The Five Main Causes of Physician Burnout

By Dike Drummond, MD

This is the first in a three-part series from Dike Drummond, MD. Dr. Drummond is CEO of TheHappyMD.com, where he provides burnout prevention and leadership development coaching, training and consulting to individual physicians and healthcare organizations. Dr. Drummond will be speaking on this topic at the 2019 SVMIC Risk Education seminars.

There is an epidemic of physician burnout in the USA. It has a pervasive negative effect on all aspects of medical care including your satisfaction with your career. In this three-part article series we will explore burnout's symptoms and causes (Part 1), proven methods to lower physician stress levels (Part 2) and proven methods to recharge and create more life balance (Part 3).

Part 1: Physician Burnout Basics – Recognizing the Beast

Before you can effectively fight an enemy, you must be able to recognize it. Physician burnout is both incredibly common and a taboo subject in the workplace. Stress management and burnout prevention are never covered in detail in medical school or residency training.

In this article we will fill this hole in your medical education by exploring burnout's prevalence, cardinal symptoms, effects, complications and five main causes. In future articles we will explore multiple field-tested burnout prevention tools to help you lower your stress levels and build more life balance and a more ideal practice.

The prevalence of physician burnout

Burnout prevalence has been exhaustively studied in all major specialties and in most first world nations over the last three decades. Here is a telling quote from one of the key researchers:

"Numerous global studies involving nearly every medical and surgical specialty indicate that approximately 1 of every 3 physicians is experiencing burnout at any given time." - Tait Shanafelt MD (1)

The 2015 Medscape Physician Lifestyle Survey (2) reported a burnout rate of 46%. This was up from 39.8% in the 2013 survey.

Why is physician burnout important?

Burnout is directly linked to an impressive list of pervasively negative consequences. (3, 4, 5, 6, 7, 8)

- Lower patient satisfaction and care quality
- Higher medical error rates, malpractice risk
- Higher physician and staff turnover
- Physician alcohol and drug abuse and addiction, physician suicide

Burnout can be a fatal disorder. Suicide rates for both men and women are higher in physicians than the general population and widely underreported.

So, before we go on, let's agree that physician burnout is bad on multiple different levels. Bad for the doctor and their family. Bad for their staff, patients and organization. And burnout is everywhere, all the time.

The origin of physician burnout

Burnout is a fundamental disorder of energy metabolism. This is not the Kreb's cycle. It is more like "the force" in Star Wars. Before we go any further, we must debunk a common metaphor for burnout: The battery. Physicians often discuss exhaustion and burnout as a state where, "my batteries are just run down." This battery metaphor is at odds with reality for the following reasons.

When a toy's battery runs out, what does the toy do? Yes, it stops working. When did you ever stop working - ever? If you had stopped working - at any time in your med school, residency or practice - what effect would that have had on your career?

A much more accurate and useful metaphor is the energetic bank account.

Like an account at the bank, it can have a negative balance. And just like a regular bank account, when you dip into a negative balance the account does not get closed. You keep working despite the fact that your energy account is in a negative balance. This is exactly what residency trains us to do. We learn to carry on despite complete exhaustion of our energy reserves.

Simply stated …

- We use energy from this account for the activities of our life and medical practice
- We recharge the account during times of rest and rebalance

Burnout is the constellation of symptoms that occur when your energy account is in a negative balance. You can continue to function in this depleted state, however, dozens of studies show you are a shadow of the doctor you are when your account is in a positive balance.

Burnout's three cardinal symptoms

The accepted standard for burnout diagnosis is the Maslach Burnout Inventory, developed by Christina Maslach at the University of San Francisco in the 1970. Her team was the first to describe burnout and name the syndrome. Here are the three main symptoms.

1) *Exhaustion*

The physician's physical and emotional energy levels are extremely low and in a downward spiral over time. A common thought process at this point is, "*I'm not sure how much longer I can keep going like this.*"

2) *"Depersonazliation"*

This is signaled by cynicism, sarcasm and the need to vent about your patients or your job. This is also known as "compassion fatigue". At this stage you are not emotionally available for your patients, or anyone else for that matter. Your emotional energy is tapped dry.

