$110,000 before we implemented the EMR to \$40,000 now," he notes. "While we have not mandated the cessation of dictation, some of our physicians have stopped dictating, resulting in no transcription costs at all," he explains.

Managers Suggest Implementation Strategies

Administrators from nephrology groups that have implemented electronic medical record (EMR) systems recommend the following steps when installing a new system.

Step-Wise Implementation. Caryl Scharpf, administrator of the Northwest Renal Clinic, a 13-physician nephrology practice in Portland, Ore., found that EMR implementation is facilitated if the physicians can adapt to the system in steps. "For example, our physicians started using the EMR by entering medications and problem lists, but still dictated their notes," she says. "Later, we added new templates and eventually eliminated dictations. Step-wise implementation helped the physicians get used to the system."

Initial Data Input. Jeff Weintraub, CEO of Southwest Kidney Institute in Phoenix, suggests that nephrologists carefully analyze the data they will incorporate into the EMR. "How much historical data should you enter, three years or six months?" he asks. "Ideally, physicians should not have to go back to the paper charts once the patient is in the electronic system. Determining how much data you need is a critical first step."

Consultation with Colleagues. Nephrologists also can learn from other practices so that they can understand the pitfalls of implementation. "EMR adoption requires a massive change in the way physicians operate," Weintraub says. "Nephrologists can benefit from consulting with colleagues who have already been through the process." —DJN

While the practice has not yet observed increases in patient volume as a result of greater efficiencies, Weintraub believes the organization will eventually be able to manage more patients as a result of better population management.

For Scharpf's practice, the system has helped to boost staff productivity. "With the EMR, we have increased the volume of work without an increase in front office staff," she notes. "We no longer have to dedicate square footage to chart storage. We have reduced the time and effort required for documentation and reporting to payers. All of these benefits have generated cost savings that have more than compensated for the EMR investment cost."

Weintraub believes that with the growing industry emphasis on quality measurement and pay for performance, nephrology groups with

EMRs are likely to earn preferred status and enjoy greater negotiating leverage with managed care organizations. "Because the EMR can track clinical trends, the ability to treat patients early and keep them healthy will be enhanced," he notes. "EMRs can also help practices demonstrate outcomes. Documenting high quality care is central to pay for performance and other quality initiatives."

Weintraub's next step is to have the doctors share best practices. "A number of the nephrologists are very proficient on the EMR, but they are proficient in different ways," he notes. "If we share all the shortcuts that individuals have developed, we will make the whole practice more efficient."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More practice strategies are available on our Web site (see page 16).

What a Chart Audit Will Tell You

Coding claims correctly in a nephrology practice is a continual learning process that involves developing an expertise with all the fine points of coding and then adjusting to changes in coding rules as they are made. That's why coders and billers in nephrology practices do routine internal audits. Regular audits can help a practice assess coding accuracy and help physicians and administrators identify ways to improve coding.

Practices that routinely audit their claims will likely see an overall rise in their billing for evaluation and management codes (E&M), says Mary McCloskey, the billing manager at Nephrology Associates, a practice of 10 nephrologists in Wynnewood, Pa., that routinely does self audits.

Addressing Undercoding

"If you audit your doctors and work with them closely, you are likely to raise the code level," McCloskey says. "Doctors are more likely to code too low because out in the physician community there is a certain amount of apprehension about coding too high."

Practices that use coding clerks to fill in their doctors' codes for them may not need to audit themselves because the claims and documentation are probably already being closely examined, McCloskey adds. But in her practice, nephrologists do their own coding and the only other routine review of the claim is a quick check by a biller before it is sent out. In this situation, she says, routine audits are wise and prudent.

McCloskey and others say, however, that many practices in which nephrologists do their own coding are not doing internal audits. Failing to do internal audits not only means lower E&M codes but also leaves mistakes that could be detected by Medicare's own auditing program, the Comprehensive Error Rate Testing Program (CERT). Started in 2002, CERT randomly chooses Medicare claims to audit and then asks practices to send in documentation.

If the documentation does not support the claim, the practice is ordered to repay the difference in reimbursement caused by the mistake, plus interest, but no fines are levied,

Medicare authorities report. Stiff fines are levied in the Medicare Fraud and Abuse program, but unintentional coding errors are not considered fraud or abuse.

