The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COBRA generally requires that group health plans sponsored by employers with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

The American Recovery and Reinvestment Act (ARRA) provides a COBRA premium reduction for eligible individuals who are involuntarily terminated from employment through the end of May 2010. Due to the statutory sunset, the COBRA premium reduction under ARRA is not available for individuals who experience involuntary terminations after May 31, 2010. However, individuals who qualified on or before May 31, 2010 may continue to pay reduced premiums for up to 15 months, as long as they are not eligible for another group health plan or Medicare.

The Unemployment Compensation Extension Act of 2010 signed by the President on July 22, 2010, did not extend the COBRA premium reduction.
Q: How do I know if I need to enroll in the Medicare PECOS (Provider Enrollment and Chain/Ownership System) or if I am already enrolled in PECOS?

A: You need to be enrolled in PECOS (pronounced “pay-cose”) if:

- You participate in Medicare or do not participate in Medicare but see Medicare patients. (See “Medicare” under the Definitions tab above for additional explanation of the difference.)
- You write prescriptions or orders for durable medical equipment (walkers, canes, crutches, etc.), prosthetics or supplies for Medicare patients, even if you have opted out of Medicare and do not receive payments from Medicare. A list of provider types is here:
  - doctor of medicine or osteopathy
  - doctor of dental medicine
  - doctor of dental surgery
  - doctor of podiatric medicine
  - doctor of optometry
  - doctor of chiropractic medicine
  - physician assistant
  - certified clinical nurse specialist
  - nurse practitioner
  - clinical psychologist
  - certified nurse midwife
  - clinical social worker
- You are a mid-level provider who does not bill Medicare under your own name/billing number, but who does write
prescriptions or orders for durable medical equipment and/or refer patients to other providers.

If you want to check and see if you are already enrolled in PECOS, a downloadable file is available here (12,000 pages!) and everyone listed in this Ordering/Referring file has approved enrollment status. Anyone not appearing on this list is not in approved status, or has opted completely out of the Medicare program (see note below.)

**NOTE** about physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit). Opt-out practitioners whose affidavits are current should have enrollment records in PECOS that contain their NPIs.

My posts on PECOS are here:

- [Providers Without a PECOS Record Will Receive a Letter From Their Medicare Administrative Contractor (MAC)](#)
- [My Notes from the CMS Open Door Forum on May 19, 2010: PECOS, DMEPOS and Blue Ink on Paper Forms](#)

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**OpenNotes**

A study currently under way, called the OpenNotes project, is looking at what happens when doctors’ notes become available for a patient to read, usually on electronic medical records. In a [report on the early stages of the study](#), published Tuesday in the Annals of Internal Medicine, researchers say
that inviting patients to review the records can improve patient understanding of their health and get them to stick to their treatment regimens more closely.

The year-long OpenNotes study, funded with a $1.5 million grant from the Robert Wood Johnson Foundation, involves 25,000 patients and their primary-care physicians at Beth Israel Deaconess, Geisinger Health System in Danville, Pa., and Harborview Medical Center in Seattle. “We want to break down an important wall that currently separates patients from those who care for them,” says lead investigator Tom Delbanco, a Harvard Medical School professor who treats patients at Beth Israel. (excerpted from “What the Doctor is Thinking” WSJ, July 20, 2010)

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**And We’re Off! Meaningful Use Notes from the CMS & ONC Press Briefing July 13, 2010**

I was fortunate enough to be listening by phone to the historic (yes, historic) announcement of the final meaningful use rules by Kathleen Sebelius, Secretary HHS; Don Berwick, MD, new CMS Administrator; David Blumenthal, MD, national coordinator for health information technology at HHS; Regina Benjamin, MD, Surgeon General and a surprise speaker, Regina Holliday, artist and activist for patient rights.
The memorable quotes I wrote down were:

Kathleen Sebelius: “When electronic health records are well-designed and implemented correctly, they can be a powerful force for reducing errors, lowering costs, raising quality of care, and increasing doctor and patient satisfaction.” That is the best one-sentence description of “Why EHR?” I’ve ever heard.

Don Berwick: “If it’s (EHR) so good, why doesn’t everyone use it? Because it’s HARD.” There is a little slice of honesty that you won’t get from most EHR vendors.

