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Medical Practice News

Use Revised ABN by Jan. 1

Providers (including independent laboratories), physicians, practitioners, and suppliers now have until Jan. 1 to begin using the revised Advanced Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131.

The original implementation date was Sept. 1, but the Centers for Medicare & Medicaid Services (CMS) extended the mandatory use date to Nov. 1 and then Jan. 1, 2012 to give providers and suppliers more time to transition to using the new form, and to use up stockpiles of old forms.

The revised form replaces the ABN-G (Form CMS-R-131G), ABN-L (Form CMS-R-131L), and NEMB (Form CMS-20007). The latest version of the ABN has a release date of March 2011 printed in the lower-left corner. All ABNs with a release date of March 2008 that are used on or after Jan. 1, 2012 will be considered invalid.

The ABN should be used in situations where Medicare payment is expected to be denied. Skilled nursing facilities (SNFs) should use the revised ABN form when services are expected to be denied under Medicare Part B only.

Download the revised ABN at ***www.cms.gov/BNI/02_ABN.asp***, available now for immediate use.

2011 eRx Incentive Final Rule Posted

The Electronic Prescribing (eRx) Incentive Program 2011 final rule has been posted by CMS. The rule fulfills requirements laid out in the Medicare Improvements for Patients and Providers Act (MIPPA) by defining what a provider must do to avoid the Medicare Physician Fee Schedule (MPFS) adjustment should he or she not adopt eRx. New "significant hardship" exemptions are intended to help physicians who are unable to adopt the program.

Under MIPPA, those who are not successfully using eRx beginning in 2012 will receive 1 percent less than outlined in the MPFS for their services. In 2013 they face a 1.5 percent reduction in

payments. Those unable to successfully adopt eRx by 2014 will sustain a 2 percent hit. Methodology for identifying successful providers is based on the Physician Quality Reporting System (PQRS).

The rule defines what is an eligible professional (EP) or a group practice. New "significant hardship" exemptions are available to providers or practices who can demonstrate the following:

- EPs who register to participate in the Medicare or Medicaid electronic health record (EHR) Incentive Program and adopt certified EHR technology;
- inability to adopt eRx due to local, state, or federal law or regulation;
- limited prescribing activity; or
- insufficient opportunities to report the eRx measure.

CMS says section 1848(a)(5)(B) of the act also provides for the secretary to exempt (on a case-by-case basis) an EP from the payment adjustment if the secretary determines (subject to annual renewal) that compliance with the eRx requirement would result in significant hardship. In the MPFS 2011 final rule, CMS established two significant hardship exemptions in the form of G codes for purposes of the 2012 payment adjustment:

- The EP practices in a rural area without sufficient high-speed Internet access (report code G8642 *The eligible professional practices in a rural area without sufficient high-speed Internet access and requests a hardship exemption from the application of the payment adjustment under section 1848(a) (5) (A) of the Social Security Act).*
- The EP practices in an area without sufficient available pharmacies for eRx (report code G8643 *The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption from the application of the payment adjustment under section 1848(a) (5) (A) of the Social Security Act).*

To request consideration for an exemption from the 2012 payment adjustment via one of these significant hardship HCPCS Level II G codes, the EP must

By Dr. David Edward Marcinko, MBA, CMP,
and Hope Rachel Hetico, RN, MHA, CMP

Plan the Future
of Your Medical Practice

Practice succession planning: A step-by-step approach for optimal results.

Succession planning is a dynamic process that requires a retiring or exiting physician to plan the future of his or her medical practice and life's work. Many physicians approach succession planning initially through the retirement and estate planning process. When doctors understand the issues and realities of this transition, they are more amenable to working out an integrated succession plan. Some doctors have not clearly articulated their goals until then, but have fragmented plan pieces that need to be analyzed to meet their personal and financial objectives.

Adopt a Step-by-step Process
We recommend 10 steps for succession planning:

1. Gather and Analyze Data
Data collection helps the doctor understand the relationships between business and personal positions and to address each as separate parts of the same equation. Reviewing hard management and financial data can also help determine whether change is necessary, and/or how to go about implementing it for transition success.

Other important elements to address include:

- The practice's operation environment

- Potential flaws in current structure, appropriate levels of key-person life insurance coverage, buy-sell agreements, and restrictive covenants

- Portfolios (qualified and non-qualified) and invested assets

- Prior retirement and estate planning efforts

- Other legal issues that may need modification

You'll need time to gather the required information. If the doctor is not motivated to gather data independently, a consultant can help. Physicians may create obstacles because they do not want to retire, talk about life after medicine, or relinquish control of the practice. These are delicate topics, and the consultant can explain the consequences of not planning.

2. Understand the Practice
By reviewing management information, consolidated financial statements (balance sheet, cash flow, and net income statements), tax returns, business and marketing plans, and pertinent legal documents, you may be able to identify areas to improve during the succession period. This is a strength, weakness, opportunities, and threats (SWOT) analysis.

3. Contact Other Advisors
After aggregating the data, the doctor should contact his or her attorney, accountant, or investment advisor in a spirit of cooperation. This will create team harmony and establish the doctor as leader.

Choose Your Successor Wisely

The exiting doctor must establish search criteria before prospecting can start. These questions help in evaluating candidates:

- Who is the ideal candidate?
- What does the practice want in education and professional experience?
- What about personality?
- What personal style blends most harmoniously with existing colleagues?
- Does the candidate need to be proficient in specific languages, or have a particular ethnic or cultural background to cater to key groups of patients, etc.?

4. Establish Fair Market Value

The doctor must determine the fair market value, or monetary worth, of the practice. The debt and capital structure, accounts receivable (A/R), financial statements, inventory, fixed assets, intangibles, and goodwill also should be reviewed to determine if there is sufficient collateral for a leveraged buy-out or other transitioning technique. The goal is to estimate the practice's selling price for a willing buyer and a willing seller, assuming:

- The buyer is not under any compulsion to buy.
- The seller is not under any compulsion to sell.
- Both parties have reasonable knowledge of the relevant facts.

For more information on how to determine the fair market value of your practice, see the accompanying article, "Factors to Establish Fair Market Value for Your Practice" on page 12.

5. Project Transfer and Estate Taxes

When disposing of a practice in a potentially taxable estate, be sure to analyze using favorable valuation discounts for loss of a key employee, lack of marketability, or minority discount for lack of control. The physician may avail himself to discounts by reducing holdings to less than 50 percent prior to death.

6. Know Your Liquidity Needs

Cash flow is the lifeblood of any medical practice so, cash is king.

Analysis of the inflow and outflow cycle determines practice solvency and value. The economy and health care reform doesn't usually allow physicians to gradually bow out of a practice and slowly decrease practice or personal cash flow needs. Office overhead doesn't go down part-time. If you want to sell your practice for a premium price, you need to keep the numbers up. Doctor colleagues need to keep practicing hard, full time, and diligently.

7. Identify Your Professional Successor

Professional succession planning ideally should begin three to five years before retirement. This is the key to transition success, passing on your practice to a like-minded successor. How does a doctor find someone suited to take over his or her life's work?

We are pretty much dead-set against the practice broker relationship or the third-party intermediary, and are highly in favor of the one-on-one mentoring philosophy. There is more than enough opportunity to befriend medical students, interns, residents, or fellows that you might feel akin to, and then develop that relationship over the years. Third-party brokers are like real estate agents; they just want to make the commissioned sale. They aren't necessarily as concerned with finding the perfect match to ensure a good legacy transition.

8. Seller Involvement

The key to successful succession planning boils down to how many of the selling doctor's patients can be transferred to the new doctor. The involvement of the selling doctor matters here. A system of financial earn-out arrangements can work well

The key to successful succession planning boils down to how many of the selling doctor's patients can be transferred to the new doctor.

