



The Doctor's Office

Practice management, reimbursement, compliance strategies & news

A Compliments of **HC Pro**

December 2010
Vol. 29 No. 12

INSIDE

Technology 3
Strategies to better track chronic conditions, coordinate treatment, and schedule timely interventions.

PRIVATE PRACTICE SUCCESS

Managed care 5
Tips on how to avoid denied claims.

Compensation 8
Survey: Performance-based incentive plans for physicians are on the rise.

Strategy 9
Fairfield Medical Center redesigns ED call payment.

Reimbursement 11
Medical groups sound the alarm on physicians' Medicare payment cuts set for December 1.

The Breakroom 12
Report: *Physician Alignment in an Era of Change*.

Is your practice prepared for an influx of patients?

by Anna Webster

According to President Obama's healthcare reform provisions, an expected 40–50 million previously uninsured patients will be gaining healthcare access during the next 10 years.

As a result, physician practices are preparing for the increased demand with a team approach to care delivery that is designed to cut down wait times and best utilize physician face time.

Reform expectations

The high demand for primary care doctors, which is predicted to increase in the next decade, comes as no surprise to healthcare leaders. **Ted Epperly, MD**, president of Leawood, KS–based American Academy of Family Physicians (AAFP), says the country will need to combat a “soaring backlog” of patient appointments by adding some 40,000 physicians over the next decade.

Wait times for an appointment to see a physician or specialist are already hitting record numbers, according to a survey by Merritt Hawkins & Associates. The survey, which includes responses from 1,162 medical offices in metropolitan areas, found the following average wait times by specialty in 2009:

- » Cardiology
 - Longest time: 104.4 days
 - Shortest time: 3.4 days
 - Average time: 22.1 days
- » Dermatology
 - Longest time: 98.7 days
 - Shortest time: 2.5 days
 - Average time: 27.5 days

- » Orthopedic surgery
 - Longest time: 59.9 days
 - Shortest time: 2.9 days
 - Average time: 16.8 days
- » Family Practice
 - Longest time: 99.6 days
 - Shortest time: 2.47 days
 - Average time: 20.3 days

“Specialty practices in the future will be asked to be much more coordinated and streamlined with whoever else is the **primary care physician of the patient.**”

—Roland Goertz, MD

“Specialty practices in the future will be asked to be much more coordinated and streamlined with whoever else is the primary care physician of the patient,” says **Roland Goertz, MD**, AAFP’s president. “The whole system, to be efficient, is going to have to change.”

Goertz predicts the following four changes will take place to accommodate the patient influx:

1. The adoption of modern tools such as electronic health records (EHR)
2. Use of creative and innovative scheduling models
3. Designing the hours of the practice to better accommodate patient need

Patient influx

continued from p. 1

4. Focusing more attention on quality measurements such as patient demographics

For example, the Waco (TX) Family Practice Center has expanded its reach by implementing EHRs at 13 sites, says Goertz, who for the past 12 years has acted as CEO of the three foundations that oversee the clinic. EHRs are more efficient than paperwork in terms of communication and data processing, he says. If clinics can speed up communications, they can speed up care delivery.

Team approach

Healthcare is an industry accustomed to steady growth. But under healthcare reform, the traditional model for care delivery will need to transform—and fast.

Although every patient wants to see his or her doctor face-to-face, many practices are now adopting a team approach to care using group clinics, patient education, and the support system of pharmacists, nurses, nutritionists, and specialists.

David Winters, MD, board chair of the HealthTexas Provider Network, which is composed of more than 470 physicians, admits that he is concerned about the expected onslaught of patients due to healthcare reform and meeting those demands. As a solution, nurses and physician assistants are being asked to step up and perform more procedures when doctors don't have time, he says.

"Those [practices] who do not use midlevels are going to have more of a problem expanding," says Winters. "As reimbursements go down, some physicians will adapt and some will retire early. We worry about wait times in Texas."

The average wait times to see a physician through the Dallas-based HealthTexas Provider Network is anywhere from six weeks to three months, says Winters.

Rod Christensen, MD, district medical director at Allina Medical Clinic, which has more than 45 locations in Minnesota and Wisconsin, is also advocating change in the healthcare delivery model. A pilot program at Allina suggests that increasing the number of clinical assistants will improve "quality access and productivity of physicians," says Christensen.

Shaking the status quo

Physician education plays a huge role in how healthcare will change in the next 10 years because changing the status quo is never easy for doctors who are set in their ways, Christensen says. Support and training classes for physicians and adopting new technology such as EHRs at clinics will help practices meet increased patient demand.

