Ten Reasons Why (Some) Physicians Aren’t Rushing to Adopt EMRs

1. Everyone is waiting for the other shoe to drop on Medicare payments.
2. Private practices may not have the in-house expertise to implement an EMR and may not be able to afford a consultant (although some states are receiving grants to help practices — check your state’s grant [here](#).)
3. There is a lot of confusion on the parts of Meaningful Use that have been clarified and of course, on those that haven’t.
4. Administrators are distracted by RAC, PECOS, HIPAA, PQRI, eRx and RCM.
5. Some practices have spent years avoiding Medicare and Medicaid patients and now don’t have the patient numbers to participate.
6. Everyone and their uncle is selling an EMR — who can tell the long-timers who are about to be bought from the short-timers who might last forever?
7. Physicians are worried about the drop in production that (some say) happens when a practice launches an EMR.
8. There seems to be as many horror stories as there are success stories with EMRs.
9. Practices that are affiliated with a hospital are nervous about tying themselves to the hospital in such a serious way as hopping on their EMR package.
10. Because two practices can have absolutely opposite experiences with the same EMR, no one can find consistent recommendations for any single product. (It’s not the product, it’s the implementation!)
11. Bonus Reason: lots of people are confused about how to qualify for the ARRA money (read my post about this...
A number of people asked me about the impact of health reform on them as individuals. Here is a great story from the Atlanta Journal-Constitution that takes specific examples of individuals and families and speculates on how the new bill(s) will impact them.

For 2010, the changes are minimal:

- Dependent children may be covered by their parents’ health insurance policies until age 26.
- A high-risk insurance pool will open for people with pre-existing conditions who have been uninsured for six months.
- In 2011 Medicare will pay for an annual checkup, and deductibles and co-payments for many preventive services and screenings will be eliminated. The Medicare prescription drug doughnut hole will gradually narrow.
every year until it is eliminated in 2020. People in the “doughnut hole” could receive a $250 rebate this year.

I have to say that I’ve been dumbfounded by the fury raised over the passage of the new healthcare legislation. I realize that the bills separate people into winners (uninsured, providers with uncompensated charity care, patients with pre-existing conditions, Medicare patients, providers who see Medicaid patients, families with adult children, etc.) and losers (companies who have to pony up more money for their retired employees, insurance companies, illegal immigrants, high wage earners, etc.), but this story placed the fury into a different perspective for me. It’s a good read.

CONCIERGE PRACTICES

What does healthcare reform mean for the physician practice? Many are predicting the rise of concierge practices (also called boutique medicine, retainer practices, VIP medicine and cash practices) as physicians find they cannot survive if their patient population is predominantly Medicare, Medicaid and uninsured patients. Concierge practices fall into two categories:

- The first operates on an insurance+ model, which means that the practice accepts and files the insurance for the patient, but also requires an additional out-of-pocket fee of anywhere from $1500 to $1800 per year to be a patient of the practice. The fee is to cover services that Medicare and commercial insurance do not, such as physicals, phone consultations, wellness counseling and patient education.

- The second operates on a strictly cash basis and the practice does not accept or file any insurance for the patient. The patient pays a flat fee per year for care (usually in the $5,000 to $15,000 range) and all primary care is provided for that amount. The patient still
needs to carry insurance for prescriptions, hospital services and sub-specialist services. Imagine being a manager in this type of practice — no pre-authorizations, no insurance department, no eligibility checking, no refunds...

Concierge medicine has not been around that long, but it is growing in popularity by leaps and bounds. The first acknowledged concierge practice was formed in 1996 in the Pacific Northwest. In 2002, CMS (Centers for Medicare and Medicaid) published a memo stating that physicians may enter into retainer agreements with their patients as long as these agreements do not violate any Medicare requirements. In 2003, the Department of Health and Human Services ruled that concierge medical practices are not illegal. Today, there are approximately 5,000 physicians using the concierge model in the United States today.

