2015 Medicare Fee Schedule Opportunities for Chronic Care Management

The final 2015 Medicare physician fee schedule was recently issued by the Centers for Medicare and Medicaid Services (CMS). But, who has time to read the final rule that is more than 1,000 pages long?

The Pennsylvania Medical Society (PAMED) has you covered with what you need to know about changes that could affect your reimbursement.

The 2015 final rule released by CMS:

- Reimburses physicians for providing chronic care management services starting in 2015, including developing and revising a patient’s plan of care, communication with other treating health care providers, and medication management. This new code could be billed once a month per patient. CMS has also added greater flexibility in the supervised clinical staff providing these services. CMS had proposed standards for EHRs, specifically, a 2014-certified EHR. Due to public comments indicating that very few practices have adopted 2014-certified EHR, the final rule says that CMS will require the version of the certified EHR that is in use on Dec. 31 of the prior calendar year for the EHR Incentive Programs to bill for these services. Rather than creating a new G-code, the final rule also says that CPT code 99490 will be used for this purpose.

- Sets Medicare payment rates for physician services in 2015, including a 21.2 percent cut in physician reimbursement due to the flawed Sustainable Growth Rate (SGR) Medicare payment formula. Note: the current temporary patch expires on March 31, 2015. Urge Congress to work in a bipartisan manner to permanently repeal SGR.

- Adjusts malpractice RVUs as part of a required five-year review. For 2015, CME conducted the third comprehensive review and update of the malpractice RVUs and proposed new malpractice RVUs for all services. CMS also is adopting new resource-based RVUs based on updated professional liability insurance premiums.

- Continues implementation of the value-based payment modifier by: Applying the 2017 VBPM, based on 2015 performance, to all physicians, regardless of group size Confirms the maximum penalty for groups with 10 or more eligible professionals of 4 percent.

What You Need to Know about PA’s New Child Abuse Laws

Pennsylvania is getting geared up for the implementation of significant changes to our Child Protective Services Law (CPSL). The law was amended to address concerns with the adequacy of protections for abused children in Pennsylvania. Physicians need to be prepared to comply with changes in their responsibilities that went into effect on Dec. 31, 2014.

The Pennsylvania Medical Society (PAMED), and the Delaware County Medical Society (DCMS) want to make sure Pennsylvania physicians are educated on the changes and how they may impact them, both as a health care provider in the office or health care facility and as a physician regardless of the setting.

The first and perhaps most important thing to know is that all Pennsylvania physicians, regardless of your specialty, are impacted by the changes in the law.

Key changes impacting physicians include:

• The new definition of child abuse is more specific and has been expanded.
• Physicians will need to report suspected child abuse identified in certain circumstances outside their professional capacity.
• Physicians will no longer be able to fulfill their reporting obligation simply by making a report to their supervisor or other designated person in their workplace.
• The penalties for failing to make a mandatory report are increased.
• Physicians have new mandatory child abuse

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Delaware County Medical Society

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2015 Medicare Fee Schedule  (continued from page 1)

-Outlines criteria for avoiding 2017 PQRS penalties, which will be based on 2015 performance. To avoid this two percent penalty, eligible professionals will general have to report nine measures next year.

-Expands the Physician Compare website to include information about quality performance for both groups and individuals Expands the list of approved Medicare telehealth services to include annual wellness visits, psychoanalysis, psychotherapy, and prolonged evaluation and management services

-Outlines CMS’ mis-valued code decisions for 2015 related to hip and knee replacements, radiation therapy and gastroenterology, radiation therapy, epidural pain injections, and film to digital substitutions

-Revises the definition of “colorectal cancer screening tests” to include anesthesia that is separately furnished in conjunction with screening colonoscopies effective Jan.1, 2015. In order to encourage beneficiaries to seek colorectal cancer screening services, the coinsurance and deductibles will be waived for anesthesia or sedation services furnished in conjunction with screening colonoscopies.