Physician Successor Prospecting

Depending upon the opportunity, there are a number of ways to generate a list of potential physician successors:

- Direct mail using a purchased list culled from criteria such as medical specialty or location (The American Board of Medical Specialties (ABMS), the American Medical Association (AMA), and licensure boards can supply these lists.)

- Personal calls following recruitment fairs and specialty meetings

- Advertising in medical and specialty journals and on the web, Twitter, etc.

- Resident campaign using posted flyers and announcements

- Physician networking based on group member recommendations

- Medical staff office contacts at the local hospital or postgraduate training programs

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if the seller continues to be involved in the practice, and can create an incentive to make the transaction work.

Be sure to send a letter to all patients singing the buyer's praises. Sellers typically remain for six months (and usually for not more than a year) to ensure a seamless transaction. If the buyer expects the seller to treat patients during this period, make sure to pay separately for that—it shouldn't be part of the purchase price. When a deal fails, it's usually due to lack of seller commitment.

9. Mentoring and Follow-up

An important corollary to the aforementioned is a strong mentoring program. In fact, retaining a new physician takes just as much energy and time as recruiting one. New doctors require attention early on to be sure all is well. Mentoring is the best way a practice can nurture its long-term investment in succession planning.

The most successful retention efforts follow a planned timetable of activities to address all aspects of fitting into the work and community environment, for the doctor and family. It's important to have an orientation plan that builds in the hospital and clinic, too.

10. Contract and Close the Deal

When a practice price is agreed upon, sales contract, succession terms, and transitioning agreements present a plethora of personal, operational, and financing challenges for both parties. For example, you'll need to negotiate bank loans (if they are even available), payment rates and length, personal promissory guarantees, down payment offsets, earn-out arrangements, and uniform commercial codes (UCCs).

Medical practice succession planning is a complex and timely process, but a stepped approach will assist physicians in successfully accomplishing their transition to a new stage in life, following a productive and fulfilling clinical career. *MPD*

Additional Resources:

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SIDEBAR—*Factors for Establishing Your Practice's Fair Market Value*

Internal Revenue Service (IRS) Revenue Ruling 59-60 (1959-1, CB 237) lists factors to be used when appraising a medical practice, including:

- **Nature and history of the practice**
- **Economic outlook and condition of the health care industry or specialty**
- **Book value and financial condition**
- **Earning and dividend-paying capacity**
- **Value of any goodwill, contracts or other intangibles**
- **Value of comparable open market sales**
- **Degree of control represented by the amount of stock interest**

Highest and Best Use

The IRS computes value based on the "highest and best use" of the practice. This means that the practice will be valued at the highest possible worth that can be reasonably justified. Valuation methods include the *asset approach*, *income approaches*, and *market approach*.

Asset approach: This is primarily used for a practice that is worth more if it's sold in pieces rather than as a whole. The tangible asset value is added to the intangible goodwill value.

Income approaches: A going-concern practice has value in its ability to produce profits in the future. These profits represent a return on the investment (ROI) using these methods:

- **Discounted future earnings method: Projected future earnings are discounted to present.**
- **Discounted cash-flow method: The doctor has a cash reserve from which to draw if the practice is discounted to present value.**
- **Capitalization of earnings method: Expected earnings are divided by the capitalization rate.**
- **Capitalization of excess earnings method: Expected earnings that are not needed in the practice are divided by the capitalization rate.**

Market approach: A practice is worth the fair market value (that is, a price at which other similar practices are selling). Referred to as the *comparable method of valuation*, it should be used only when the comparable practice is truly comparable.

Medical practices depend on the highly specialized skill of physician providers. With the exception of real estate, the majority of practice value usually lies in intangible goodwill. There are two types of goodwill—and one is more valuable than the other.

1. Professional and Personal Goodwill
Professional and personal goodwill results from the charisma, knowledge, skill, and reputation of a specific practitioner and may include such characteristics as: (1) transferability lack; (2) specialized knowledge; (3) personalized name; (4) inbound referrals; (5) personal reputation; (6) personal staff; (7) age, health, and work habits; and, (8) knowledge of end-user patients. Because these attributes "go to the grave" with the individual physician and can't be sold, they have little economic succession value and are not, as a practical matter, transferable.

If this sounds unfair, think back to the last time a dentist, doctor, accountant, lawyer, or other professional you used for years decided to retire. Now, ask yourself: Did you stick with the person who took over the practice, or did you go elsewhere? When you leave a professional practice, the value plummets. If your patients don't like the new doctor for any reason, they will pull their files and seek another doctor. It's not uncommon for a professional practice to loose half of its patient base within three years of changing hands. Be-

cause of this high rate, most medical practices sell at a significant discount to their actual current value. Modern social media has only accelerated this "transition attrition rate."

Personal goodwill value has also declined of late as doctors become commoditized within the health care system. For example, consider how the rise of evidence-based medicine (EBM) and treatment guidelines decrease cognitive physician value as they strive to improve quality, move care down the treatment chain to mid-level providers, and decrease costs (for more, see *http://thehealthcareblog.com/blog/2011/04/21/are-decision-support-tools-turning-doctors-into-idiots/*).

2. Practice and Commercial Goodwill
Practice and commercial goodwill is defined as the propensity of patients (and their revenue stream) to return to the practice in the future. It includes characteristics like: (1) number of offices; (2) location; (3) multiple providers; (4) health information technology (HIT) systems; (5) years in business; (6) outbound referrals; and, (7) marketing endeavors, among others.

This goodwill component is increasing today as mergers and acquisitions fever grows for more health care corporations, medical franchises, physician-hospital organizations (PHOs), retail clinics, hospital chains, etc.

Note: For more information on medical practice valuation techniques, see the articles "How Much is Your Practice Worth?: Establish Your Practice's Fair Market Value," August 2011, *Medical Practice Digest*, pages 16-19 and "Understand the Art of Selling Your Practice" September 2011, *Medical Practice Digest*, pages 15-17.

ICD-10 Will Change Everything

Will you be ready?

PHYSICIANS
- **Documentation:** The need for specificity dramatically increases by requiring laterality, stages of healing, weeks in pregnancy, episodes of care, and much more.
- **Code Training:** Codes increase from 17,000 to 140,000. Physicians must be trained.

CLINICAL
- **Patient Coverage:** Health plan policies, payment limitations, and new ABN forms.
- **Superbills:** Revisions required and paper superbills may be impossible.
- **ABNs:** Health plans will revise all policies linked to LCDs or NCDs, etc., ABN forms must be reformatted, and patients will require education.

NURSES
- **Forms:** Every order must be revised or recreated.
- **Documentation:** Must use increased specificity.
- **Prior Authorizations:** Policies may change, requiring training and updates.

MANAGERS
- **New Policies and Procedures:** Any policy or procedure associated with a diagnosis code, disease management, tracking, or PQRI must be revised.
- **Vendor and Payer Contracts:** All contracts must be evaluated and updated.
- **Budgets:** Changes to software, training, new contracts, and new paperwork will have to be paid for.
- **Training Plan:** Everyone in the practice will need training on the changes.

LAB
- **Documentation:** Must use increased specificity.
- **Reporting:** Health plans will have new requirements for the ordering and reporting of services.

BILLING
- **Policies and Procedures:** All payer reimbursement policies may be revised.
- **Training:** Billing department must be trained on new policies and procedures and the ICD-10-CM code set.

CODING
- **Code Set:** Codes will increase from 17,000 to 140,000. As a result, code books and styles will completely change.
- **Clinical Knowledge:** More detailed knowledge of anatomy and medical terminology will be required with increased specificity and more codes.
- **Concurrent Use:** Coders may need to use ICD-9-CM and ICD-10-CM concurrently for a period of time until all claims are resolved.