CERT and another Medicare auditing program, the Hospital Payment Monitoring Program, showed a combined national error rate of 9.3% for claims for fiscal year 2004, according to a March 2006 report by the Government Accountability Office. GAO reports that the top reason for errors was insufficient documentation.

Conducting An Audit

McCloskey performs internal audits every two to four weeks, so that all 10 of her nephrologists get a chance to be audited at least once a year, she says. In each session, she examines two claims from one nephrologist and all the documentation that goes with those claims. It takes her about one hour and she usually does so over lunch. She works with another doctor (but not the one being audited) or a nurse and one of her billers. The doctor or nurse helps her understand the clinical language, and the biller takes notes as McCloskey ponders the documentation. She needs to concentrate to accurately interpret the handwritten hospital notes and the more thorough office notes, which generally are more detailed.

She reports results to the nephrologist. "I'm lucky," McCloskey says. "I work with a very proactive group of doctors. They want to know about this."

To help her carry out the audit, she uses an audit sheet that she prints from the Web site of her regional Medicare carrier, HGSA administrators, in Camp Hill, Pa. The form is used to determine the correct level for each E&M code. But using the

What Medicare Auditors Find

Listed below are Medicare fee-for-service error rates for fiscal 2004, as measured by two Medicare auditing programs, the Comprehensive Error Rate Testing Program and the Hospital Payment Monitoring Program.

Category of error	Percentage of all audited claims
Insufficient documentation	4.1%
Non-response	2.8%
Medically unnecessary	1.6%
Incorrect coding	0.7%
Other	0.2%
All types of error	9.3%

Note: Numbers do not add up exactly due to rounding.

Source: Government Accountability Office, March 2006.

coding sheet correctly, she says, means understanding some rules that aren't always intuitive. For example, she needs to check off pertinent parts of the body and organ systems. When the nephrologist treats edema related to cardiovascular problems, she does not check off "extremities (with or without edema)," but instead "cardiovascular."

Nuances in wording on the bill can reduce the E&M level, McCloskey says. For example, to qualify for a high-level consultation (an E&M level of 4 or 5), the physician would need to show that he or she reviewed 10 systems or more but has to list only those systems in which conditions have changed. For the other systems, McCloskey says, the physician would use the term, "all other negative." If the doctor wrote "not applicable" or another term, she says, the claim could be downcoded.

Staying Current

McCloskey and two members of her billing staff are trained to perform the internal audits, having taken outside courses and seminars on correct coding sponsored by the Renal Physicians Association, HGSA, and private consultants. In addition, at least one of her nephrologists goes to the coding session at each RPA meeting.

Keeping staff up to date on coding issues is an ongoing task. "It's not something that can happen overnight," McCloskey says. "You've got to go to the seminars and figure out how to do this."

The nephrologists and other staff at Nephrology Associates also learn from HGSA coding nurses, who have come on-site to the practice twice. Before the visit, McCloskey provides the HGSA coding nurses with five claims at different E&M levels, stripping them of all patient identification. The coding nurses then review these claims in sessions that can last two hours, she says. The

Ways to Avoid Undercoding

Some nephrology practices avoid meticulous coding by doing what she calls "flat lining," which means coding almost everything as a level 3 E&M visit, says Doris Fullerton, a coding consultant in Roundup, Mont.

For a level 3 E&M visit in Chicago, Medicare pays \$57.59. But Fullerton says a nephrologist's average E&M level is likely higher. In Chicago, she says, Medicare reimburses at \$90.22 for a level 4 visit and \$130.74 for a level 5.

Physicians' notes often lack details, such as a "review of symptoms (ROS)" or "past, family social history (PFSH)," that qualify the claim for a higher E&M level, Fullerton says. Even if the patient's status has not changed since the last visit, the chart should show that the review took place, she says. The doctor can write, "PFSH remains unchanged from previous visit" and enter the date.

Also, nephrologists frequently undercode. "They are not communicating the common things at the complexity that they should be and consequently they're getting underpaid," Fullerton says. She offers this example: An established patient presents in the office with a cold. He also has kidney disease, heart disease, and hypertension. The ICD-9 code for a cold (460) would support the E&M level of 99212, she says. But if the patient's other conditions affected the physician's medical decision-making, the physician could use the 460 code and the ICD-9 code of 404.12, a bundled diagnosis code for hypertension with heart disease and kidney disease that would support an E&M level of 99214.