-Finalizes CMS’ proposal to eliminate the use of 10 and 90-day global surgical codes starting in 2017

-Creates a process for added transparency in developing payment rates to ensure that changes to rates for certain services are only effective after CMS has responded to public comments. The final rule says that CMS will transition in 2016, with full implementation in 2017

-Makes numerous changes to Open Payments.

Watch the Daily Dose
PAMED’s daily all-member email, for more information.

Send address changes to:

Delaware County Medical Society
600 North Jackson Street, Suite 201A Media, PA 19063-2563
email: roemcneal@comcast.net

The Bulletin of the Delaware County Medical Society is published bi-monthly by the Delaware County Medical Society (ISSN 1044-4653). Material for publication must be received by the tenth of the month for the following month’s issue.

The publisher reserves the right to accept or reject any advertising. Advertisements do not represent approval or recommendation of the Delaware County Medical Society. The opinions expressed in The Bulletin do not reflect official policy or proceedings unless so stated. Printed on re-cycled paper by The Country Press in Lima, PA Annual subscription rate: $50.00 Second class postage paid at Media, PA 19063
Key Physician Contract Issues

by Karen E. Davidson, Esquire

For most physicians their first encounter with a contract is when they receive one in anticipation of post training employment. By the very nature of medical practice, these contracts encompass relationships with hospitals/health systems, academic medical center and private practices. A well-drafted contract should specify the duties and obligations of the physician and employer, provide for appropriate compensation, address how problems arising during the relationship will be resolved and delineate termination rights. Several of these areas are briefly discussed in this article; a comprehensive discussion is beyond its scope. This article also does not provide legal advice. Rather, it is intended to raise awareness of certain key contract issues in an effort to put physicians in a better position to work with their own attorney in negotiating a satisfactory contract and assessing attendant risks. Since risk is inherent in any business relationship especially those in the practice of medicine, the critical question is whether the physician accepts the contract risks knowingly.

Compensation

While compensation seems as if it should be one of the most settled areas of a physician contract with the least amount of risk, changes in reimbursement and the health care system in general have greatly increased the complexity of physician compensation and shifted risk to physicians. Historically, physician compensation was a set amount with annual increases. What exists now, however, are evolving compensation models that typically provide a guaranteed base compensation for a year or two, after which the base and/or bonus compensation are subject to a variety of productivity factors. These include items such as work relative value units (known as wRVUs), collections for professional services, patient encounters and quality measures. Physician compensation models based on productivity factors contain targets established as the basis for determining whether the physician will retain or garner a certain level of compensation. Consequently, physicians should fully understand their productivity targets and the likelihood of achieving them and determine, if possible, the amount or range of compensation to which they ultimately will be entitled.

Malpractice Insurance

Physician contracts typically contain terms addressing malpractice insurance including identifying the party responsible for obtaining the applicable policies and the type of coverage. There are essentially two types of malpractice insurance, namely claims-made and occurrence-based policies. Occurrence-based policies provide coverage regardless of when the malpractice claim is filed so long as the policy was in effect when the alleged injury occurred. Claims-made policies require, not only, that the policy be in effect when the alleged injury occurred, but also, that the policy be in effect when the claim is filed. In order to extend the coverage period of a claims-made policy (typically, beyond termination of employment), an extended reporting period endorsement, also known as “tail coverage”, needs to be purchased. Tail coverage is expensive and can run anywhere from 150% to 200% of the physician’s current annual malpractice premium. Absent an express written obligation by an employer to purchase tail coverage, the physician is usually held liable for the cost. It is therefore critically important to ascertain, before signing a contract, whether the employer, physician or some combination of the two will be responsible for obtaining and paying for tail coverage, and the circumstances under which they must do so. Given the potential risks, physicians should ensure that contract terms related to malpractice insurance are unequivocal.

Term and Termination

Prospective employers often indicate during the interview process or in the offer letter that the anticipated contract will be for a specified term, such as one, two or three years. Yet, the contract language may allow the employer (and physician) to terminate the arrangement on relatively short notice, such as sixty or ninety days, at any time and for any reason. This is known as a “without cause” termination right.