FRONT DESK
- **HIPAA:** Privacy policies must be revised and patients will need to sign the new forms.
- **Systems:** Updates to systems may impact patient encounters.

AAPC

www.aapc.com/icd-10

By Robert James Cimasi, MHA, ASA, MCBA, AVA, CM&AA

Weigh CAPITAL Costs of Accountable Care Organizations

See if the potential savings are worth the capital investment.

Historically, the health care industry has promoted accountability as a means to improve health and lower costs. This concept emerged with the Committee on the Costs of Medical Care in 1932 and progressed to represent a key component of Health Maintenance Organizations (HMOs) and managed care.

Accountable Care Organizations (ACOs) perhaps represent the newest accountability-centered construct, in which a set of providers, usually physicians and hospitals, are held accountable for both the cost and quality of care delivered to a specific local population.[1]

In 2005, the Physician Group Practice (PGP) Demonstration project tested whether 10 physician groups could achieve decreased overall medical costs by providing financial incentives for successfully improving patient outcomes through comprehensive patient care coordination and implementation of new care management strategies into daily operations.[2] A 2006 discussion between Dr. Elliott Fisher of Dartmouth Medical School and Glenn Hackbarth of the Medicare Payment Advisory Commission

(MedPAC) coined the term "ACO."[3] This name, and the PGP project, led to a 2009 MedPAC report, "Improving Incentives in the Medicare Program," which established a plan for large-scale implementation of ACOs. The MedPAC plan was signed into law in March 2010 through the Medicare Shared Savings Program (MSSP), section 3022 of the Patient Protection and Affordable Care Act (ACA).[4]

What Is an ACO?

ACOs are ostensibly designed to increase health care quality and decrease costs by delivering coordinated care to patients, while providing physicians with greater autonomy than generally seen in integrated health systems.[5] To incentivize quality versus quantity of care, ACOs use value-based purchasing, where the provider ACO and the insurer share savings achieved by coordinated and better care.[6] Whether an organization is a private or federal ACO depends on if savings payments are contracted through a private insurer or the Centers for Medicare & Medicaid Services (CMS).[7]

Federal ACOs refer to those entities approved by CMS to receive shared savings payments for Medicare beneficiaries. With three-part health

care reform (better care for individuals, better health for populations, and lower expenditure growth) in mind, the ACA mandated that CMS create rules for the formation, operation, and reimbursement method for eligible organizations.[8] While the final rules have not yet been released, CMS' March 31, 2011 proposed rules set the groundwork for entities eligible for federal ACO status, these entities' structure, and quality metrics required for shared savings payments.[9]

Private ACOs realize shared saving through insurer contracts instead of Medicare incentives, and are generally formed one of three ways:

(1) through shared savings contract with third-party payers;

(2) insurer-run medical institutions; or,

(3) health systems with internal health plans.

Systems become financially invested in the health of patients through coordinated high-quality care, without being subject to the heightened financial risks caused by the uncertain outcomes and tight scrutiny of the federal MSSP.[10] Although private ACOs use a variety of reimbursement

models (capitation, bundled payments, etc.), their value and capital costs are similar to federal ACOs.[11]

Value Metrics for Accountable Care

Value is the expectation of future economic benefit. In health care, value has two prongs: value to society and value to providers. Value to society is the future benefit to the population as a whole (e.g., patient outcomes or quality improvements and lower price of health care), while the value to providers is focused on economic returns to individual enterprises, assets, and services. To analyze value, each metric must have a means of being measured—for example, benchmarked to industry norms and historical trends.

The stated intention of ACOs notes their potential value to society: better outcomes for individuals and populations, accompanied by lower growth in expenditures.[12] It is hoped that ACOs can achieve both of these goals, supplying value measured by savings achieved, as well as better health outcomes. Quality of care can be measured through patient outcomes metrics, including, among others: average length of stay; number of readmissions; and, patient satisfaction surveys. Federal ACOs are required to submit 65 quality metrics annually.[13]

The future value of ACOs to providers can be measured through provider expectations related to greater financial returns and value from their practices by lowering practice expenditures through administrative efficiency, coordinating patient care, and incentivizing reimbursement payments from better patient outcomes.

To prepare for ACOs, many hospitals are acquiring physician practices. From a physician perspective, hospital employment provides lower risk and greater work-life balance.[14] Hospitals positioning for ACO status are also acquiring increased market share, adding financial value from higher leverage in negotiating with payers.[15]

It's been said that value is best predicted by the performance of the immediate past. The lack of historical accounting presents many uncertainties leading to the perception of investment risk, which affects value. For example, the translation of lower costs for providers into lower costs for patients is not reflected in the history of powerful managed care providers, where the opposite is generally true (that is, greater power of providers tends to lead to larger costs for patients).[16] An ACO's value—either to society or to providers—must be weighed against the prospective costs.

Capital Planning: Prepare for the Costs of ACOs

Substantial financial capital is required for a health care organization to position itself as a functional ACO.[17] Capital costs include:

- clinical and administrative coordination systems;
- information technology needed for coordination and quality reporting; and,
- potential increases in clinical staff and practice expansion, among others.[18]

CMS has estimated the investment requirements for federal ACOs to be $1.8 million, but commentators have

estimated this number to be closer to $11.6 million for small ACOs, and $26.1 million for medium ACOs.[19] A significant capital infusion must be made to create and sustain an efficient ACO, whether federal or commercial. Based on several case studies of hospitals that have begun positioning themselves for ACO status, as well as results from early pilot programs, the American Hospital Association (AHA) has estimated that the initial start-up costs for ACOs could be approximately $5.3 million for small ACOs and $12 million for medium ACOs. AHA has further estimated that the ongoing costs for ACO operation could be $6.3 million for small ACOs and $14.09 million for medium ACOs.[20] As of this date, it remains uncertain as to what actual payouts ACOs can expect from CMS or commercial contracts.

Risk vs. Reward

While the health care industry as a whole is generally supportive of the accountable care concept, there is much controversy as to whether the potential savings are worth the capital investment.[21] With costs in the millions and rewards hypothetical, and given that health care entities—especially hospitals—heavily rely on borrowed money and philanthropy for capital requirements (which are harder than ever to achieve in the current economic climate), only those organizations with the necessary infrastructure already in place (that is, integrated health systems) are likely to successfully transition to an ACO.[22] Smaller health care entities may struggle in ACO development due to limited access to capital and the inability to accept

financial risk.[23] Some advisors suggest that providers not put all their eggs in one ACO basket, and instead examine joining the MSSP in addition to commercial ACO-like contracts.[24]

Future Outlook

The altruistic ideals to contain costs and integrate health systems through the 1990's HMO model of managed care resulted in a backlash against the capitated forms of payment that had resulted in physicians underproviding care.[25] To succeed, ACOs will need to demonstrate what many believed managed care lacked: that is, public understanding and support; payer support; partnerships between physicians and hospitals; up-front financial resources; and, sufficient time for the integration process to occur.[26] As ACOs grow from a concept into operational organizations, it should become clear whether they were worth the price and actually meet the goals of health care reform in creating value for both society and providers. *MPD*

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4   "Chapter 2: Accountable Care Organizations By MedPAC, Report to Congress: Improving Incentives in the Medicare Program," June 2009, Page 39; "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice" Federal Register, volume 76, No. 67, April 7, 2011, page 19531.

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12   Federal Register, volume 76, No. 67, April 7, 2011, page 19531.

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23   Fishman, June 17, 2011.