3) *"Lack of Efficacy"*

You begin to doubt the meaning of your work. "What's the use, my work doesn't really serve a purpose anyway." Or you may worry that you will make a mistake if things don't get better soon.

Gender differences

Recent research shows that both men and women suffer from exhaustion and compassion fatigue equally. However, symptom three, "Lack of Efficacy", is much less common in men. Male physicians are far less likely to doubt the quality of their work than women no matter how burned out they are. (9)

Fast and slow and the role of trauma

Burnout can happen slowly over time in a chronic grinding fashion – the classic “death by 1000 paper cuts.” It can also crash down on you in a matter of minutes when it is triggered by a traumatic outcome, lawsuit, devastating medical error or equally tragic circumstance in your larger life. Trauma can drain your energy in mere moments, robbing you of the will to go on. The lifetime incidence of this level of trauma in practicing physicians is extremely high. In some specialties repeated practice trauma is a constant feature of the physician’s professional life.

The 5 main causes of burnout

In over 1500 hours of one on one coaching experience with burned out physicians, here are the five commonly seen causes of burnout.

1) The practice of clinical medicine

Being a physician has been and always will be a stressful job. This is a fundamental feature of our profession for a simple reason. We are dealing with hurt, sick, scared, dying people and their families.

Our work takes energy even on the best of days. Our practice is the classic high-stress combination of great responsibility and little control. This stress is inescapable as long as you are seeing patients, no matter what your specialty. As you read on, note that this is the only one of the five causes of burnout we actually experience in our training.

2) Your specific job

On top of the generic stress of caring for patients stated above, your job has a very specific set of unique stresses. Everyone’s matrix of job-specific stresses is unique. They include the hassles of your personal call rotation, your compensation formula, the local healthcare politics associated with the hospital(s) and provider group(s), the personality clashes in your department, your leadership and your personal work team and many, many more.

You could change jobs to escape your current stress matrix and your next position would have all the same stressors at different levels of intensity. It is also tempting to believe a different practice model would be less stressful. However, moving from an insurance based practice model to concierge or direct pay simply switches one set of stressors for another.

3) Having a life

In an ideal world, your life is the place where you recharge from the energy drain at work. Two major factors can prevent this vital recharging activity.

a) We are not taught life balance skills in our medical education. In fact, our residency training teaches us just the opposite. We learn and practice ignoring our physical,

emotional and spiritual needs to unhealthy levels and then carry these negative habits out into our career. You work until you can't go any longer, then you keep going. To do otherwise could be seen as a sign of weakness. (see cause #4 below).

b) Multiple situations could arise at home that eliminate the opportunity to recharge your energy account. Your life outside your practice then switches from a place of recharge and recuperation to an additional source of stress.

The causes range widely from simple conflict with your spouse, through illness in a family member (child, spouse, parent), to financial pressures and many more.

This can lead to the common situation where you watch a colleague take on the downward spiral of burnout at work in the absence of any new work stress. If you reach out to a colleague who appears to be suffering with burnout, you must ask, "How are things at home?" to reveal this burnout cause. (10)

4) The conditioning of our medical education

As premeds, several important character traits become essential to graduating from medical school and residency. Over the seven plus years of our medical education they become hardwired into our day to day physician persona, creating a double edged sword. The same traits responsible for success as a physician simultaneously set us up for burnout down the road. Here are the top five I see in my physician coaching practice:.

Workaholic
Superhero
Perfectionist
Lone Ranger
Emotion Free

In addition, we absorb two prime directives. One is conscious and quite visible:

"The patient comes first"

This is a natural, healthy and necessary truth when we are with patients. However, we are never shown the off switch. If you do not build the habit of putting yourself first when you are not with patients, burnout is inevitable.

The second prime directive is never stated, deeply unconscious and much more powerful. It goes like this:

"Never show weakness"

To show you this programming,, please try this thought experiment. Imagine you are back in your residency. A faculty member walks up to you and says, "You look really tired. Is everything OK?" How would you respond – and how quickly would that response come out of your mouth? That is the essence of this deeper prime directive. This kneejerk defense

makes it very difficult to help physician colleagues even when their burnout is clear to everyone on the team.