In addition, physicians will need to be increasingly flexible, perhaps adding more office hours or being open to pilot programs, Winters says.

Having physicians change their processes takes leadership. "We start with pilots and we have physician champions who go around and teach how to use new protocols," says Winters.

One of the new protocols Winters is advocating is the patient-centered medical home, which makes the physician responsible for the patient wherever he or she goes. In addition, the use of care coordinators is an ongoing initiative at HealthTexas Provider Network to help prepare facilities to become accountable care organizations.

Christensen stresses the importance of patient education to help reduce the number of unnecessary phone calls or visits as well. Support staff such as pharmacists, nurses, and nutritionists should provide patients with information on their condition and should be encouraged to answer patient questions.

Other solutions healthcare leaders recommend to prepare for the influx of patients include e-messaging, e-visits, and group clinics. "We don't think healthcare will be one size fits all—we think more patients need to be reached in more ways," says Christensen.

For example, group clinics can address multiple patient needs at a single time by a single provider. Diabetes patients often endure many of the same issues and can share experiences and questions through these group clinics, says Goertz. Using this method of care delivery, patients can still get physician face time, and the physician can cut down on repetitive appointments.

Cultural shift

Many established practices are already at capacity when it comes to accepting new patients. Thus, newly insured patients may have limited access to physicians or will need to turn to younger physicians.

As the primary care demand increases, Goertz expects younger, newly established doctors to answer the call—even though many are choosing areas other than primary care to practice. “I am an underlying believer in medical students and trainees responding to this cultural shift,” he says.

HealthTexas Provider Network’s goal is to expand with 30–40 new primary care physicians per year, says Winters, adding that it is finding there are fewer primary care doctors. The lure of a specialty practice with a narrowed variety of problems is appealing to new physicians, he says.

In addition, the new healthcare delivery model will focus more on communications technology.

High-speed Internet access enables doctors to look up facts without having to run down the hall to hit the books. EHRs also allow more patient-physician face time because less time is spent coordinating treatments, Goertz says.

Open-access scheduling is another tool physicians are considering to cut down on their wait times. If implemented correctly, this can be a powerful tool. Practices shouldn’t be daunted by blank appointment spaces if they can be filled at the right rate during the day. The process involves monitoring the number of last-minute appointments within a clinic. If there appears to be a trend, setting aside extra time during the day can reduce patient wait times.

No patient wants to wait until their doctor is ready—they want their doctors ready and waiting for them. ■

[after story]

Rethinking the future of outpatient chronic care

by Janice Simmons

The next 20 years could be thought of as the next great migration—when 77 million Americans, the biggest group ever, move through the window for ages 55–75. It’s the baby boomers and generation Xers getting older, bringing with them new challenges and pressures inside and outside the healthcare system.

“That window is the highest period of healthcare utilization for the average American. It’s when most chronic diseases manifest,” says **C. Martin Harris, MD, MBA**, chief information officer at Cleveland Clinic.

At the same time, the number of physicians and physician offices is not expected to keep pace to provide for that demand for care. “Our ability to deliver the care in the same model that we have today is going to be very tightly constrained—if not impossible,” Harris says. “There are many reasons now to start thinking about how we can deliver this care in a more effective manner going forward.”

The current medical model treats chronic disorders, such as hypertension or diabetes, as though they are episodic, calling for visits to a physician perhaps three or four times per year, Harris says. “If we could start to manage it in a more continuous way, then we could affect the quality of the care

we’re delivering—essentially because we could make more adjustments at more appropriate times.”

To address this, Cleveland Clinic decided to better track chronic conditions, coordinate treatment, and schedule timely interventions.

In December 2008, the clinic, working with Microsoft, started a physician-driven pilot project to follow patients with multiple chronic diseases in a clinical setting. The hospital paired its EMR system with Microsoft’s online HealthVault™, a Web-based storage platform, to monitor patients’ health conditions.

More than 250 participants enrolled: 26% with diabetes, 6% with heart failure, and 68% with hypertension. The patients used at-home heart rate monitors, glucometers, scales, pedometers, or blood pressure monitors, depending on the disease, to follow their conditions. The devices uploaded the patients’ data, which then would be connected to the physicians’ EMRs and to the patients’ personal health records.

In results released earlier this year, the project found a change in the average number of days between physician office visits for patients. Diabetic and hypertensive patients were able to make doctors’ visits less often—increasing the

continued on p. 4

Outpatient chronic care

continued from p. 3

number of days between appointments by 71% and 26% respectively, indicating that patients had better control of their conditions.