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25   "Accountable Care Organizations: Will They Deliver?" Marsha Gold, Mathematica Policy Research, Inc., January 2010, page 5.

26   Crosson, page 1254.

Will Your Documentation Be Ready for ICD-10?

Documentation dissection highlighting the increased specificity required to code for ICD-10-CM:

7th Character
Injury codes require a 7th character extender that identifies the encounter. Documentation must be clear so that the correct extender can be applied.

Applied Specificity: Concussion
For a concussion documentation needs to include if the patient suffered loss of consciousness.

Acute vs. Chronic
Documentation of the patient's condition must include acute or chronic to assign the most appropriate ICD-10 code.

S: Mrs. Finley presents today after having a new cabinet fall on her last week, suffering a concussion, as well as some cervicalgia. She was cooking dinner at the home she shares with her husband. She did not seek treatment at that time. She states that the people that put in the cabinet in her kitchen missed the stud by about two inches. Her husband, who was home with her at the time, told her she was "out cold" for about two minutes. The patient continues to have cephalgias since it happened, primarily occipital, extending up into the bilateral occipital and parietal regions. The headaches come on suddenly, last for long periods of time, and occur every day. They are not relieved by Advil. She denies any vision changes, any taste changes, any smell changes. The patient has a marked amount of tenderness across the superior trapezius.

O: Her weight is 188 which is up 5 pounds from last time, blood pressure 144/82, pulse rate 70, respirations are 18. She has full strength in her upper extremities. DTRs in the biceps and triceps are adequate. Grip strength is adequate. Heart rate is regular and lungs are clear.

A: 1. Status post concussion with acute persistent headaches
2. Cervicalgia
3. Dorsal somatic dysfunction

P: The plan at this time is to send her for physical therapy, three times a week for four weeks for cervical soft tissue muscle massage, as well as upper dorsal. We'll recheck her in one month, sooner if needed.

External Cause
The falling cabinet is what caused the injuries. Description of the cause is required.

Activity
In ICD-10 the activity of the patient needs to be documented. An activity code is only used once at the initial encounter.

Location
Documentation needs to include the location of the patient at the time of injury or other condition. In ICD-10 the details include the actual room of the house the patient was in when the injury occurred.

Relief or No Relief
Intractable vs. non-intractable are an inherent part of the ICD-10 code for headache and documentation needs to be clear for the appropriate code to be assigned.

ICD-10 Coding	
S06.0x1A	Concussion with loss of consciousness of 30 minutes or less initial encounter
G44.311	Acute post traumatic headache intractable
M54.2	Cervicalgia
M99.01	Segmental and somatic dysfunction of cervical region
W20.8xxA	Struck by falling object (accidentally) initial encounter
Y93.g3	Activity, cooking and baking
Y92.010	Place of occurrence, house, single family, kitchen

One of the largest problems following the October 1, 2013 implementation date for ICD-10 will be documentation insufficient to support the specificity required for the new ICD-10 code sets. We believe a behavioral change in documentation habits for most providers will be necessary—and now is the time to start preparing.

Center Practice Marketing
Around Modern Women

By Jamie Verkamp

When it comes to family health care, mother knows best.

A 2010 study by *Advertising Age* and Boston Consulting Group concludes that women make 73 percent of household financial decisions. This includes health care decisions, and these women are in search of a better health care experience for themselves and their families. As new generations of women enter motherhood with growing household incomes under their control, they drive a communication shift from traditional standards of health care marketing, and how we look to increase patient volumes.

In defining the new generation of mothers, let's look specifically at the women of the Millennial generation and Generation X, which include women aged 18-46. This patient population can be a great resource to your practice as you tap into the nearly 4.3 trillion dollars of spending these women under age 44 control in the United States. (*Advertising Age* and Boston Consulting Group study 2010).

These women challenge communication standards and aspirations set by their mothers. No longer does "having it all" mean wanting to do it all. In fact, these generations of mothers understand that they may not be able to be the perfect mother, wife, friend, and employee but instead are in search of an effective balance between the many facets of their lives. To achieve this, they increasingly look for products and services to add convenience and make them feel less guilty about not striving for perfection. These women communicate that they want to be seen as individuals, and that "one-size-fits-all" options do not help them to achieve their life betterment.

Internet Is Integral to Women's Lives

These modern mothers are also networking savvy, especially social networking savvy. They turn to the Internet for work, as well as to play, and add value to their lives and the lives of their families. Social networking is central to women's Internet experience, and their use of social networking sites (such as Facebook) are nearly one-third higher than males their age (Comscore "Women on the Web: How Women are Shaping the Internet" June 2010). A February 2011 study through iVillage reports four

out of five women cite that anonymous peer networking and sharing common experiences drive them online for health matters, and 49 percent report say that online is the first place they go to research a health question—that's nearly double the number who say they would go to a doctor first.

Lessons for Health Care Marketing

Online networking and communication are staples in the lives of these modern mothers, but how does this information pertain to a physician, an administrator, or a hospital marketer looking to grow an organization through increased patient volumes?

your organization. These mothers are social in nature, and when they find a service provider that understands their need for life betterment, they are willing to share it with their many peer groups.

When developing a marketing message to reach this modern mother market, think about the resources you have within your organization. Your physicians are experts within their specialty, and they have a wealth of valuable health information to share with your community and patients. Capture that expertise on video by prompting your physicians to talk about common health ailments they treat, the frequently asked questions

appreciation for this valuable resource through comments on the practice's Facebook page, her own Facebook page, and many conversations with her other new mom friends. This video was certainly an added value to patients, and a marketing win for the practice by increasing word of mouth marketing efforts.

2. Communicate on their terms.
Don't expect the modern mom to seek you out; you must go where she is already communicating. When looking to share your message of education, convenience, and patient focus, look for creative ways to do so. Instead of placing a newspaper advertisement, a Facebook ad may bode well in your

> "... four out of five women cite that anonymous peer networking and sharing common experiences drive them online for health matters ..."

Health care marketers must remember these two concepts when looking to attract and retain this modern mother as a patient:

1. It's all about the message.
Communicate and converse with women, don't simply market your practice, your physician, or your health services to them. These generations are looking to learn about their health options and be active participants in the health care process, both individually and with their families. If you provide them with options, add value to their lives, become a trusted health resource by making educational content available to them, and make your services as convenient as possible, you will win their business and a key advocate to share the message about

(FAQs) of preparing for surgical procedures, home care after procedures, and how to stay safe and healthy to avoid trips to the doctor's office. (Yes, you can use self-produced videos in your marketing strategy. No longer are professionally produced videos a necessity; in fact, self-produced videos are preferred in most social media outlets.)

One pediatric practice captured a physician on video talking about proven ways to sooth newborns into more restful sleep at night. A tired mom was up at 2 a.m. with a restless baby and searching online for ways to help get her child to sleep. She pulled up this video by her pediatrician, tried a few of the tips he suggested, and one worked. She shared her relief and also

strategy. Be sure your online presence is strong. Use social networking tools to connect with this patient population.

You may also think about using local resources such as "mom groups" and other women's networking organizations to contribute your physicians' expertise. This allows the practice to become a health resource in the community, rather than an advertiser in a static medium such as billboards or the Yellow Pages.

When diving in with an online strategy, the three key outlets to start with are your practice website, Facebook, and YouTube. The practice website is your online business card or brochure; it's a home or reference point for all of the information you'll be sharing with

your target audience. Facebook and YouTube work very well in health care because most users of social networking start with these two outlets. In fact, 87 percent of people under age 30 are Facebook users, according to Eric Qualmann, Socialnomics (*www.socialnomics.net/2011/08/16/social-network-users-statistics*). With this heavy penetration, when looking to maximize social networking power with the modern mom population, your efforts are best spent starting where they are already networking. The more personal you can make your chosen forms of communication, the more valuable this group of mothers will see your experts and the health care services you offer.