Put the five personality traits together with the two prime directives and you have the complete conditioning of a well-trained physician. Combine this with a training process that is very much like a gladiator style survival contest, and doctors become hardwired for self-denial and

5) The leadership skills of your immediate supervisors

Outside of healthcare there is a management saying, “People don’t quit companies; they quit their boss”. There is wide acceptance that your work satisfaction and stress levels are strongly affected by the leadership skills of your immediate supervisor.

Now we know this is true for physicians too. A recent study shows a direct relationship between the quality of your boss and your burnout and job satisfaction levels. (11) In this era where physician groups are forming much more quickly than they can find trained doctors for their leadership positions, having either an unskilled, or worse, an absent boss , is very common. This fifth cause of burnout has only recently joined the classic four above. It is a significant source of stress for many employed physicians.

The pathophysiology of burnout

How does burnout work in the body of its victims? Let’s go back to two concepts discussed above – the energy account and the symptoms of the Maslach Burnout Inventory (MBI).

It is most useful to understand we each have more than one internal energy account. There are actually three energy accounts inside each of us. They correspond to the three symptoms of the MBI.

1) *Exhaustion = your physical energy account*

You make energy deposits here by taking care of your physical body with rest, exercise, nutrition – all the things we learned not to do in our training.

2) *Compassion fatigue = your emotional energy account*

You make energy deposits here by maintaining healthy relationships with the people you love – your friends and immediate family. Recharging here is essential if you are to have energy to be emotionally available for your patients and staff, family and friends.

3) *“What’s the use” = your spiritual bank account*

You make deposits here via a regular connection with your personal sense of purpose. In your practice this occurs when you have an ideal patient interaction. This is the visit where you say to yourself afterwards, “Oh yeah, that is why I became a doctor”. You can connect with purpose outside of work as well. One example for me is when I coach my children’s

youth soccer teams. If you go long periods of time without connecting with purpose, this account is drained and you have a lot of trouble seeing a reason to carry on.

"(Burnout is) … an erosion of the soul caused by a deterioration of one's values, dignity, spirit and will." - Christina Maslach

The physician's ethical imperative

As physicians, we each have an ethical imperative to keep our energy accounts in a positive balance. All good things flow from this positive energy state. Our leadership skills, quality patient care, empathy, our skills as a spouse and parent … all of these rely on a positive energy balance

And yet you can see we are not trained to notice, or care for, our energy levels and our job places us at very high risk for burnout.

How can we stop or prevent physician burnout?

There are two fundamental mechanisms to drive a positive energy balance.

- Lower your stress levels and the drain they produce
- Improve your ability to recharge your energy accounts

Most physicians will use a combination of both methods to treat and prevent burnout. We will discuss multiple tools in both categories in future articles.

One more thing – beware of Einstein's insanity definition and the comprehension trap.

Before we end this introductory article, let me show you an extremely common form of "mind trash" that stops many physicians from preventing burnout in the first place - the comprehension trap. The tendency to study a concept until you understand it, then fail to put it into action.

Einstein's insanity definition: "*The definition of insanity is doing the same things over and over and expecting a different result.*" (12)

Now that you have a better understanding of burnout, do not stop here. You must take different actions to get different results in your practice and your life. In order to prevent or recover from burnout you must rise above the habits you learned in training and take new actions to lower stress and create more balance.

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(12) There is no evidence Einstein ever said this. That does not make it any less powerful.

Self-Inflicted Wounds

By Jeff Williams, JD

Lisa Owens was a sixty-year-old female.[1] By most standards, she had a good life. Mrs. Owens had a loving husband, adult-aged children and young grandchildren. Mrs. Owens and her husband were both at the twilight of their respective careers and were looking forward to retirement, which meant spending more time with their grandchildren and a lot more leisure travel. But, Mrs. Owens' health was sub-par and had been so for quite some time. Morbid obesity was the genesis of her health problems. Being overweight for most of her adult life eventually caused chronic back problems, sleep apnea, a host of heart problems, fibromyalgia and other health issues.