However, heart failure patients visited their doctors more often—decreasing the number of days between visits by 27%—indicating that patients were advised to see their healthcare provider in a more timely manner to avoid complications and stay out of the hospital.

“This [telemedicine] concept has been around, but when it was done a decade or so ago, it wasn’t done with technology; it was done by calling patients at home. It worked but was cost-prohibitive,” Harris says. The current project required no extra practitioners. “We just built it into their work flow.”

The big challenge will be getting reimbursement systems to reflect this kind of model of care. “There’s no question in my mind that reimbursement systems today are based on the old model of care, which is we get reimbursed when the patient is sitting in front of us,” Harris says. “Part of this study is to demonstrate we can deliver high-quality care and we can do it at lower cost.”

Medical home model

At the Vanderbilt Medical Group and Clinic in Nashville, one question sticks in the mind of **Jim Jirjis, MD**, the chief medical informatics officer: At the end of the day, do people want to pay today for the benefit tomorrow?

For those who are the sickest of the sick, the answer is simple: Yes, it makes sense to help that population, Jirjis says. But what about that middle territory, where individuals aren’t really ill yet, but could be in the very near future if they don’t get appropriate care now? This includes treatment for chronic conditions such as high blood pressure, diabetes, or congestive heart failure.

The future primary care system will not have anywhere near the capacity to take care of all those chronically ill patients under the old model, says Jirjis, who is now implementing a medical home pilot using Vanderbilt’s homegrown EMR that can assist in data mining and decision support.

Jirjis says this new model looks at providing “advanced stratification” for various chronic conditions. Rather than

simply label patients “hypertensive,” for example, they are grouped into one of five categories: prehypertensive, new diagnosis, established but controlled, newly out of control, and ill with comorbidities.

“The reason we make those distinctions is that they require different levels of intervention,” he says. In the current medical model, hypertensive patients often fail to make a physician appointment or no one keeps in touch with them between physician visits. This model is cheap now—when care is delayed or nonexistent—but can rapidly inflate with time.


Instead, if efforts are made to provide care at the appropriate intervals and make sure conditions are monitored, patients’ conditions will be prevented from deteriorating. In the average practice, about 40%–50% of patients have their high blood pressure under control. Using a proactive approach, this rate can increase to 80%.

That improvement translates into fewer strokes and heart attacks. Using mathematical projections, Jirjis predicts that in a group of 10,000 hypertensive patients, approximately 37–40 fewer heart attacks or strokes would occur over a five-year period, translating into several million in savings during that time.

These savings could be reinvested back into the practice to help supply other providers, including nurses or physician assistants, to provide ongoing care. “We should be able to double our capacity of patients,” Jirjis says.

Self-management is an area that could receive additional attention among the chronically ill population, says **Shirley Moore, PhD, RN**, a professor of nursing at Case Western Reserve University in Cleveland and director of its Self-Management Advancement through Research and Translation Center.

“Promoting self-management of health . . . can have some great downstream effects in terms of mitigating problems with chronic illnesses,” Moore says.

“Medication adherence is a huge area” that could benefit populations with multiple chronic illnesses because of the number of medications they are on, she says. 

[after story]



PRIVATE PRACTICE SUCCESS

Independent advice for building and running
a top-performing private medical practice.

Avoid denials with clean claims, accurate information

Accuracy rules the day when it comes to submitting claims and avoiding denied claims. The simplest oversight on a claims submission can result in lost dollars, not just from the claim that isn't paid, but also from the additional time and effort expended by staff.

Inaccurate insurance information is probably the leading cause of denied claims, says **Bill Gilbert**, vice president of marketing at AdvantEdge Healthcare Solutions, one of the top 15 medical billing providers in the United States, based in Warren, NJ. In most cases, the insurer replies that the patient is not covered.

"Often that's just a matter of the insurance number being entered wrong, perhaps transposed," Gilbert says. "That's easy enough to fix, but it's a simple oversight that will cost you money no matter how the claim ends up. The simplicity of the error, or the ease with which you can correct it, doesn't mean that no harm is done."

Gilbert's company has done research that suggests even the simplest fix for a denied claim will cost the provider between \$50 and \$100 in staff time and other associated costs. Preventing the denial in the first place is a much better goal, he says.

Submitting the claim to the wrong carrier is another common mistake, Gilbert says. For instance, the claim may be submitted to the patient's workers' compensation carrier when the claim really should have gone to the regular insurance carrier.

"In practices that have a lot of workers' comp cases, it is fairly common to see the claim go to the wrong carrier the first time and then have to get it sorted out," he says. "Each one of those costs money to fix. If it becomes the norm, if you just accept that some percentage of claims are going to bounce back to you like that, you're throwing away money."