As you look to grow your patient volume and structure your marketing strategy to connect with the modern mother, be sure to look within your four walls. Remember: Mothers are in search of a better health care experience, and they expect to be treated individually. If your organization still has a physician- or staff-centric culture, it's time to change that culture to that of a clear focus on your patients. And don't think simply changing your mission statement will suffice. This modern mother is very keen on detecting authenticity in marketing messages. She will see right through that "renewed focus" if, when she calls your office, she is greeted by a less-than-helpful telephone receptionist,

or if she comes in for a visit only to feel processed like a medical chart rather than a person. Not only will she not be back, but chances are she'll share her negative experience online with her peers. *MPD*

Jamie Verkamp is a health care consultant who has worked and owned her own businesses in the industry for more than 10 years. Her background in marketing and consumer behavior pairs with her involvement in health care, enabling her to train health care leaders to understand patient behaviors. As managing partner at (e)Merge, a medical growth consulting firm, Jamie works with medical professionals in hospital and clinical settings to improve their patients' experience and to increase her clients' referral volumes and bottom lines. She shares her knowledge at more than 30 events per year and she is published in multiple industry publications.
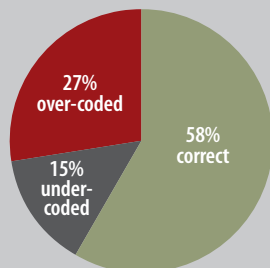
Letter to the Editor

More Resources for Patient-Centered Medical Homes

I'd like to thank you for your recent article, "Get Comprehensive Information on PCMHs" (September 2011, pages 10-13), which explored patient-centered medical home (PCMH) health care delivery models. I'd also like to offer additional information for readers who may be interested in learning more about PCMHs.

A valuable resource for those wishing to assess the success of PCMHs across the country is the Patient-Centered Primary Care Collaborative (PCPCC), *www.pcpcc.net*. The PCPCC monitors the outcomes of PCMH demonstration projects across the country since 2006, and produces public pilot reports on their success. One of their most informative reports, "Patient Centered Primary Care Collaborative and the National Patient Centered Medical Home Movement," released in 2009, provides an overview of activity covering 27 multi-stakeholder and other pilots across 18 states. This report shows health systems achieving a 14 percent decrease in hospital admissions, improvements in diabetes and heart disease care, a 9 percent reduction in costs, and a return on investment greater than two to one.

As of July 2011, the National Committee for Quality Assurance (NCQA) has granted PPC-PCMH Recognition to approximately 2,500 sites and 13,000 clinicians within practices of all sizes. Since the program's inception in 2008, much has been learned. Through this growth process, NCQA has revised the 2008 PPC-PCMH Standards to reflect these points in the latest version, PCMH 2011, which was released by NCQA in January 2011.

Each of the four organizations offering PCMH accreditation programs offers benefits. Among the specific values of achieving NCQA recognition are:

- Identification as a recognized PCMH to health plans and industry professionals
- Certificate of recognition
- Advertisement as a PCMH on NCQA website
- Media kit/marketing and advertising guidelines to help promote recognition within local community
- Five press releases to their choice of publications
- Monthly distribution in the list of recognized physicians to sponsors
- Maintenance of certification part IV credit from American Board of Family Medicine
- Possible pay-for-performance opportunities through state agencies, health plans, and regional individual practice associations

For additional information on the NCQA standards for PCMH 2011, visit the NCQA website: *www.ncqa.org/recognition.aspx.*

Paige Robinson
Manager, Recognition Programs/ Customer Outreach, NCQA

EHRs Alter Physician Practice Roles

By James M. Taylor, MD, CPC

Clinician and coding staff roles will change as EHRs emerge in practices.

Many new tools have been introduced into the clinical documentation and coding environment, but no previous change has intimately integrated clinical coding and documentation with the revenue cycle to the same extent as the electronic health record (EHR). EHRs seamlessly and simultaneously link clinical documentation, coding, and claim generation. This concept of auto-adjudication can be a provider's biggest victory—or worst nightmare.

Recent financial incentives made available by the American Recovery and Reinvestment Act of 2009 (ARRA) is motivating providers to implement an EHR, and will continue to do so over the next few years (*www.recovery.gov*). Financial penalties beginning in 2015 for failure to implement an EHR is another good motivator.

But providers still face the inevitable challenge of implementation and its associated impact on their practices. Coding in an EHR can have many unintended consequences. For example, physicians suddenly find themselves in an environment that places new responsibilities and "rules" on their documentation.
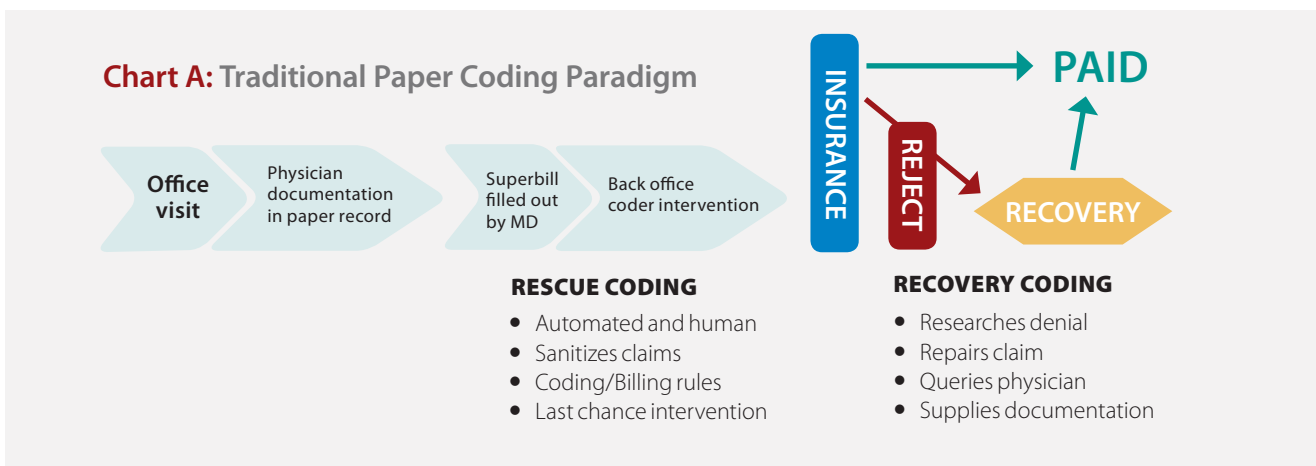
The objective of the EHR is to transform the physician's documentation into coding and billing terms that drop onto claims that leave the facility immediately. With ICD-9-CM, HCPCS Level II, and CPT® codes being embedded in documentation, physicians are becoming "de facto" coders, directly affecting claim quality. No longer able to document and code in the usual fashion, physicians must choose diagnoses and procedure codes that are correct in the clinical setting, as well as align with coding and billing constraints.

For this to work, however, physicians must know coding and billing rules. And coders need to evolve from back-end "rescue and recovery" coders to clinically embedded auditors and educators.

Impact on Coders: Rescue and Recovery Transitions to Auditor and Educator

Just because physicians do all of the coding in an EHR does not mean that providers should reduce their coding and billing staff. Denver, Colo. hospital Kaiser Permanente, for example, has seen the roles of both coders and physicians evolve due to EHR implementation—a technology that improves faster than it can be implemented.