David Blumenthal: “We are only as good in treating patients as the information we have.” Wow, an admission that could rock the medical world if we stopped and thought about it.

Regina Holliday: “I will not stop until we all have the right to see our own information.” Regina’s Medical Advocacy Blog is here. Her lauded mural “73 Cents” refers to how much per page she was told by the hospital medical records department she would have to pay to get a copy of her husband’s records while he was still in that hospital.
The Meat: Specifics of Stage 1 Meaningful Use (2011 and 2012)

Meaningful use includes both a core set and a menu set of objectives that are specific for eligible professionals and hospitals.

For Eligible Professionals (definition here), there are a total of 25 available meaningful use objectives. 20 of the objectives must be completed to qualify for an incentive payment. 15 are core objectives that are required, and the remaining 5 objectives may be chosen from the list of 10 menu set objectives.

For Hospitals, there are a total of 24 available meaningful use objectives. 14 are core objectives that are required, and the remaining 5 objectives may be chosen from the list of 10 menu set objectives.

Stage 1 (2011 – 2012) sets the baseline for electronic data capture and information sharing.

Stage 2 (est. 2013) and Stage 3 (est. 2015) will continue to expand on this baseline and be developed through future rule making.

Summary Overview Of Meaningful Use Objectives

(full article from New England Journal of Medicine here)

As I am sure you expect, there will be much more information to come.
A QR (Quick Response) Code is a two-dimensional matrix/bar code created in 1994 by Japanese corporation Denso-Wave for inventory purposes.

Users hold their phone up to the code displayed on a sign, in a book, on a computer screen, tv, or almost anywhere. The phone camera snaps the code and takes the user to a website with more information — no typing needed — just point and click.

QR Codes are most common in Japan where they are currently the most popular type of two dimensional codes. Most Japanese mobile phones can read this code with their camera. (definition courtesy of Mashapedia = wikipedia and Mashable)

For healthcare think: detailed information on drugs, facilities, services advertised in magazines, tv, signs and billboards.

How about a QR attached to a GPS to direct travelers to the closest emergency room?
CMS and ONC Will Announce Final Rules on Meaningful Use, Standards & Certification 7/13/2010

U.S. Department of Health and Human Services

WHAT: CMS and ONC will host a press briefing to announce the final rules on Meaningful Use and Standards and Certification under the HITECH Act’s Electronic Health Records (EHR) incentive program.

WHO: Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services
Donald Berwick, M.D, Administrator, Center for Medicare & Medicaid Services
David Blumenthal, M.D., M.P.P., National Coordinator for Health Information Technology
Regina Benjamin, M.D., M.B.A., Surgeon General

WHEN: Tuesday, July 13, 2010 10:00 a.m. EDT

WHERE: Great Hall, Hubert H. Humphrey Building 200 Independence Avenue, S.W., Washington, D.C. 20201

Call in: 800-857-6748 Verbal Passcode: HHS
Healthcare Fatigue – Are You, Your Staff and Your Physicians Unusually Stressed?

Note: I am republishing this to my email subscribers because none of the links worked the first time around. I’ve fixed everything now – so sorry for the error – must have been healthcare fatigue!

I’ve noticed that a lot of people in healthcare seem unusually tired and even, if I dare say so, somewhat cranky. This includes me. I’ve decided we’re all suffering from healthcare fatigue – fatigue from dealing on a daily basis with so much change, uncertainty, and financial stress. Here’s my top ten list of healthcare management stressors accompanied by posts I’ve written that discuss the topic or suggest resources for the challenge.

10. Red Flags Rules – on again, off again, patients don’t want to have their pictures taken or let you copy their driver’s licenses.

- Red Flags Rules (RFR) Delayed for the Fifth Time “This Time Until December 31, 2010
- Red Flags Rule and Identity Theft Prevention: You Don’t Have To, But You Should!
9. HIPAA – don’t be fooled, HIPAA is not something we handled years ago and it’s taken care of; there are new requirements and penalties associated with HIPAA breaches. HIPAA is a biggie and something that now infiltrates almost every facet of healthcare.

- **ARRA Changes Rules for HIPAA”” Did You Miss These Three February Deadlines?**

8. Employment Uncertainty – both for you and your staff – the aftermath of layoffs can be even more demoralizing to those who didn’t lose their jobs. Also, many healthcare entities are still freezing raises. If I hear one more time “we’ll just have to do more with less” I might just scream.