Frontline staff make a difference

Inaccurate information often originates with the appointment scheduler or other front office staff, Gilbert says. If they are careless with taking insurance information or inputting it into the system, the mistake can be perpetuated and sent on down the line until it results in a denied claim. These personnel should be trained to understand the ramifications of a data error—and trained frequently because there is such high turnover in these positions, he says.

"If you look at your denials and see that a disproportionate number are coming from the patients referred by one physician, you need to go back in a nice way and see if the procedures in that office **can be improved or handed off to you in a better way.**"

—Bill Gilbert

"When a new person takes over that desk, they may know they are supposed to make a copy of the insurance card, but they may not understand how important it is to enter that information correctly," Gilbert says. "That kind of training, both for new hires and as a refresher for existing staff, can make a real difference."

Making a copy of the card and entering the name and number into the computer system isn't enough, Gilbert says. Those staff members should be trained to question the patient about information that could affect how the claim is submitted, he says. They should ask whether the claim is related to a motor vehicle accident or anything at work, and

continued on p. 6

Avoid denials

continued from p. 5

they should ask whether the patient has any additional insurance coverage.

“Having a script or a checklist is a good way to ensure that you get that information, but a lot of practices don’t take the steps to make sure they get that information right up front,” Gilbert says. “The best way is to get the insurance information at the time of scheduling, rather than waiting until the patient comes for the appointment.”

Also remember that the claim can be sent off the rails by incorrect information about your own practice or hospital, Gilbert says. Outdated data such as addresses, telephone numbers, system identifiers, and so forth can cause the payer’s system to reject the claim. It is important to update templates and computer systems with any new information as soon as possible so old data are not carried forward for weeks or months, he says.

Referring physician has to help

The scheduler can then verify insurance coverage, Gilbert says. Some practices obtain the information at scheduling and at the appointment as an added measure of security.

Another common cause of denials is inaccurate or insufficient referring physician information, Gilbert says. This is a particular problem for specialists, who have most of their patients referred from another doctor. The solution involves putting into place good procedures for obtaining that information from the referring physician, but the specialist is forced to rely on the other practice to provide accurate information.

“The specialist may have to put in more work to obtain enough information about the referring physician and accurate data,” he says. “If you look at your denials and see that a disproportionate number are coming from the patients referred by one physician, you need to go back in a nice way and see if the procedures in that office can be improved or handed off to you in a better way.”

One in five claims processed inaccurately by insurers

It’s not always your fault when claims are denied. Payers routinely err in their handling of claims, sometimes leading to the denial of claims that should be paid, according to a recent report from the AMA in Chicago.

The AMA report shows that one in five medical claims is processed inaccurately by health insurers. This was the key finding of the AMA’s 2010 National Health Insurer Report Card, which for the first time benchmarked the overall claims processing accuracy of the nation’s largest health insurers, says **Nancy H. Nielsen, MD**, the AMA’s immediate past president.

“The finding that one in five medical claims are processed by insurers with errors emphasizes the huge potential for reducing administrative costs for physicians and insurers,” Nielsen says. “Creating a single transparent set of processing and payment rules for the health insurance industry would create systemwide savings and allow physicians to direct time and resources to patient care and away from excessive paperwork.”

According to the AMA’s findings, the health insurance industry as a whole has about an 80% accuracy rate for processing

and paying claims. Coventry Health Care, Inc., came out on top of the seven commercial health insurers measured by the AMA with a national accuracy rating of 88.41%.

The AMA estimates that \$777.6 million in unnecessary administrative costs could be saved if the health insurance industry improves claims processing accuracy by just 1%. Increasing the health insurance industry’s accuracy rating to 100% would save up to \$15.5 billion annually that could be better used to enhance patient care and help reduce overall healthcare costs, Nielsen says.

“Each insurer uses different rules for processing and paying medical claims, which cause complexity, confusion, and waste,” Nielsen says. “Simplifying the administrative process with standardized requirements will reduce unnecessary costs in the health system and eliminate the variability that makes it necessary for physicians to maintain costly claims management systems for each health insurer.”

Response time varies widely

To encourage a more efficient and streamlined payment system, the AMA’s National Health Insurer Report Card provides a

Know the system

A key to avoiding denials is to know the payer's payment policy and understand how it works, says **Eileen Parsons, JD**, attorney with Ver Ploeg & Lumpkin in Miami, who helps clients appeal denied claims. The provider should know the policies on payment before entering into an agreement with the payer, particularly if the provider is involved with cutting-edge procedures or anything out of the norm, Parsons says.