Transitioning Role of Coders from Rescue and Recovery to Educator and Auditor

Chart A: Traditional Paper Coding Paradigm

Office visit → Physician documentation in paper record → Superbill filled out by MD → Back office coder intervention → INSURANCE → PAID / REJECT → RECOVERY → PAID

RESCUE CODING
- Automated and human
- Sanitizes claims
- Coding/Billing rules
- Last chance intervention

RECOVERY CODING
- Researches denial
- Repairs claim
- Queries physician
- Supplies documentation

Chart B: New Proactive Paradigm

Office visit → Physician documentation coding → Auto-adjudication → Charge router coding rules → Resolute production coders → INSURANCE → PAID / REJECT → RECOVERY → PAID

PROACTIVE EDUCATION
- Documentation improvement to support code selection
- Correct CPT® selection
- J-code quantities
- Diagnosis specificity

RESCUE CODING
- Minimal

RECOVERY CODING
- Researches denial
- Repairs claim
- Queries physician
- Supplies documentation

The coder's traditional primary role is to add correct codes, modifiers, and other essential coding elements to ensure accuracy before claims leave the business office. Coders essentially rescue claims from denial. Another key function is recovering denied claims. Coders recover a claim by addressing the issue(s) that caused its rejection by adding additional information, and by querying the physician when necessary.

In an EHR environment, however, physicians "choose" the codes as they document a service. And the role of the coder is to ensure complete and accurate documentation through physician education.

In the new paradigm, coders educate physicians so they know:

- All tests must have a linked diagnosis to pass correct coding initiative and other edits built into payers' software

- Which procedure display name to use for benign versus premalignant codes

Impact on Physicians: Drowning in emails?

"Secured messaging" is EHR-speak for patient-to-doctor emails. When results come in, one of the options in an EHR setting is to notify the patient via email instead of a phone call. Sometimes, this generates additional questions—both related and unrelated to the original problem addressed—lengthening the process. With high deductable plans and higher co-pays, patients attempt to get the care rendered through free emails versus an office visit or waiting on hold on the phone. Kaiser Permanente's scheduled doctor-patient telephone visits went up 300 percent from July 2009 to July 2011. This time-consuming problem remains unsolved.

IM Visit Frequency

Email Encounters

24000	
18000	
12000	

Jul 09   Nov 09   Mar 10   Jul 10   Nov 10   Mar 11
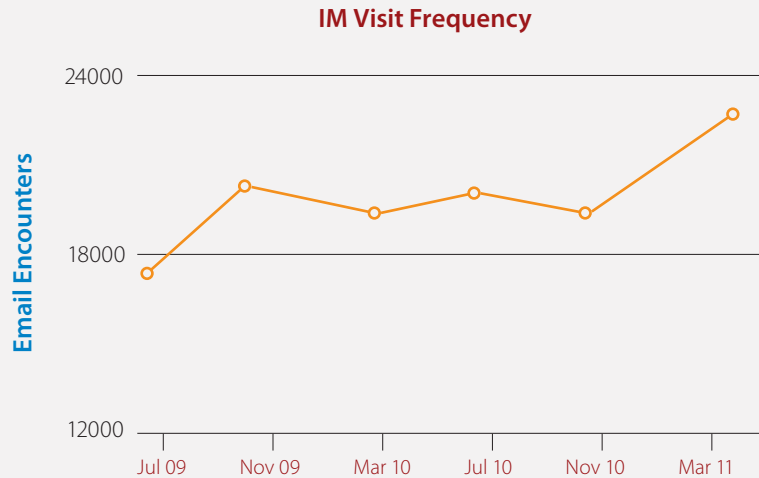
- Freezing two premalignant lesions requires entering both the base code and the add-on for the second through 14th lesion

- How to do all of the above in the "Procedure" and "Diagnosis" entry fields (Just show me what to type, where)

- Most importantly, how to code electronically with the fewest "clicks"

Having the skill set to accomplish this training requires a paradigm shift of coders being "introverted librarians" to being confident, on-site educators who can effectively communicate with busy clinicians.

Kaiser Permanente looked for specific skills when hiring 25 coding educators for its 1,000 physicians. Requiring the following skills took the organization from being a coding-averse health maintenance organization (HMO) to one with 95 percent coding accuracy:

- Certified Professional Coder (CPC®) or Certified Coding Specialist - Physician-based (CCS-P) certification and two years of experience in education

- Ability to pass a mock feedback session with the organization's physicians

- Professionalism in demeanor, dress, and communication style

- Ability to become competent domain experts in the EHR diagnosis and ordering fields

The mock feedback session was videotaped. During the session, job applicants were asked to demonstrate the ability to relate:

- Coding concepts (Why do I need to enter this information?)

- In-clinic speak (not coding speak)

- EHR context (What do I type, where?)

Impact on Physicians: De Facto Coders

Although physicians will always need a traditional subjective, objective, assessment, plan (SOAP) note to document patient care, the EHR changes the way the documentation is created and appears. The EHR also facilitates linking documentation directly to revenue cycle functions with no intermediary.

For example, during a visit for a patient's uncontrolled diabetes, the physician notices the patient's ear has two actinic keratoses (AK) that require cryotherapy. When documenting the visit in the EHR, the physician chooses diabetes mellitus type II from a drop-down menu and links it to a fasting blood sugar that was ordered during the visit. He also chooses AK from a drop-down menu and links it to a cryotherapy procedure display name. When printed, the electronic note looks no different than a dictated note in the paper world. Because the process was completed in an EHR with embedded codes, however, a hidden level of coding flows directly to the billing system.

The physician actually chose 250.00 *Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled* and linked it to 82947 *Glucose; quantitative, blood (except reagent strip)*, which will pass claims software edits. He also chose 702.0 *Actinic keratosis* and linked it to 17000 *Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion*

and +17003 *Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion).*

The software recognized the combination of services and codes and applied modifier 25 *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service* to the claim. Full, prompt payment is anticipated.

Impact on Physicians: Computer Savvy Technicians?

When implementing an EHR, physician behavior becomes very interesting and very predictable. The following observations have been made by many in organizations implementing the keyboard-based documentation tool:

1. **Docs don't scroll:** It better be in plain sight or you won't get it.

2. **Medical spam is still spam:** Pop-ups are frequently overridden if not minimized and used effectively.

3. **Clicks are the new currency:** If you want it done, design it with minimum clicks.

4. **Let the tool do the work:** Maximize configuration options to minimize work effort.

Make EHRs Work

Too often, providers rely on the configuration of the EHR to drive accurate claims. A certified EHR that meets ARRA meaningful use criteria is the starting point, not the final answer. By shifting coding resources from the back end of the revenue cycle to the front end, providers can enjoy significantly higher auto-adjudication rates with very high accuracy rates for diagnoses, procedures, and evaluation and management (E/M) coding. This benefit results from EHR implementation and a successful paradigm shift.

A physician as a de facto coder is a frightening thought. With methodical procedure and diagnosis display name maintenance, aggressive drop-down list management, and proactive rather than reactive coding education, however, this problematic concept can become a peaceful and productive reality. MPD

James M. Taylor, MD, CPC, is medical director of revenue cycle, Kaiser Permanente, Denver and serves as the chairman of the board of directors for the 1,000 physician group: Colorado Permanente Medical Group. He can be reached at james.m.taylor@kp.org.

By Craig Bridge

Pursue Optimal Efficiency

Use six key workflow strategies to improve your bottom line.

Successful practices provide quality patient care while achieving good revenue cycle performance. They seek to be more efficient. From the front end of the office to the back, each employee finds ways to be more productive and ensure that the revenue stream is maintained.

In such practices, revenue cycle management is not haphazard, but involves specific workflow strategies that streamline processes, enhance productivity, and bolster patient satisfaction. Let's take a closer look at six specific workflow strategies to help your practice improve overall efficiency and, ultimately, strengthen its bottom line.