- **My Take on “10 Ways to Keep Employees Happy” in Medical Practices**
- **Dear Mary Pat: Should Staff Be Allowed to Use The Internet on Their Smart Phones at Work?**
7. **Unrealistic Workloads** – directly related to #9, most staff and managers have much more work to do than they did just two years ago. Couple that with the ability for managers to be available and work by computer, phone, text message, email or Skype 24/7 and you have fatigue that you understand only when you truly, truly stop and wind down for more than three days at a time.

- Long Vacations are Good for Employees, the Company and Me!

6. **Hospitals Buying Practices** – this could be a good thing or a bad thing, but as you and I know, change is completely unnerving to most people. Hospitals have very different cultures than private practices and trying to marry the two takes skill, patience and excellent leadership.

- Change in the Group Medical Practice: Customers, Consequences, Control, and Culture
5. **Stimulus Money for Using EMRs** – it’s a big decision and many practices are very nervous about purchasing an EMR. Many think that meaningful use components are unrealistic and even more are fearful of the inevitable productivity drop when the EMR is implemented and for months afterwards.

- **ARRA Eligible Providers: Who Is Eligible to Receive Stimulus Money and How Much is Available Per Provider?**
- **FAQ on HITECH, Meaningful Use, Eligible Providers, and the Stimulus Money**
- **Ten Reasons Why (Some) Physicians Aren’t Rushing to Adopt EMRs**
- **Electronic Medical Record Guru Rosemarie Nelson Reveals Best EMR Product on the Market Today**

4. **Unhappy Patients** – lots of patients are also trying to do more with less (argghhh!) and are avoiding coming to the doctor whenever possible. The front desk staff and the phone staff in particular are getting a lot more heat when they inform patients they’ll have to make an appointment.

- **50 Customer Service Ideas to Treat Your Patients to Friendly, Easy and Unexpected Service**
- **How To Be A Billing Advocate for Your Patients**
- **How to Apologize to a Patient**
- **A Memo to the Staff: The Preciousness of Patients**

3. **PECOS** – be glad if you don’t know what PECOS stands for, or be very, very afraid.

- **Providers Without a PECOS Record Will Receive a Letter From Their Medicare Administrative Contractor (MAC)**
- **My Notes from the CMS Open Door Forum on May 19, 2010: PECOS, DMEPOS and Blue Ink on Paper Forms**
- **Is Your Practice Ready for the 60-Day PECOS Countdown?**

2. **Medicare Reimbursement** – this year has been as exhausting as watching a single point of ping pong played for hours – there will be cuts, there won’t be cuts, there will be cuts,
there won’t be cuts. Gird your loins as the November 30 deadline looms for the next potential cuts.

Deja Vu All Over Again: The Medicare Fee Cut is Pushed Back to November 30, 2010
Attention Medical Practice Staff: Medicare Changes the Rules for Credentialing and Retro-Billing
91 Physician Organizations Sign Statement Naming Congress in “Mismanagement of the Medicare Program” and Imploring it to “Honor its Obligation”

1. The Bottom Line – we have RAC audits, more pre-certification and pre-authorization and pre-notification requirements, more denials, high deductible plans, formularies and 50 other things that are making it difficult to know which hoop to jump through to get paid. Expenses continue to go up, reimbursement continues to go down, and the healthcare world spins faster and harder, making us all wonder when it will, or if it ever will slow down.

- There is No Such Thing as a 10-Minute Office Visit
- The ABN: The Most Misunderstood and Underutilized Document in Healthcare
- 101 Ideas for Increasing Revenue and Decreasing Expenses in Your Medical Practice
- How to Develop a New Financial Policy For Your Practice:
A Short Course

Independent Diagnostic Testing Facilities (IDTFs) Can Expect Quarterly Letters From Medicare A/B MACs About January 2012 Accreditation Requirement

For more information on the Medicare accreditation requirement for entities billing the technical component for advanced diagnostic imaging (CT, MRI, PET/Nuclear Medicine) effective January 1, 2012, read my post here.

Medicare Learning Network (MLN) just released MM6912, effective August 2, 2010: Mailing To All Individual Practitioners, Medical Groups and Clinics and Independent Diagnostic Testing Facilities (IDTF) Who Are Billing or Have Billed For The Technical Component of Advanced Diagnostic Imaging Services

What exactly is an IDTF?