Rather than a cold, Fullerton says a more accurate diagnosis might be "upper respiratory infection," with an ICD-9 code of 465.9, which supports an E&M level of 99214. Furthermore, that ICD-9 code, when used with the bundled diagnosis code of 404.12, would support a level of 99215.

In another misguided attempt to simplify coding, Fullerton says some nephrology practices print up blank superbills listing 50 common diagnoses. The physician checks off one or more diagnoses to describe the visit. She calls such superbills "the single most damaging piece of paper in the practice," because this ICD-9 list may not contain the right code or allow additional modifiers to improve accuracy.

Instead, Fullerton advises practices to print a more extensive master list of 300 to 500 commonly used ICD-9 codes for nephrology, which the physician can use to improve coding accuracy. Such lists are available in coding and auditing software, she says. —LP

service is free. Other Medicare carriers may provide similar arrangements because, just as HGSA would do, Medicare penalizes carriers for a high claims error rate.

Many practices don't take advantage of such free offers to improve coding because they are nervous about inviting Medicare authorities into their practice. But McCloskey is

not worried because the sessions are just informational, the setting is convenient for her doctors, and the price is right.

Reviewing Documentation

Coding correctly is a discipline that takes experience to understand fully, says Joyce Cox, a procedure coder at Southwest Kidney Institute in

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Tempe, Ariz., a practice with 23 nephrologists. Cox and her staff routinely check their physicians' coding and are considering adopting a more formal auditing process. The practice already has certified coders on staff and they are essential for a proper audit, she says.

When reviewing a claim, auditors should consider whether all relevant ICD-9 codes are listed, Cox explains. More codes allow for a higher E&M level. For example, if the nephrologist is performing interventional surgery for dialysis, such as doing angioplasty for a clotted vein, the primary diagnosis is "clotted vein." The secondary diagnosis would be ESRD (585.6) and if the patient is a failed transplant, there would be a third code for that condition as well, she says.

Sometimes internal auditors encounter Medicare carriers who have a different interpretation of the coding rules, which may require an appeal. Recently, a patient had four outpatient dialysis visits and then was admitted to the hospital at the end of the month, Cox explained. The Medicare carrier carves out the doctor's portion of the hospital visit and makes it an outpatient visit for a "transient" patient (a patient who has dialysis done at a location away from home) even though this situation does not apply to the case at hand, she says. When the group appealed to

Every practice needs up-to-date coding reference books, which can cost \$250 to \$300 annually, Fullerton advises.

the Medicare carrier, the issue was resolved in the group's favor.

Using Best Practices

Large groups and hospital-owned nephrology practices tend to self-audit, but many smaller groups do not audit at all, says Doris Fullerton, a coding consultant in Roundup, Mont., who works almost exclusively with nephrology practices. She reports that new federal requirements oblige practices to perform internal audits on "a regular basis." That's a vague mandate, but she interprets it to mean auditing once a month, or at least once a quarter for each physician.

When Fullerton performs an internal audit, she randomly selects five to 15 records per physician or about 35 records for an entire practice. Completed records of internal audits should go into a three-ring binder along with the practice's coding policies, she says. If Medicare audits or investigates the practice, the documents would show that it is making a good-faith effort to code properly, she adds.

Nephrologists who have the proper training can perform their own

internal audits on each other and spend only a few hours on such audits each month, Fullerton says. But she concedes that many doctors may feel they do not have the time and would rather assign coding tasks to staff or a consultant.

Regardless of who does the auditing, the practice needs to have up-to-date coding reference books, which cost \$250 to \$300 each year, Fullerton advises. Some practices don't want the extra expense and have books that are more than 10 years old, which is unacceptable, she says. Practices also can buy software to double-check coding that is basically the same product that insurers use to screen claims, she adds. UnicorMed, a private coding book publisher and coding software development company in Montgomery, Ala., offers the Alpha II Coding System for \$1,295 for a single user. It checks for the proper ICD-9 and CPT codes, among other functions, she says.

Electronic medical record systems can help with coding, but Fullerton warns that some EMRs give a false sense of security because they can introduce coding errors. She advises practices to look for EMR programs that link the diagnosis to the procedure and validate the claim.