Physicians are often surprised to learn that the relationship can be terminated on such short notice, well-before expiration of the anticipated term. When assessing the impact of “without cause” termination rights, physicians should consider their own life circumstances (perhaps weighing the effect of an abrupt termination), and ascertain if they are responsible for any costs or expenses upon termination. For example, a physician might have been paid a
sign-on-bonus, reimbursed for moving expenses or benefited from the payment of loans, and nevertheless be held liable to repay those amounts in full upon a “without cause” termination of the contract.

Physician contracts also contain provisions setting forth the basis of “for cause” termination usually under a variety of extreme circumstances, such as loss of medical licensure, resulting in immediate termination. These provisions should also be closely reviewed and analyzed in concert with other contract provisions because the physician may be liable for costs and expenses (such as tail coverage), or may have to forgo certain compensation (such as a bonus), in the event of a “for cause” termination.

Non-Competition Clauses

Non-competition clauses (also known as restrictive covenants) generally limit a physician from practicing within a specific geographic area during the term of the contract and for a certain period of time after the relationship ends. Contrary to popular lore in the medical community, the laws of most states uphold non-compete restrictions so long as they legitimately protect an employer from unfair competition and are reasonable in terms of geographic area and length of time. Time restrictions for most non-competes typically limit physicians from practicing in the applicable restricted area for one to two years, a time period which is usually upheld by courts as reasonable. In contrast, the reasonableness of geographic limitations can vary depending on where an employer is located and the extent of the restriction. For example, a five mile non-compete may be reasonable in a suburban locale, but perhaps unreasonable in heart of a city.

One issue that often arises in connection with non-competition clauses concerns the location from which the restriction applies. If it applies from every site or location where a prospective employer provides services, the physician might need to relocate upon termination of the relationship. Although such a broad restriction may be reasonable from a court’s perspective, it may not be from the physician’s especially if the physician will only be practicing in one location.

Physicians need to be aware that non-compete restrictions are generally upheld. They should therefore assess the impact of the proposed non-compete in light of their personal circumstances and consider seeking limitations on the restrictions.

Summary

Physician contracts contain a number of provisions including those pertaining to compensation, malpractice insurance, term and termination and non-competition that could have significant implications for them personally and professionally. Thus, physicians should closely review and analyze their contract and consult with an attorney to ensure they fully understand its attendant risks.

About the Author:

Karen E. Davidson, Esquire is a founder of Mackarey & Davidson, P.C. and a healthcare attorney in Conshohocken, Pennsylvania with over two decades of experience serving the legal needs of her physician clients in business matters.

Ms. Davidson is a graduate of the Temple University – James E. Beasley School of Law, licensed to practice law in the Commonwealth of Pennsylvania, State of Maine and the District of Columbia (inactive), and a member of the Bar Associations in those jurisdictions. She is also a member of the American Health Lawyers Association, Health Care Compliance Association and the Board of Directors of the Southeastern Pennsylvania Area Health Education Center (SE PA AHEC).

Ms. Davidson speaks regularly to professional groups in an effort to provide practical insight into legal issues in medical practice, she can be reached by telephone at 610-940-4041 or email at karend@md-healthlaw.com. An unabridged version of this article (including all footnotes), is available - call the DCMS staff at (610) 892-7750 or email delcomedsoc@comcast.net
DCMS Health Literacy Update

As many DCMS members are aware, our county medical society has helped to organize the Delaware County Health Literacy Coalition to raise awareness of low health literacy as an important subject; to enhance communication and understanding between medical personnel and patients; to promote use of diagnostic tools as well as resources and activities and have a positive impact on the health of the community; and to enhance patient outcomes and provider quality scores.

Health literacy refers to the individual’s ability to obtain process and understand basic health information and the services needed to make appropriate decisions for their care. Health literacy abilities vary tremendously and should be understood by those who are providing care so that they can take steps to ensure good communication with all of their patients. The concept of health literacy is not brand-new. In fact, over the past two decades steps have been taken to address the gap in health literacy by many hospitals, health systems, physicians, nurses and other medical and behavioral health professionals.