"At least understand up front what those requirements are going to be," she says. "Setting aside medical necessity issues, I find that the most common problems providers run into with denials is that they didn't understand the payer's policies and so they didn't comply with what the payer expected of them."

Once you know you are working within the payer's system, the paramount concern is to provide a clean claim—and don't underestimate how clean it should be, Parsons says. Squeaky clean. Neurotic, obsessive-compulsive clean.

The effort put into submitting a clean claim will pay off in the long run when you have to spend less time on appealing denials or simply writing off the money because it isn't worth appealing.

"You want them to be as defensible as you can up front," Parsons says. "Before you ever send that claim to the payer, you want to know that if it comes back denied, they're wrong, they made a mistake, and you can show them why. You want to shoot for that level of confidence with every claim, and that takes some work up front." ■

Source

Adapted from *Managed Care Contracting & Reimbursement Advisor*, October 2010.

[after story]

useful snapshot of how each of the nation's seven largest commercial health insurers can improve their claims processing performance. The systems health insurers use to process and pay claims were measured according to these factors:

- » **Accuracy.** In addition to measuring overall claims processing accuracy, the report card examined how accurately insurers reported the correct contract fees to physicians. Commercial health insurers made large improvements during the past three years. Contracted fees were correctly reported 78%–94% of the time in 2010, compared with 62%–87% of the time in 2008. UnitedHealth showed the largest improvement in reporting correct contract fees, while Health Care Service Corporation scored the highest. The performance of insurers varied significantly by state, ranging from 58.6% to 96.9%.
- » **Denials.** The inconsistency found among health insurers in 2008 continued to be demonstrated in 2010. There is wide variation in the frequency of denials by insurers, ranging between 0.7% to 4.5%. Lack of eligibility continues to be the most common reason for claim denials, signaling the need for employers and insurers to help educate patients about

the limits of their insurance coverage. Physicians can help reduce denials by ensuring that all claims are complete and accurate, the AMA says.

- » **Timeliness.** The report card found that insurers' response time to a claim varied from five to 13 median days. With the exception of CIGNA, all the insurers measured in 2009 showed slight increases in the number of days needed to respond to a claim.
- » **Transparency.** Payers have made significant improvements since 2008 in their efforts to disclose vital policies and information to physicians through their websites. Greater transparency in insurer fee schedules is likely responsible for more consistency in the payment process, fewer payment disputes, and less paperwork.

You can download the entire report for free at www.ama-assn.org/ama1/pub/upload/mm/368/2010-nhirc-results.pdf. The AMA's Practice Management Center offers online resources for preparing claims, following their progress, and appealing them when necessary. The Practice Management Center's library of education materials and practical tools is available online at www.ama-assn.org/go/pmc.

Physicians' performance-based incentive plans increasing

by John Commins

Annual performance-based incentive plans are growing for physicians in both presence and scale, according to consultants Hay Group's 2010 Physician Compensation Survey.

The survey found that 92% of group-based organizations offer incentive plans to their physicians, up from 75% in 2009.

Physician incentive plans are also being offered by 63% of hospitals this year, as opposed to 51% in 2009. The percentage of integrated health systems (IHS) offering physician incentive plans remained steady between 2009 and 2010 at 67%. Of the 28 organizations that responded that they had no physician incentive plans, 39% said they were considering them.

"There is safety in numbers, and it has never been truer in healthcare than it is now," says **CJ Bolster**, national director for Hay Group's healthcare practice. "Integrated health systems have scale, and they can offer job security in lieu of having to offer higher incentives. Group practices that are not directly tied to a hospital or system will traverse a bumpier road in the post-reform era, but they will continue to attract physicians with an entrepreneurial drive and an acceptance of risk."

The incentive plans are also increasingly tied to performance measures, with patient satisfaction and quality the leading factors for all surveyed organizations. Fifty percent of group-based practices tie incentives to patient satisfaction and quality; that percentage is slightly lower for hospital-based (43%) and IHS-based (46%) organizations.

"No one should be surprised that healthcare organizations are moving to link pay to performance," says **Ron Seifert**, executive compensation practice leader for Hay Group's healthcare practice. "Hospitals will increasingly be rated on performance metrics such as patient satisfaction, readmissions, and clinical outcomes, and reimbursements are likely to be linked to these as well. Financially, it's in an organization's best interest to embrace these changes now, rather than waiting for all the reform dust to settle. Communally, a hospital focusing on the needs and health of patients is good for everyone."