Some suppliers that perform diagnostic tests, other than
clinical laboratory or pathology tests, are required to enroll with Medicare as an Independent Diagnostic Testing Facility (IDTF). Not all suppliers that perform these diagnostic tests are required to enroll as an IDTF. Generally, entities can bill for the technical component of the diagnostic tests without an IDTF enrollment if it has the following characteristics:

- A physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital
- A facility that primarily bills for physician services and not for diagnostic tests
- A facility that furnishes diagnostic tests primarily to patients whose medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions
- If a substantial portion of the facility’s business involves the performance of diagnostic tests, the diagnostic testing services may be a sufficient separate business to require enrollment as an IDTF. In that case, the physician or physician group practice can continue to be enrolled as a physician or physician group practice but are also required to enroll as an IDTF. The physician or group can bill for professional fees and the diagnostic tests they perform on their patients using their billing number. Therefore, the practice must bill as an IDTF for diagnostic tests furnished to Medicare beneficiaries who are not regular patients of the physician or group practice.

Who will receive a mailing?

Enrolled physicians, non-physician practitioners, including single and multi-specialty clinics, and IDTFs who have billed
the Medicare program for the **technical component of advanced diagnostic testing services** within the preceding six month period and who continue to have Medicare billing privileges with Medicare contractors (carriers and Part A/B Medicare Administrative Contractors (A/B MACs)) are affected.

If you have billed the Medicare program for the technical component of advanced diagnostic testing services within the preceding six month period and continue to have Medicare billing privileges with Medicare contractors, you will receive a letter from your Medicare contractor advising you of the need to become accredited by January 1, 2012, in order to continue to provide these services and bill Medicare.

When more than one physician or non-physician practitioner is operating within a group, such as a single specialty or multispecialty clinic, only the group will receive the letter, not each of the individual physicians or non-physician practitioners working for the group.

**What will the mailing say?**

You must be accredited by one of the three Centers for Medicare & Medicaid Services (CMS) approved national accreditation organizations
by January 1, 2012, in order to be eligible to continue to furnish the technical component of advanced diagnostic testing services to Medicare beneficiaries and submit claims for those services to your Medicare contractor.

Your contractor will be mailing the letter quarterly beginning with July 2010 through July 2011. If necessary, follow the instructions in the letter to become accredited by January 1, 2012, in order to continue billing for the technical component of advance diagnostic imaging services. Make sure that your office staffs are aware of these new accreditation requirements and begin the accreditation process as soon as possible to protect your Medicare billing rights for these services.

Why do IDTFs have to become accredited now?

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary, Health and Human Services, to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component (TC) of advanced diagnostic imaging services.

What qualifies as an advanced
diagnostic imaging procedure?

MIPPA specifically defines advanced diagnostic imaging procedures as including:
"¢ Diagnostic magnetic resonance imaging (MRI),
"¢ Computed tomography (CT), and
"¢ Nuclear medicine imaging, such as positron emission tomography (PET).

MIPPA expressly excludes from the accreditation requirement x-ray, ultrasound, and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement diagnostic and screening mammography, which are subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.

How long does it take to become accredited?

Since CMS expects that it may take as much as nine months from the time you initiate the accreditation process to completion, you should begin the accreditation process for advanced diagnostic imaging services as soon as possible, but not later than March 2011.

Who are the accrediting organizations?

CMS approved three national accreditation organizations – the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission – to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures. The accreditation will apply only to
the suppliers of the images themselves, and not to the physician interpreting the image. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff.

If you have questions, contact your Medicare carrier and/or A/B MAC at their toll-free number, which may be found here (zip file.)

The letter will look like this:

[DATE]

[Supplier Name and Address]
Dear Physician/Non-Physician Practitioner/IDTF owner:

In accordance with Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities that furnish the technical component (TC) of advanced diagnostic imaging services must be accredited by January 1, 2012 in order to continue to furnish these services to Medicare beneficiaries.