The Delaware County Health Literacy Coalition includes representatives from the Delaware County Medical Society; the Delco Chapter of the Professional Association of Healthcare Office Management (PAHCOM); several county government agencies including the Department of Intercommunity Health and COSA; The Taylor Community Foundation; The Crozer-Keystone, Main Line and Mercy Health Systems (six hospitals); pharmacists; The Delaware County Literacy Council; The Women’s Commission; several medical insurance payers; Neumann University’s School of Nursing as well as home-care, pharmaceutical companies, home nursing and hospice providers.

Research has shown that many groups of individuals such as older adults may be at risk of having inadequate or marginal health literacy. This risk negatively impacts the health outcomes and the cost of caring for patients with health literacy challenges. Literacy skills are a strong predictor of a person’s health status and limited skills increase the disparity in access to health care, especially among vulnerable populations. More than 66% of US adults age 60 and over have inadequate or marginal literacy skills.

Other than age, individuals with less education, lower incomes and poor health status (physical and mental) can often be at risk of low health literacy skills. Providing care to some of these patients is also complicated by commercially prepared healthcare reading materials and presentations that are too often written well above the average national literacy level. One out of five American adults reads at the 5th grade level. Yet most health care materials are written at or above a 10th grade level.

Low health literacy is an enormous cost burden on our US health system and the annual costs for the care of people without adequate skills are 4 times higher than for those with higher skills. Many problems with patient compliance and medical errors may be based on a poor understanding of health care information. Only about 50% of all patients take their medications as directed. Patients with lower skill levels are also at much higher risk for being hospitalized. They also tend to make more medication errors and are less able to comply with long and complicated courses of treatment.

The Delco Health Literacy Coalition will be engaged in ongoing activities to work with professionals who are providing care to patients. We’ll also be approving and promoting several programs to help patients to be better prepared for their medical appointments. Enhancing health literacy is a two-way street and it begins with the recognition that our communications need to be understood so that patients can be responsible and more compliant.

(continued page 6)
Physicians have new mandatory child abuse recognition and reporting training requirements as a condition of licensure.

The increased penalties already are in effect. The remainder of these changes will take effect at the end of this year.

PAMED has developed a suite of materials to help physicians understand the child abuse law changes and is making all materials available to all Pennsylvania physicians. These include:

- An overview of the physician’s reporting requirement
- An explanation of the expanded definition of child abuse
- Frequently asked questions
- Risk factors, signs, and symptoms of child abuse

Under the amended CPSL, all physicians seeking to renew their license on or after Jan. 1, 2015, will need to complete two hours of approved training on child abuse recognition and reporting as a condition of licensure.

However, if you renew an unrestricted license before Dec. 31, 2014, you will have until 2016 (when these licenses are scheduled to be renewed again) to meet the new training requirement. PAMED plans to apply to become an approved provider for the required child abuse recognition and reporting training that you’ll want to complete after Jan. 1 to meet the required 2015-2016 CME licensure requirements.

PAMED and DCMS will notify you about additional educational opportunities as they become available.

Delco Health Literacy Coalition (continued from page 5)

This past fall we coordinated a number of “brown bag medicine reviews” for older adults at various senior centers in Delaware County. We also wrote and submitted op-ed pieces for local newspapers and a series of “Health Literacy Tips of the Day” which were emailed and faxed to hundreds of medical practices in the county. We’ve also put together a one hour CME course entitled “Health Literacy – How Effectively Are We Communicating?” We’ve delivered this program at Medical Grand Rounds at Taylor Hospital and would like to schedule presentations with more groups.

In 2015 the coalition will host an open meeting on Friday January 16th from 11:00 am – 1:00 pm at the Delaware County Intermediate Unit in Morton. This meeting will include a brief presentation and some discussion about our plans for 2015, we’d welcome some new participants – if interested, please call the DCMS office (610) 892-7750.
Members Wanted

The DCMS leadership is looking for members who would like to participate!

Board Members

Writers/Editors

Webmaster

Qualifications:

An interest in promoting the medical profession & enhancing the doctor/patient relationship

Ability to attend (infrequent) evening meetings

Please contact our staff or any of our leadership (page 2)

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