Mrs. Owens' back pain had become so unbearable there were days that she could not walk without the assistance of a cane. The time had come to see a specialist about her debilitating back pain. Enter Dr. Linda Houser, a neurological surgeon, practicing in the same town for over twenty years. During that time Dr. Houser had seen thousands of patients with diagnoses nearly identical to that of Lisa Owens: chronic back pain and other health issues, the common denominator being morbid obesity. She had performed many surgeries involving her patients' spinal column without any major issues.

Dr. Houser diagnosed Mrs. Owens with disc herniation of the lower lumbar region and concomitant canal stenosis. This all contributed to the pain radiating throughout her lower body and was the primary cause of her inability to walk without assistance on a frequent basis. After some attempts at conservative treatment, Mrs. Owens indicated her desire to pursue surgical intervention. The surgery would be a lumbar decompression and microdiscectomy. She chose the surgery despite Dr. Houser's warnings that due primarily to her poor physical condition and health, she was at-risk of complications during the surgery, including but not limited to death.

Dr. Houser sent Mrs. Owens to her cardiologist for an assessment and surgical clearance from a cardiac standpoint. The cardiologist issued a letter clearing her for the surgery, but indicated that the patient was a moderate risk for a cardiovascular event during and subsequent to the procedure. The hospital performed a sleep apnea assessment pre-operatively, which placed the patient in a high risk category, consistent with her history of sleep apnea.

Dr. Houser performed the lumbar laminectomy without issue. Mrs. Owens was then transferred to postoperative care. She was given high dose I.V. narcotics in the immediate postoperative period. Upon admission to the floor, her vital signs were stable. After a few hours, the patient requested that the nurse remove the pulse oximeter. The nurse obliged

as she had worn it long enough to meet the hospital's postoperative protocol. The next day Mrs. Owens was found unresponsive in her hospital bed and shortly thereafter, she expired. The cause of death was most likely severe anoxic brain injury as result of respiratory arrest.

After her passing, a wrongful death lawsuit was filed against Dr. Houser, the hospital and other providers. The primary allegation directed towards Dr. Houser was that she breached the standard of care by not ordering telemetry monitoring subsequent to the procedure. The allegations in the lawsuit insinuated that Dr. Houser was simply going through the motions preoperatively and failed to be forward thinking enough to order appropriate postoperative monitoring. The allegations against the hospital were primarily focused on the nursing staff's failure to appropriately administer and monitor the pulse oximeter that was placed on the patient while in recovery.

As this case developed, there were indicators that the patient should have been placed in the cardiac-telemetry unit immediately after the surgery, as the patient had pre-existing heart problems. But, Dr. Houser had performed procedures like this for years on patients similar to Lisa Owens without such a catastrophic outcome. Indeed, had Dr. Houser ordered telemetry monitoring for every one of her patients similarly situated to this patient, certain units in the hospital may well have a shortage of beds. Of course, this is not a defense in a wrongful death case. Lawsuits often have this familiar tenor: "If the doctor would have done _____. Then, the patient would not have suffered harm." This is viewing patient care in hindsight. The practice of medicine is complex by its very nature. In a lawsuit, the allegations against the physician are made with the benefit of hindsight. This can be vexing to a physician that has been sued, as no doctor has ever been afforded that benefit while treating a patient.

This case was settled amicably amongst the parties without the necessity of trial. Use this story as a cautionary tale going forward. Good patient experiences in the past may not serve as an accurate predictor of future outcomes. Carefully review sleep apnea evaluations (e.g. STOP-BANG or similar assessment), which could influence your postoperative orders, including the need for pulse oximetry or cardiac-telemetry unit. When writing postoperative pain medication orders, indicate which medication should be used for each type of pain (mild, moderate, severe) and take into consideration whether the patient is opiate naïve when deciding medication types and amounts. Patients oftentimes present with co-morbidities that predict a greater chance of a shortened life. The reality is that the co-morbidities in which Lisa Owens suffered from have become more prevalent in modern society. With each patient encounter, take a step back, try not to become desensitized by the patient who has health problems that you have seen time-after-time.