Strategy No. 1:
Communicate Proactively with Patients

Share information proactively with patients about what they can expect from your practice—both clinically and financially—to help avoid misunderstandings, enhance patient satisfaction, and encourage repeat business. And, have an employee make courtesy calls prior to patients' visits to explain both payment policies and expectations and to help patients become aware of their out-of-pocket costs.

This call also provides the opportunity to address any potential payment problems early on, and avoid reimbursement issues on the back end. Informed patients improve morale because back-end staff spends less time chasing down payments and talking to patients who are dissatisfied because they did not fully understand their obligations to the practice.

Strategy No. 2:
Verify Eligibility Upfront

To support proactive communication, revenue cycle staff must know a patient's insurance coverage, co-pay, and other financial details. Verifying this information prior to a patient's arrival at the practice allows staff to determine upfront whether a procedure is allowable through insurance; what the fee schedule is for the procedure; and the approximate patient responsibility. This helps avoid unwelcome surprises, minimizing practice risk and preventing physicians

from providing services for which they will not be paid.

Eligibility verification can be done manually or automatically. In a manual process, assigned staff members contact insurance providers via phone or website to verify patient benefits and eligibility. An automated process, which involves verification software, requires fewer staff resources and can lead to quicker eligibility verification. Either way, verification should be done prior to the patient visit.

Strategy No. 3:
Seek Prior Authorization

This is critical because failure to obtain proper authorization can have a drastic affect on practice income. Insurers will not pay for procedures if the correct prior authorization is not received, and most contracts restrict practices from billing the patient in these situations.

Although necessary, keeping track of prior authorization policies is challenging. Each health plan has its own set of requirements, which can change frequently. Some Medicaid payers, for instance, request one "blanket" referral authorization before patients see certain specialists; the specialist is not required to obtain prior authorization for every procedure. Other plans are much more restrictive, approving prior authorization for specified procedures only when certain criteria and diagnoses are met.

Here are three actions you can take to help navigate the prior authorization process:

1. **Designate someone to oversee all authorizations.** This allows a particular individual to become knowledgeable about each payer's unique requirements. This person should track the authorizations allowed and used for procedure codes and visits, and be diligent about obtaining authorizations. By gaining a more thorough understanding of payer policies, this person can better fight inappropriate authorization denials.

2. **Open the lines of communication.** Two-way communication between physicians and authorization staff is essential. Providers should document completely and

An important way to improve the timeliness of charge entry is to ensure coding staff has a solid understanding of ICD-9, ICD-10 (prior to October 2013), CPT®, and HCPCS Level II codes, and modifiers.

tell staff why a patient is being seen, so staff can inform providers about the treatment options the patient's payer will accept. Providers can then make treatment decisions based on all relevant knowledge.

3. **Leverage technology.** It can be helpful to develop a spreadsheet listing the guidelines for payer authorizations, including which specific codes require authorization. The spreadsheet should explain what justifies medical necessity for each procedure, according to each payer. Using this tool, you can quickly decide when to submit an authorization request. Note: Some payers publish their pre-authorization guidelines on their website, while others require you to call and request these.

Strategy No. 4:
Ensure Timely Charge Entry

Lagging charge entry can delay payment and hinder accounts receivable (A/R), negatively affecting your practice's bottom line. An important way to improve the timeliness of charge entry is to ensure coding staff has a solid understanding of ICD-9, ICD-10 (prior to October 2013), CPT®, and HCPCS Level II codes, and modifiers. Hold meetings once or twice a month for coding staff to discuss coding-related issues and new developments to make sure everyone is up to speed on current requirements.

Educate physicians on the importance of timely charge entry, as well. Such education may involve explaining the consequences of delayed charge entry, and how those consequences affect physicians directly.

Once coded, claims may be run through claim scrubbers, clearinghouse applications, or other tools that verify accuracy. By ensuring a clean claim upfront, your practice can avoid costly delays and reimbursement headaches from denials down the road.

Strategy No. 5:
Track Denials

Don't underestimate the importance of following up on denials. They often can be reversed on appeal; even if they cannot, they can help identify flaws in upfront processes

that can be fixed to prevent further denials. Typically, there are filing deadlines associated with appeals, so you should run denial reports daily to support quick identification and response.

Strategy No. 6:
Provide Effective Cross Training

Although it is a time-intensive endeavor, cross training can bring more to your practice than just staff coverage during illnesses or vacations. When done well, cross training promotes better patient service and improves financial performance by broadening the knowledgebase of every employee.

Thoroughness is the key to a good cross-training program. Offering front-desk staff only a high-level view of back-office operations, for instance, is not enough. Instead, solid cross training should reveal in detail how front-desk tasks affect the back-end, and vice versa. An effective program will also:

- Engage the most experienced individuals in the "teaching" roles
- Map out specific learning objectives for each staff member
- Occur frequently (ideally, twice per year, or more frequently in instances of high staff turnover)
- Allow staff members to experience both morning and afternoon shifts during training, with no department having more than one person cross-training at a time

These workflow strategies require commitment and buy-in from everyone in your practice—including providers, administrators, and staff. While not always easy to implement, these strategies can enhance revenue cycle management and improve efficiency, ultimately helping your practice realize measurable financial gains. *MPD*

Craig Bridge is the chief operating officer at Navicure, a leading web-based medical claims clearinghouse. For more information about Navicure, visit them at **www.navicure.com** or call 877-409-5828.

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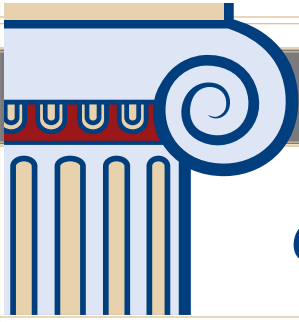
Legal Forum

Can I Steer Clear of a Litigious Patient?

According to an article, "Doctors' Complaints About Patients' Behavior," featured in About. com's Patient Empowerment section, the following complaint was cited in an informal survey of more than three dozen health care professionals as a reason why a physician may refuse to see a patient: "Some patients file lawsuits. While some lawsuits are justified and fair, others are not … You can't blame a doctor for not wanting to treat a patient who is regularly litigious." (*http://patients.about.com/ od/doctorsandproviders/a/ doctorcomplaints.htm*)

Question:

If a patient has a history of litigious behavior, are there any legal barriers you are aware of to refusing to see that patient?

Response:

Aside from being the on-call doctor in an emergency room (ER) where the Emergency Medical Treatment and Active Labor Act (EMTALA) is applicable, nothing obligates a physician to accept a particular patient into care. Once a doctor-patient relationship exists, nothing obligates the doctor to continue the relationship provided that prior to dismissing the patient from care, the physician does so in compliance with state licensure standards regarding abandonment. In most cases where a doctor-patient relationship al-

ready exists, and ongoing management is necessary, the doctor can terminate the relationship by providing the patient with a list of other doctors who can take over management of the patient's condition and by providing a reasonable period of time for the patient to get established with one of those doctors. These rules are state-specific, so be certain to review your state statutory and regulatory requirements governing termination of a doctor-patient relationship. *MPD*

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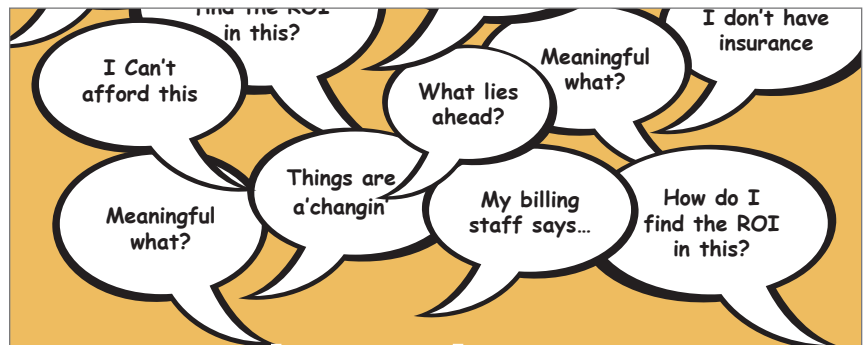
Word on the Street

Each month we'll share what the word on the street is.