Incentive bonuses typically supplement base salaries, which are holding flat in hospital-based organizations, with

2.8% increases in 2009–2010 and 2.9% planned increases for 2010–2011. Group-based physician practices offer higher salary increases (4.8% granted in 2009–2010), but the planned base salary increases for 2010–2011 dropped to 3.3%.

Salary structures and salary planning for physicians remain flexible in 2010, respondents show. Half of hospitals and IHSs and 54% of group-based physician practices say that their process is independent, meaning that they have a philosophy and structure, but that positions, specialties, departments, and specific doctors are reviewed individually for their salary potential and subsequent increases.

The 2010 survey participants included IHSs, hospitals, and group-based physician practices and covers 128 physician specialties, including 40 pediatric specialties, 16 non-physician provider positions, and 13 medical directors.

The Hay Group survey findings are consistent with a recent study by the Medical Group Management Association and the Society of Hospital Medicine, which showed that base salary affects both productivity and overall compensation for hospitalists.

According to the study, *State of Hospital Medicine: 2010 Report Based on 2009 Data*, hospitalists who receive a lower proportion of total compensation paid as base salary tend to be high producers who are incentivized to earn more.

The report, which contains information on 443 hospital medicine groups and 4,211 hospitalists, found that:

- » Hospitalists who received 50% or less of their compensation as fixed base salary reported the highest median work relative value units (wRVU) at 5,407.
- » Hospitalists who received 51%–70% of their compensation as base salary performed 4,591 wRVUs, compared to 3,859 wRVUs for hospitalists who received 71%–90% of their compensation as base salary.
- » Hospitalists who received 91%–100% of their compensation as base salary reported 3,571 wRVUs. ■

[after story]



Fairfield Medical Center redesigns ED call payment and aligns physician-hospital interests

It seems like an unwinnable game of cops and robbers. Physicians demand to be compensated for ED call, and the hospital refuses to meet those demands because it will eat the bottom line. Physicians retort with threats to cease providing service if the hospital does not meet their demands, and the hospital shoots back with threats to employ physicians, thus creating competition with independent members of the medical staff.

Like many hospitals, contention regarding ED call at Fairfield Medical Center in Lancaster, OH, was just a symptom of deeper systemic problems, and the organization almost lost its OB service before the problems were diagnosed and treated.

Dilemmas and deals

Fairfield's medical staff is made up primarily of independent physicians in solo practice or small groups. Several years ago, these physicians dismissed the hospital's offer to hire hospitalists for fear that the hospitalists would intrude on the businesses that they worked so hard to build. However, they soon changed their tune when the ED call burden became too heavy to carry.

"Over three years, we saw physicians wanting to get more into broad call groups or delegate their practice call coverage—not their unassigned—to the larger groups who wanted to do in-house work," says **Mina Ubbing**, CEO of Fairfield.

To alleviate fears of hospitalists stealing the independent physicians' patients, Fairfield hired an external group of physicians who practiced in-house to cover adult primary care cases; none had private practices. Although it helped family practitioners with their ED call schedule, physicians in other specialties began asking, "What about me?"

Soon after, OBs approached Ubbing, demanding that the hospital hire a laborist (an OB hospitalist) to cover their late night deliveries. "The cost of the laborist for a hospital that does 1,000 deliveries a year, the majority of which are Medicaid, is just not practical," says Ubbing.

The hospital hired a single OB but learned the hard way that it wouldn't help the situation. Rather, independent OBs

felt that because the employed OB got paid regardless of whether he or she was called to the ED, they also should also get paid for taking ED call. It wasn't long before the independent OBs laid down the gauntlet and threatened to stop taking emergency call unless they received compensation.

"We thought our choices were to shut down the OB service or to keep the service and pay for call. We didn't feel like it served our community well to deliver babies in the ED, so we agreed to pay," says Ubbing.

Within hours of agreeing to pay OB for call, Ubbing received a petition signed by physicians from nine other departments demanding to be paid for ED call. "Quick math on the nine specialties would have cost us more than our bottom line," she says.

Although it was not administration's intent to conduct an under-the-table deal with OB, the medical executive committee perceived it as such.

Assigning a dollar value to ED call burden

It took a committee of 20 people and several meetings over eight weeks to come to an ED call compensation resolution that everyone at Fairfield could accept. It also took the wherewithal of a handful of physician champions to lead the way.

"I helped serve as a voice of reason because some of the other departments were being less than reasonable in terms of their expectations of what the hospital could and should provide for coverage," says **Robin Rhodes, MD, FAAP**, former chair of the pediatrics department at Fairfield. "Physicians who weren't being affected significantly in terms of the

continued on p. 10

Don't miss your next issue!