Think back to your first patient. You lacked experience, but you were likely very alert while treating Patient #1. Assess each patient as if he or she was your first. This approach may serve as a safeguard to assure you are making a complete assessment of the patient's medical needs presently and into the future. In so doing, you will hopefully avoid the

second guessing that comes along with adverse outcomes and zealous plaintiff's lawyers.

[1] Names and identifying details have been changed for confidentiality.

Records Go Missing After EMR Outage

The following article is based upon an actual claim situation experienced by an SVMIC policyholder. The details have been altered to protect our policyholder's privacy.

It was day that began like any other for Dr. Sandra Lynn, an internal medicine doctor and the head of a multi-specialty clinic made up of 15 physicians. She began with 30 minutes on the treadmill, followed by a quick shower and a smoothie for breakfast on the way to the office. Soon, the day would take a dramatic turn.

As she drove to the office, her phone rang and she answered it using the Bluetooth feature in her car. It was her practice administrator, Martha. Dr. Lynn knew that Martha would not call so early in the morning unless something was wrong so she answered the phone by asking, "Are you okay?" Martha assured her that no one was sick or injured, but that their EMR system was offline. Martha had tried to reach the EMR vendor, but was unable to get through at the time of her call to Dr. Lynn.

Dr. Lynn's office had protocols in place for power outages and other types of emergencies. One preemptive practice was the daily printing of the appointment calendar with patients' names, phone numbers and reasons for their visits. Martha used this list to contact the non-acute patients to reschedule their appointments.

Martha continued working with the EMR vendor to get the system up and running while the doctors treated their remaining patients. These patients were asked to complete a medical history upon arrival, including medication list, and the doctors and staff took copious notes that were later scanned and entered into the EMR once it was available. Yet, not having access to the patients' treatment notes and health histories was worrisome from a treatment standpoint.

Finally, the EMR system came back online, and the doctors were relieved - until Dr. Lynn opened the records for her next patient, whom she had been treating for a wound infection for three weeks. All of the treatment records for the last month were gone. She looked up the record for the following patient, who had been in two weeks prior for a UTI, and those treatment notes were gone as well.

Relief turned into panic as Martha conducted a search of the EMR records for the month in question, and all of the treatment data was gone for patient visits during that time period. To make matters worse, the EMR vendor was not at all helpful. They indicated that the records were lost and irrecoverable.

Martha had recently attended a luncheon with a speaker who talked about cybersecurity insurance, which prompted a conversation with SVMIC regarding the cybersecurity coverage that is included with the doctors' professional liability policies. The practice had

subsequently purchased the increased limits cybersecurity insurance policy through SVMIC's partnership with NAS Insurance.

Both the embedded and the increased limits coverage included Network Asset Protection* which was described as "coverage for amounts incurred to recover and/or replace electronic data that is compromised, damaged, lost, erased or corrupted due to (1) accidental damage or destruction of electronic media or computer hardware, (2) administrative or operational mistakes in the handling of electronic data, or (3) computer crime/attacks including malicious code and denial of service attacks. Coverage also extends to business income loss and interruption expenses incurred as a result of a total or partial interruption of the Insured's computer system directly caused by any of the above events."

Martha contacted SVMIC's claims department who then notified NAS. A forensic expert helped recreate the records from the practice's own backup system. When they were finished, the only records not in the EMR system were the patient visits from the morning when the system was down.

In addition to the cybersecurity coverage through NAS provided in SVMIC's medical professional liability policy, other tools are available to our policyholders. Through SVMIC's partnership with NAS, our policyholders have access to NAS cyberNET. This site features monthly cybersecurity updates, webinars and online training and support. Access this site here. In addition, SVMIC's Medical Practice Services Department offers consulting and training related to cybersecurity and HIPAA.

** Cybersecurity coverage is subject to terms, conditions and exclusions not described in this article. The information contained in this article concerning cybersecurity insurance is intended to give you an overview of the coverage available. None of the information—including any policy or product description—constitutes an insurance policy or guarantees coverage. The policy contains the specific details of the coverages, terms, conditions and exclusions and coverage determination is made by the company at the time of a claim.*

Changes to Evaluation & Management Coding to Have Major Impact of Government's New Ruling

By Elizabeth Woodcock, MBA, FACMPE, CPC

On November 1, the Centers for Medicare & Medicaid Services (CMS) released the Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019. This highly anticipated, hefty 2,378-page federal ruling outlines key reimbursement changes for 2019 – and beyond. Overall, physicians will experience a small upward bump in reimbursement, with the conversion factor increasing from $35.99 to $36.04.