**MEDICARE CUTS, MEDICARE CLAIMS AND DON BERWICK**

Shortly after all the shouting and voting on healthcare reform was over, Congress recessed for two weeks leaving the controversy over the 21.5% cuts required by the SGR formula still unsettled. CMS has advised the MACs to again hold claims for services provided from April 1 to April 10 to give Congress a chance to get back to work and back to voting for an additional delay (or not) for the cuts. If the cuts are allowed to stand, many physicians will start making their own cuts by minimizing the number of Medicare and Medicaid patients they will see.

Amidst this craziness, a voice of sanity is heard and it is Donald Berwick, MD, current President of the Institute for Healthcare Improvement (IHI) and probable Obama pick for the head of CMS. If you don’t know Don Berwick or the IHI, click here to read an interview with him about the IHI’s “100,000 Lives Campaign” or watch the video below of him speaking about the dimensions of quality. Good stuff!
**Cash Flow Statement**

The Cash Flow Statement answers the question: where did the cash and any profit (positive margin) go? It reflects where the money came from and how the business spent it.

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**Income Statement**

The Income Statement reveals a profit or a loss for a specific accounting period. The statement itemizes income, cost of goods, operating expenses and other income/expense data.

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**Balance Sheet**

A Balance Sheet is a snapshot of the assets, liabilities and net worth of the business on a specific date, indicating the financial health of a company at one point in time.
Here’s a refresher from CMS on NCCI for those of us experiencing acronym-exhaustion:

The CMS (Centers for Medicare and Medicaid Services) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association’s CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs as a general reference tool that explains the rationale for NCCI edits.

Carriers implemented NCCI edits within their claim processing systems for dates of service on or after January 1, 1996. More information here.

If you’ve been reading my website for awhile, you know I’m a big Frank Cohen fan. He espouses the idea of giving away lots of good free stuff and his work is topnotch! If you’ve never taken one of his free webinars, do yourself a favor and tune in. I don’t see any webinars on his website currently, but
As usual, he offers his analysis of the most recent CCI Edits. Franks states:

Version 16.1 of the CCI edit database is scheduled to be effective on April 1, 2010. There are 2,054 new edit pairs effective for this release. 35 of these are effective retroactive to October 1, 2009. This means that if you billed for and were paid on one or more of these retroactive edits, you may be subject to repayment.

142 edit pairs are reported as terminated (no longer effective) for this release. Four are terminated retroactive to December 31, 2005; four are retroactive to December 31, 2006 and 76 are shown as terminated retroactive to December 31, 2007. I guess this means that if you were denied due to a CCI edit pair during these periods, you should be able to resubmit the claim and get paid.

You can expect 1,947 changes with respect to the modifier indicator with 1,892 going from an indicator of 0 (no modifier permitted) to an indicator of 1 (modifier permitted). 55 edit pairs report a change in the modifier indicator from a 1 to a 0.

In total, there are 1,337 duplicate edit pairs in the database. These are records that were made effective at one point, then terminated and then made effective again. There are also currently 5,309 swapped pairs. These are edit pairs that were introduced in one order (i.e., 99350 as column 1 and 96416 as column 2), terminated and then re-activated in the opposite order (i.e., 96416 as column 1 and 99350 as column 2).

For a worksheet that contains all of the changes, edits and updates, go to www.mitsi.org and click on the Download tab. It is the third link down the page. Frank invites all readers to email him with any questions or comments to fcohen@frankcohen.com.

Thanks, Frank!

Photo Credit: Mary Pat Whaley – taken at the Lone Star
Barbeque and Mercantile in Santee, South Carolina (great food!)

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**NCCI (National Correct Coding Initiative)**

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More information from CMS [here](#).
Job Description: Practice Administrator/Chief Operating Officer (Courtesy of Marshall Baker)

Job Description: Practice Operations Director (Courtesy of Marshall Baker)

Job Description: Practice Manager 2 (Courtesy of Marshall Baker)