If it's been more than six months since you purchased or renewed your subscription to **TDO**, be sure to check your envelope for your renewal notice or call customer service at 800/650-6787. Renew your subscription early to lock in the current price.

ED call

continued from p. 9

number of times they were being called or how onerous the interaction was were sometimes being the most demanding in terms of reimbursement.”

To find out just how much burden each specialty shouldered, Fairfield, with the help of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, collected two weeks of ED data for each specialty.

“We performed a detailed analysis of medical records for all patients coming into the ED, along with coding what the physicians did by CPT code and payer, to determine for each specialty precisely what the burden of call is and how much physicians are likely to bill and collect for what they did,” says **Richard A. Sheff, MD, CMSL**, chair and executive director of The Greeley Company.

The analysis included frequency of call, intensity of physicians’ tasks when on call, malpractice liability risk, and follow-up referrals to physicians’ offices.

Analyzing data in this way enabled Fairfield to assign a dollar value to the level of burden for each specialty. For example, “The GI doctor doesn’t have to come in right away, but the pediatrician for the emergency C-section has to be within 10 minutes of the hospital the whole time they are on call,” says Rhodes.

Fortunately, the numbers Fairfield determined were close to the numbers reported in the Medical Group Management Association’s *Physician Compensation and Production Survey*. Having those external data helped mitigate emotion and ground physicians whose perception of their ED call burden might have been skewed.

Getting to ‘we’

Greeley consultants interviewed medical staff members, board members, and administrative staff to get to the bottom of the contention over ED call compensation. They found that lack of alignment was the real issue. Physicians viewed their relationship with the hospital as an adversarial one, rather than a partnership.

The consultants also found that many of the grudges that fed misalignment were decades old. With the help of a mediator, all parties decided that although some issues

still needed to be resolved, they would agree to let go of the past.

Before the organization could work on resolving past issues and aligning physicians with its financial and operational goals, it needed to keep its word on previous promises. For example, the OB physicians expected the hospital to nullify their contracts and pull them into another ED call compensation model.

“I had an opportunity to make an announcement in front of everyone that we honor our existing contracts,” says Ubbing. “That was a moment of credibility and truth, and it helped.”


Ubbing framed the alignment effort as “getting to ‘we.’” If Fairfield couldn’t align physicians with its financial and operational goals, it couldn’t afford to pay physicians for ED call, she says.

“The point the hospital made was that this needs to be a give-and-take. If the hospital is going to pay for ED call, the physicians need to contribute to the bottom line,” explains Rhodes.

The organization began looking for ways for physicians to partner with the organization, such as reducing length of stay or ordering lab work at the hospital instead of an outside vendor. “We looked for mutually satisfying arrangements whereby the hospital benefits, the patients benefit, and the physicians benefit from streamlining care,” says Rhodes.

For example, if a physician has a higher-than-average length of stay, that physician is encouraged to compare his or her practices to those of peers and find ways of practicing more efficiently.

In the end, an ED call compensation package that was sure to put the hospital in the red was doable thanks to better performance resulting from alignment.

“The fact that Fairfield is a strong medical center that attracts a broader base of payers helps physicians be more successful,” says Rhodes. 

Source

Adapted from **Medical Staff Briefing**, September 2010.

[after story]



Medical groups sound alarm on SGR 'crisis'

by Cheryl Clark

The dreaded sustainable growth rate (SGR) formula that cuts physicians' Medicare pay doesn't take effect until December I, but already the AMA, 66 specialist practitioner societies, and 50 state medical groups are sounding the alarm. Again.

If nothing is done, the 23% cut in physician fees December I, will be followed by another 6.5% cut January I, reductions that could seriously impair the ability of seniors to access care because many physicians who now accept Medicare beneficiaries will stop doing so, physician groups say.

"Without action to stop the cuts, Congress will create a Medicare meltdown with access to care threatened for seniors and baby boomers who will begin entering Medicare in January," AMA President **Cecil B. Wilson, MD**, said in a statement. "Ultimately, a permanent solution must be passed to fix this broken system, but Congress must first stop the 30% payment cuts threatening seniors' access to care now."

The SGR has called for across-the-board reductions in physician payment rates to take effect in every year since 2002. But every year, the cuts have been postponed by legislation, after dire warnings and alarms from medical groups.

On June 25, the reductions were postponed again when President Obama signed into law congressional legislation that postponed the SGR's implementation of 21.3% cuts, plus a physician fee increase of 2.2%. Combined, they total a 23.5% decrease in reimbursements through November 30.