Our records indicate that you have furnished advanced diagnostic imaging procedures such as diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET) within the last six months. If you are not accredited by one of the organizations shown below by January 1, 2012, you will not be eligible to bill the Medicare program for advanced diagnostic imaging services. This letter requests that you take the necessary action to become accredited by the January 1, 2012 deadline. Since we expect it can take up to nine months from the time you initiate the accreditation process to completion, we urge you to begin the accreditation process for advanced diagnostic imaging services as soon as possible.

MIPPA expressly excludes from the accreditation requirement x-ray, ultrasound, and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement diagnostic and screening mammography which are already subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.

The Centers for Medicare & Medicaid Services (CMS) approved three national accreditation organizations “the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission – to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures. The accreditation will apply
only to the suppliers of the images themselves, and not to the physician interpreting the image. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff. The accrediting organization that issues your accreditation will notify Medicare once your accreditation is complete and approved.

To obtain additional information about the accreditation process, please contact the accreditation organizations shown below.

American College of Radiology (ACR)
1891 Preston White Drive
Reston, VA 20191-4326
1-800-770-0145

Intersocietal Accreditation Commission (IAC)
6021 University Boulevard, Suite 500
Ellicott City, MD 21043
1-800-838-2110

The Joint Commission (TJC)
Ambulatory Care Accreditation Program
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
1-630-792-5286
If you have questions about this letter, contact [carrier or A/B MAC phone number/contact person].

Sincerely,

[Name of carrier or A/B MAC]

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Supplier Billed Advanced Medical Imaging CPT codes for Section 135 (a) of the MIPPA to Receive Accreditation Requirement Notification Letter

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The Cohen Report: CMS Releases New RBRVS Data Set Effective June 1, 2010
As many of you may already know, July 1, 2010 CMS released yet another RBRVS (Resource Based Relative Value Scale) data set that will be used to pay physicians under Medicare effective June 1, 2010. This data set includes the 2.2% increase in the CF. This puts the current conversion factor at $36.8729.

The link to the CMS file is here.

The good news is that the Conversion Factor (CF) increased by 2.2%.

The bad news is that for 2,226 procedure code/modifier groups within the database, the RVU (Relative Value Unit) values decreased by anywhere from 0.65% to 50% (or 0.01 to 2.04 RVUs). The median change was only 0.12 RVUs, which in and of itself doesn’t seem like much, but if you add them up, you get a total reduction of 492.95 RVUs for just these procedure codes.

This doesn’t consider frequency of use. For example, procedure code 75825 26 saw a reduction in RVUs of 1.16. In 2008, this procedure was reported to Medicare 60,864 times. That results in a net decrease in RVUs to those practices of 70,602 RVUs.
At the current conversion factor, that is a payment reduction of $2.6 million.

In addition to the RVU changes, there were 180 non-RVU changes, including changes to the PC/TC (Professional Component/Technical Component) policies, new records, modified status, etc.

Note: Frank ran a side-by-side analysis of the changes for these procedure codes. If you would like a copy of his worksheet, go to his site and click on the Download tab. Even if you don’t want this file, he has lots of other goodies on his site for free. As always, thanks Frank!

[Links: email Frank, visit Frank’s site]
Note: I am very pleased to welcome the eloquent Dr. Charles of Examining Room fame to Manage My Practice. On his website, Dr. Charles tells us ”I am a family medicine physician” and says “Home-grown tomatoes have a special place in my heart.”

What Makes Us Happy

by Dr. Charles

The bilious oil hemorrhaging from the bowels of the Earth, coupled with the usual stressors of life, makes me feel sad and pessimistic of late. And while I’m still pretty sure that ignorance, intolerance, and our polluting routines will be our ruin, I also search for ways to retain optimism and hope. Amid the constant erosion there are basic roots that hold life together. If you share the belief that life is fundamentally absurd, then life is truly what you make it. Are there small steps proven to make us happier?

Psychology often concerns itself with helping ailing people get back to a neutral ground, but the field of positive psychology aims to do more. University of Pennsylvania psychologist Dr. Martin Seligman, positive psychology’s most renowned proponent, once said: “I realized that my profession was half-baked. It wasn’t enough for us to nullify disabling conditions and get to zero. We needed to ask, ”˜What are the
enabling conditions that make human beings flourish?”

To that end, research on happiness, optimism, positive emotions and healthy character traits has been increasing in psychology. Some surprising results challenge our assumptions, such as the fact that once basic needs are met, money does not increase happiness. Neither do high education or high IQ. Older people tend to be happier than young. The sunny weather in California and Florida does not make people happier than those living in colder and cloudier climes.