Fullerton says auditing means being careful and thorough, but it should never be used as a way to game the system to increase reimbursements. "The aim is to get paid for the work you are doing," he says. "I don't want practices to underbill or overbill. Coding is nothing to play games with."

—Reported and written by Leigh Page, in Chicago. More information on nephrology practice strategies is available on our Web site (see page 16).

New Codes for Chronic Kidney Disease

The new 585 series of ICD-9 codes for chronic kidney disease and end-stage renal disease became effective in October.

Old term	New ICD-9 code
CKD stage one	585.1
CKD stage two	585.2
CKD stage three	585.3
CKD stage four	585.4
CKD stage five	585.5
ESRD	585.6

Source: Renal Physicians Association

Patient Volume Stretches Resources

A recent study showed that a high percentage of patients with early kidney disease are not getting the care they need. The result is that many of the 20 million Americans with chronic kidney disease are at risk for developing preventable complications such as kidney failure and heart disease, the researchers said. The research was presented at a conference this spring that was sponsored by the National Kidney Foundation.

Given that there are so many patients with kidney disease and not enough nephrologists, the health system will need to find ways to help primary care physicians get more involved in the treatment of these patients, says James Weiss, MD, one of 16 physicians at Renal Endocrine Associates in Pittsburgh.

Consulting Opportunities

“Given the millions of patients with CKD, there is no way nephrologists can provide adequate care to all of these patients,” Weiss says. “And so the issue is not how can nephrologists accommodate these patients but how can nephrologists work with primary care physicians effectively so that PCPs can give better care to people with early stage CKD. Can a nephrologist be a consultant and see the patient once a year or every other year and help give some guidelines to the PCP to care for the patient the rest of the year?”

The 11 nephrologists and five endocrinologists at Renal Endocrine Associates are seeking to develop strategies to deliver care to their patients in Western Pennsylvania more efficiently. The group has 50 employees including six physician extenders (nurse practitioners and physician assistants), says Lisa Simonton, the executive director.

The NKF researchers found that many primary care physicians routinely test blood and urine for signs of kidney trouble. But then, these physicians do not act on the results by prescribing the proper medications or doing more tests.

“Could we accommodate more of these patients in our office?” Weiss asks. “Yes, we want to see more office patients though that’s an interesting question because while our focus is on delivering high quality care we estimate that we lose some money now or at best break even on our office practice. That is typical of a lot of groups like ours. And we are already fairly far behind in terms of accommodating new patient visits. Along with many physician groups, we are working to improve both our office practice efficiency and the delivered quality of care. Making sure that the office practice finances works out while we expand office services is a challenge.

“Nephrologists want to take good care of patients and not have their clinical activities even subtly influenced by reimbursement policy,” Weiss adds. “However, we all recognize that in one way or another reimbursement policy does have some impact on how resources are allocated and on how physician groups divide their time. There are many recent examples. This is one of the premises for the current broad push for pay for performance.

“For most nephrologists, the business aspects of treating patients who are on dialysis or for hospitalized patients works out okay; however, the overhead for a nephrology office practice is much higher,” Weiss explains. “When you see one patient in the office, you have many related important activities that take time and have associated costs, including

gathering up all the records, dictating and reviewing notes, and then you frequently want to talk with the patient and family when the lab tests come in. That’s all related to the one office visit. It’s all part of good care. No one disputes the importance of these activities. You get paid for the office visit but many physicians spend 25% to 50% more time on paperwork and follow up with a large number of their patients. That makes office visits inefficient. Giving good office care to medically complex patients who typically need to see several specialists is time consuming and expensive.

“Part of the solution for these problems comes with better information technology,” he adds. “The Renal Physicians Association Advanced CKD Patient Management Toolkit also provides an impressive array of resources to help nephrologists improve delivered quality of care while being attentive to time constraints and relationships with PCPs.

“We need to be much more efficient and creative in our office patient practices to allow us to see more patients who have even earlier kidney disease,” Weiss says.

“The way things are set up, nephrologists had been focusing on care of the sickest nephrology patients,” he says. “In many ways that is appropriate, though it also results in giving less attention to patients who if helped early may not progress to becoming one of the sicker patients. Given the patient numbers, it is unrealistic and unnecessary to expect just the nephrologists to be able to do the work of caring for patients with early kidney disease. We need much more of a collaborative relationship with PCPs.”

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