According to CMS Administrator Seema Verma's separate November 8 announcement, it is worth noting that "exceptional performance" participants in the Merit-based Incentive Payment System (MIPS) will receive an additional, maximum 1.88% boost in 2019. Although that wasn't the increase successful participants hoped for, only 5% of physicians will experience the federal program's 4% decline. The lack of failure, ironically, left little to distribute to the "winners."

The federal ruling announced a multitude of new policies, but perhaps the most wide-reaching one pertained to the significant changes to the evaluation and management (E/M) codes. CMS is using a phased-in approach, starting with documentation requirement changes; the reimbursement modification will hit in 2021.

The alteration to documentation reflects an easing of requirements: "…when relevant information is already contained in the medical record [for established patients], practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements." Furthermore, CMS asserts: "…for new and established patients for [E/M office] visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary." Both of these declarations may signal an opportunity to alter or revise existing workflow related to recording key elements of the visit although CMS makes it clear that the changes are optional: "Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so. We note that this policy to simplify and reduce redundancy in documentation is optional for practitioners, and they may choose to continue the current process of entering, re-entering and bringing forward

information."

Per CMS, "For CY 2019 and 2020, we will continue the current coding and payment structure for E/M office/outpatient visits, and, therefore, practitioners should continue to use either the 1995 or 1997 versions of the E/M guidelines to document E/M office/outpatient visits billed to Medicare for 2019 and 2020 (with the exception of our final policy to eliminate redundant data recording)."

As of 2021, CMS is allowing physicians to choose the level of the E/M service based solely on time regardless of the time involved in counseling and/or coordination of care, although it is important to note that the agency's emphasis is that there is a requirement to document that the visit was "medically reasonable and necessary."

For CY 2021, the codes 99212 through 99214 and 99202 through 99204 will be collapsed into single rates for established and new patients, respectively. CMS is also creating new add-on codes – GPC1X and GCG0X, respectively - for the "additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care." In addition, practitioners will be able to signal an "extended visit" with a new add-on code to be used for additional resources. The new payment rates – set to go into effect in 2021 – are highlighted in this table.

Finally, CMS is eliminating the requirement for a home visit to be substantiated by "remov[ing] the requirement that the medical record must document the medical necessity of furnishing the visit in the home rather than in the office."

Although the E/M changes represent a significant departure from current practice, the new payment for virtual care is truly groundbreaking. Administrator Verma declared when the ruling was released, "(F)or the first time in 2019, Medicare will pay doctors for virtual check ins with their patients, virtual consultations between physicians, evaluation of remote pre-recorded images and video…". CMS specifically stated that these visits are not telemedicine encounters so that they are not subject to the geographic and other restrictions on telehealth services.

As of January 1, 2019, CMS offers two new payable codes:

Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion, e.g. virtual check-in.

G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or

soonest available appointment.

CMS notes: “We are finalizing that the follow-up with the patient could take place via phone call, audio/video communication, secure text messaging, email, or patient portal communication.”

Furthermore, CMS asserts: "remote evaluation of recorded video and/or images submitted by an established patient...allow[s] practitioners to be separately paid..."

Verbal consent should be noted in the medical record for each billed “virtual visit,” although CMS expressly points out that electronic consent can be gathered for the G2010 service. There is no frequency limitation, although CMS declares its intention to analyze utilization in the coming year. CMS is not requiring any service-specific documentation requirements for this service, but it must be “medically reasonable and necessary” in order to be paid by Medicare. The payment rate is ~$14 for either service, and the services are subject to beneficiary cost sharing, which means that you must bill the patient for their portion of the financial responsibility, typically the co-insurance.