"Physician practices simply cannot absorb cuts of this magnitude in programs as important as Medicare and TRICARE," medical groups wrote in a letter to U.S. House of Representatives Speaker Nancy Pelosi and House Minority Leader John Boehner.

Congress enacted short-term stopgap measures, but three times failed to act in time and Medicare payment cuts of more than 20% went through. CMS held back payments until the legislation was passed. However, the groups' letter emphasizes, there were highly disruptive consequences. "Many practices were forced to seek loans to meet payroll expenses, lay off staff, or cancel capital improvements and investments in electronic health records and other technology" the letter states.

"There is an imminent crisis," the letter continues. "A statutory payment update that lasts at least through the end of 2011 will provide time for Congress and the physician community to develop a long-term solution, to ensure that seniors can count on finding physicians to care for them, and that physicians will not view Medicare and TRICARE as threats to the viability of their practice." ❏

[after story]

Are you interested in having the latest industry news delivered to your inbox daily or weekly?

Try one of HealthLeaders Media's free e-mail newsletters

Go to www.healthleadersmedia.com/enewsletters or to http://hcmarketplace.com/listings-M1_MKT.html for more information or to sign up for one of our free e-mail newsletters.

PhysicianLeaders Daily News

This daily e-zine offers concise updates on the top industry news affecting physician leaders in hospitals, health systems, health plans, and large physician practices. This online publication also offers physician leaders best business practices from industry experts.

HEALTHCARE Leadership Trend Watch

This weekly e-zine offers insights into the latest trends for healthcare leaders in hospitals and keeps them abreast of the most pertinent news and information.

HealthLeaders Healthcare Business News

Whether it's about government, technology, business, managed care, pharmaceuticals, or the latest trends in healthcare, **Healthcare Business News** delivers the top stories of the day, each weekday.

E-HEALTH TREND WATCH

This weekly e-zine offers concise reviews of new Web sites and Internet resources, summaries of content from the newsletter **Medicine on the Net**®, news, resources, and more.

HEALTHCARE STRATEGIST TREND WATCH

This weekly e-zine covers highlights from the newsletter **Healthcare Marketing Advisor**, marketing news, resources, and more.

THE PITCH

This weekly e-zine features three current communications campaigns from hospitals, health systems, and other healthcare facilities of all sizes. Topics covered include advertising campaigns, marketing strategy, public relations, and branding, among others.



[back logo]

[return address]

Editorial Board

Group Publisher: **Matt Cann**
 Executive Editor: **Rick Johnson**
 Senior Editor: **Carrie Vaughan**
cvaughan@healthleadersmedia.com



JOEL V. BRILL, MD, AGAF, FASGE, FACG, CHCQM
Chief Medical Officer
 Predictive Health, LLC
 Phoenix, AZ

CHARLENE BURGETT, MS-HCM, CMA (AAMA), CPC, CCP, CMSCS, CPM
Administrator
 North Scottsdale Family Medicine
 Scottsdale, AZ

JENNIE L. CAMPBELL, CMPE
COO
 Summit Medical Group
 Knoxville, TN

JUDY CAPKO
President
 Capko & Company
 Thousand Oaks, CA

JEFFERY DAIGREPONT
Senior Vice President of Business Development
 The Coker Group
 Roswell, GA

KENNETH T. HERTZ, CMPE
Principal Consultant
 Medical Group Management Association
 Alexandria, LA

JILL LEWIS
CEO
 Urology Austin, PLLC
 Austin, TX

MAGGIE M. MAC, CMM, CPC, CPC-E/M, ICCE
Consulting Manager
 Pershing Yoakley & Associates, PC
 Clearwater, FL

The Doctor's Office (ISSN: 0733-2262 [print], 1937-7460 [online]) is published monthly by HealthLeaders Media, 200 Hoods Lane, Marblehead, MA 01945. Subscription rate: \$199/year. • **The Doctor's Office**, P.O. Box 1168, Marblehead, MA 01945. • Copyright © 2010 HCPro, Inc. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HealthLeaders Media, or the Copyright Clearance Center at 978/750-8400. Please notify us immediately if you have received an unauthorized copy. • For editorial comments or questions, call 781/639-1872 or fax 781/639-2982. For renewal or subscription information, call customer service at 800/650-6787, fax 800/639-8511, or e-mail: customerservice@hcpro.com. • Visit our websites at www.hcpro.com or www.healthleadersmedia.com. • Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the marketing department at the address above. • Opinions expressed are not necessarily those of **TD.O**. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.