Question: According to CMS only 6% of the 77,000 providers registered for the Meaningful Use Program have received an incentive payment. What has been your biggest challenge associated with being able to collect an incentive payment?

Curious what your colleagues think? We'll pose the question; you share your experiences.

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By Meredith Gould, PhD

Create an Online Presence that Works for You

Engage health care consumers online.

It's hard to imagine any medical practice, of any size, functioning without an online presence these days. At minimum, this presence should take the form of a website. Whether you want to add social media to your online presence or not depends on a few key factors.

Like other business decisions, those about medical practice marketing must be carefully considered. Deciding how, when, and where to establish and maintain an online presence requires strategic thinking. And—let's face it—thinking strategically requires a level of time and focus that can be difficult to muster during the daily bustle of managing a medical practice. Given the increasingly complex reality of Internet-based options, it also requires a specific knowledge and skill set.

It's no wonder why many medical practices try to get by with doing next to nothing in the form of an online presence, making do with websites that are behind the times; or, worse, squandering big bucks on snazzy websites that are all flash (excuse the pun) and little substance. This begs the question: What constitutes a minimally acceptable and useful online presence?

Why Be Online?

Time moves very quickly in the world of online communications. As recently as five years ago, medical practice managers could and did successfully argue that patients neither wanted nor needed online access. This is no longer true, even for practices that provide care to an aging patient population.

If aging patients aren't computer-savvy, you can safely assume they have children, grandchildren, and caregivers who are. Social observers have noted how the desire to stay in communication with children and grandchildren accounts for the upward shift in age of those using Facebook® (social media), Skype™ (VoIP technology), Flickr® (photo-sharing), and YouTube (video sharing).

Your medical practice needs to be online because your patients and their families are online. What do they want and need from your website? Probably more than you'd expect.

Build Your Website

We know, primarily from current research by social scientists at the Pew Internet & American Life Project, that the Internet has become the go-to place for health information. It isn't unusual for patients to show up for appointments with printouts or handwritten notes they've generated after "Googling" conditions (real or imagined).

This doesn't mean your website needs to provide the same content as WebMD, Mayo Clinic, or PatientsLikeMe.com. But it would be smart to let both established and prospective patients know your practice is in synch with the times by providing ways to:

- Read up on the qualifications and experience of medical and administrative personnel
- Book or confirm appointments
- Reach your office via private or public transportation, and where to park
- Download and fill out history and insurance forms in advance
- Learn how to prepare for office-based lab tests
- Request pre-certifications and referrals
- Leave messages for medical and administrative personnel
- Download and submit insurance forms
- Explore third-party sources for health education and medical information

It isn't enough to simply have some or all of these features available for visitors to your website. Information must be easy to find, read, and understand. Your website must also:

- Include intuitively easy navigation
- Offer accessibility options for visitors who may have difficulty seeing or typing
- Invite engagement with a pleasing color palette and readable fonts

If your website is more than three years old, it probably needs tweaking—if not a complete do-over.

How Does Social Media Fit in?

Social media are broadly defined as online platforms that generate and sustain interaction between individuals; individuals and groups; and, groups. Once considered the quirky domain of communication among Millennials, social media are now commonly used for educating consumers and promoting business. This is accomplished via interactions that generate community around shared interests.

During the past four years, a staggering number of health care and patient communities have emerged on Facebook

- Who in your practice can monitor the account and interact with visitors?

Having neither the time nor inclination to explore these issues is a good sign that highly interactive social media, such as Facebook and Twitter, probably won't work for your practice as a whole. The good news is: Your practice probably won't suffer as a result.

Make It Happen

Online engagement requires focused time and energy, as well as an ongoing financial commitment. The ever-growing sophistication of health care consumers also means you'll need to commit to developing and sustaining an online presence that works well.

Plan to invest wisely in vendors with expertise in online marketing for medical practices. You'll need to engage: 1) a strategist who understands health care-specific positioning and branding; and 2) a website team that includes a designer,

Your medical practice needs to be online because your patients and their families are online.

and Twitter. In 2010 alone, there was an exponential increase in health-related chats for patients, practitioners, and caregivers, as well as professionals active in various sectors of the health care industry (e.g., information technology (IT), pharmaceuticals).

These days, hospitals and large medical practices maintain at least one Facebook page and, in many instances, a Twitter account. Some also sustain blogs whose content is provided by members of the management team and generally edited by someone in the communications department.

Should your medical practice get involved with social media? It depends.

Like print advertising and billboards that do not work unless they appear in the same place(s) at the same time(s), social media will not work unless it's used consistently over time. Unlike print advertising and billboards, social media requires active, focused involvement. But before making Facebook or Twitter part of your online presence, you'll need to grapple with the following questions:

- What do you hope to accomplish by using social media?
- Is your current and prospective patient population likely to use social media relative to your medical practice?

writer, editor, and (possibly) a technology whiz.

When shopping for a vendor, make sure the person or firm:

- Has demonstrably effective experience with the health care industry
- Understands the particular needs of a medical practice of a size and scale matching yours
- Is an active participant in health care industry-specific Twitter-based chats (e.g., #hcsm)
- Can provide references (that you absolutely commit to contacting!)

Feeling a headache coming on? Don't worry. There are plenty of solo health care marketers and small boutique firms out there who are willing and able to help, setting you free to focus on enhancing wellness and delivering health care. *MPD*

Meredith Gould, PhD, is a marketing communications professional with decades of experience, specializing in conceptualizing and creating online content. An advocate for using social media to communicate health and build community, she serves on the External Advisory Board of the Mayo Clinic Center for Social Media and is on faculty for Mayo's Social Media Residency program. For more information, visit www.meredithgould.com.

have reported the G code at least one time on a claim between Jan. 1, 2011 and June 30, 2011. A group practice participating in the eRx group practice reporting option for 2011 must have requested the significant hardship exemption at the time the practice self-nominated to participate.

Rule May Grant Patients Access to Lab Test Results

A proposed rule, drafted jointly by CMS, the Office for Civil Rights (OCR), and the Centers for Disease Control and Prevention (CDC), would amend a patient privacy provision of two federal laws to grant patients access to test results directly from laboratories through the use of health information technology (health IT). The proposed rule, posted Sept. 14 on the Office of the Federal Register's (OFR) website (*www.gpo.gov/fdsys/search/getfrtoc.action*), would amend the Clinical Laboratory Improvement Amendments of 1988 (CLIA) so that, at a patient's request, laboratories would be allowed to provide an individual with access to his or her complete test reports using the lab's authentication process to ensure privacy.

The proposed rule would also amend the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. HIPAA generally requires covered entities to give patients access to their records, but one exception to this general mandate is a provision that exempts entities subject to CLIA where a law bars disclosure. If finalized, the proposed HIPAA amendments will remove this exception, and CLIA-certified labs and CLIA-exempt labs will be required to provide patients with access to test reports.

Comments will be accepted until 5 p.m., Nov. 14. For details, please see the proposed rule (*www.gpo.gov/fdsys/pkg/FR-2011-09-14/pdf/2011-23525.pdf*). MPD

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