The trait most shared by happy people seems to be close connections with family and friends, bolstered by a commitment to spending time with them.

Other factors that are associated with happiness include contributing to the lives of others, a good relationship with a spouse, control over one’s life and decisions, time for leisure, spirituality or religion, and the holiday periods. The following graphic comes from a Time Magazine article on positive psychology:
The daily activities of life versus the overall experience also affects our opinions of what makes us happy. For example, parents typically consider their children the greatest source of happiness in their lives, but when asked about the day-to-day activities of caring for children, most considered it less than inspiring. One study of 900 women in Texas found that “caring for children” ranked well below sex, socializing, relaxing, praying or meditating, exercising, and watching TV. In fact, taking care of children ranked below cooking and only slightly above housework. Yet when asked what one thing has brought people the most happiness, children and grandchildren are most frequently cited. There is a difference between the “experiencing self” and the “remembering self.”

In addition to the big things in life, are there small steps we can take on a daily basis to improve our sense of...
happiness? According to positive psychology the answer is yes. Research supports the following measures that increase engagement, pleasure, and meaning:

1) **Count your blessings.** “At the University of California at Riverside, psychologist Sonja Lyubomirsky is using grant money from the NIH to study different kinds of happiness boosters. One is the gratitude journal”“ a diary in which subjects write down things for which they are thankful. She has found that taking the time to conscientiously count their blessings once a week significantly increased subjects’ overall satisfaction with life over a period of six weeks, whereas a control group that did not keep journals had no such gain.”

Instead of only complaining at the dinner table of the things that went wrong at work, recounting three positives each day will produce more happiness in your life. Gratitude exercises also help physical health and may alleviate the distress of chronic pain and illness to some degree.

2) **Practice altruism.** Volunteering at a hospital, cooking a meal for a friend, letting a stressed mother cut in front of you in the grocery line, mowing a neighbor’s lawn, sending a care package to a grandparent”“ all these examples of kindness create connections between people, increase your sense of capability, generosity, and perhaps open the door to reciprocal acts that foster community and friendship. Altruism is a fine way of pleasing yourself and others at the same time.

3) **Take time to delight in the world.** Did you really taste that bowl of coffee ice cream? Did you pause to wonder at the crescent moon and the stars beyond? Did you revel in the moment you pulled up the cotton sheets and felt luxurious in your safe bed before sleep? Living in the moment”“ sensually, intellectually, creatively, wondrously”“helps to ward off despair.
4) **Thanking a mentor** in your life is important, and actually benefits you, too. One study showed that writing a letter to someone to whom you owe a debt of gratitude produced positive effects on the writer that were significant for over a month. Of course the recipient of such a letter is thrilled.

5) **Forgive others.** Writing a letter of forgiveness, whether delivered or not, helps purge negative emotions and desires for revenge. It the first and most important step in moving on.

6) **Devote time and energy to relationships.** Ties with family and friends are the most consistently cited predictors of happiness. Although the deserted island in the middle of the tropics sounds great, in reality we are fulfilled by the webs we weave and the connections we make throughout life.

7) **Use your body.** Stretch. Exercise. Laugh. Walk. These things reduce anxiety and improve mood.

8) **Develop effective coping mechanisms.** Hardship, adversity, and tragedy will always be a part of life. Cultivating faith, whether religious or secular, has been shown to help people cope. Even believing a simple dictum like “This too shall pass” relieves the stress of the moment.

A perpetual state of happiness is not possible. As I write this I finish a fairly crappy day, and I just learned that Medicare (thanks to Senate Republicans) is cutting its payments to physicians by 20%. This will be disastrous for doctors, medical practices, and ultimately patients. But I went for a run today. I ate tasty fish cooked with garlic and tomatoes. I saw a beautiful sky at dusk and basked in a breezy, humidity-free day. I am thankful that I am not in pain, and that I was able to help some people through my work.

Flourishing isn’t easy, and positive psychology sounds like fluff when you are in the dumps, but it’s worth a Sisyphean try to be happy.
You can visit Dr. Charles on his website [The Examining Room of Dr. Charles](#), and you can follow him on [Twitter here](#) or check out his [Facebook page here](#).