CPT codes 99451, 99452, 99446, 99447, 99448, and 99449 describing Interprofessional Consultations were formulated years ago, but they never had payment status. CMS’ stance changes in 2019, allowing payment for consultation between “practitioners that can bill Medicare independently for E/M services.” Like the other codes cited herein, Medicare requires the patient’s verbal consent to be noted in the medical record, as beneficiary cost-sharing applies.

In addition to these new codes and payment policies, CMS added two CPT codes for prolonged preventive services to the list of payable telehealth services, a modifier to distinguish telestroke services, "virtual communication" codes for community health centers, and telehealth-based home dialysis monthly ESRD-related clinical assessments.

Furthermore, CMS adds new payable services related to the opioid crisis. Instituting a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT), CMS will include the patient’s home as a “permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder” after July 1, 2019.

Payment amounts for drugs under Part B will be reduced, although the impact will be limited as the policy only applies to *new* drugs and only to the time period when an ASP (average sales price)based payment limit is not available: “WAC [wholesale acquisition cost]-based payments for new Part B drugs will utilize a 3 percent add-on in place of the 6 percent add-on that is currently being used.”

Welcome news to physicians involved in imaging, CMS has reduced the restrictions on supervision of registered radiologist assistants (RRA) and radiology practitioner assistants (RPA), replacing the “personal” supervision to that of a direct level of supervision as permitted by state law, and state scope of practice regulations.

CMS officially discontinues the functional reporting requirements for outpatient therapy services furnished on or after January 1, 2019, although they can still be reported in the coming year if the practice so chooses. For physical and occupational therapy, there are two new payment modifiers – CQ and CO – to identify services furnished by assistants.

Therapists are among the practitioners now considered eligible for participation in the Merit-based Incentive Payment System (MIPS); the list of participating providers is expanded to include: physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dietitians or nutrition professionals. Notably, these new, eligible practitioners will automatically be assigned a zero percent weighting for the Promoting Interoperability category of MIPS.

The minimum threshold for MIPS participation in 2019 is 30 points, and exceptional performance was raised to 75.

In addition to the fact that participants must use 2015 Edition certified EHR technology in 2019, the government made changes to each of the MIPS reporting categories:

- Adding 8 new quality measures, and removing 26; offering a small-practice bonus score.
- Increasing the cost category to 15% of the total MIPS score, bumping quality down to 45%; adding payment-standardized, risk-adjusted episode-based measures for cost analysis.
- Adding 6 new improvement activities, modifying 5 and removing 1.
- Changing the old “meaningful use” (and, subsequently, advancing care information) category to “promoting interoperability,” with four all-or-nothing categories: (1) eRx; (2) health information exchange; (3) provider-to-patient exchange; and (4) public health and clinical data exchange. Exclusions are available for small practices (15 eligible clinicians or less), as well as certain categories based on this broad exclusion: “Any MIPS eligible clinician who is unable to implement the measure for a MIPS performance period in 2019 would be excluded from this measure.”

Attestations can be submitted via “direct, login and upload,” or “login and attest,” replacing the EHR and registry submission terminology for reporting. CMS finalized a policy to allow clinicians, who otherwise would have been excluded under the low-volume threshold, the option to participate in MIPS. Once a physician chooses to opt in, however, the decision is irrevocable for the participation year, and he or she is subject to the penalty. As it relates to exclusions, CMS clarified that the minimum volumes of patients – 200 patients – and allowed charges - $90,000 – were based on *covered* professional services. Finally, the

200 was also applied to professional services so that the exclusion also applied if not more than 200 services were rendered.

CMS' November ruling follows on the heels of the American Medical Association's (AMA) issuance of the 2019 CPT Codes in September. There are a total of 335 changes - 212 codes added, 73 deleted and 50 revised - heading into the new year, to include three new remote physiologic monitoring codes (99453, 99454, and 99457), as well as two new interprofessional internet consultation codes (99451 and 99452), all five of which CMS agreed to cover as a paid service. In addition to these codes, the AMA announced new and revised codes for skin biopsy, fine needle aspiration biopsy, adaptive behavior analysis, and central nervous system assessments including psychological and neuropsychological testing.

2019 will most certainly be another exciting year in practice management, with novel challenges, but also new opportunities.
