MOVING INDIANA FORWARD

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INDIANA PODIATRIC MEDICAL ASSOCIATION

Forward

ISSUE ONE | SPRING 2024

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PRESIDENT'S MESSAGE

KATHLEEN NEUHOFF, DPM | IPMA PRESIDENT

I hope everyone has had a good start to 2024. The year has already been a busy one for IPMA. The Association continues to work and monitor a multitude of bills being considered by the Indiana General Assembly. You can see a full report on page 3 provided by IPMA lobbyist Rhonda Cook.

Two events are quickly approaching. Next month, an IPMA Delegation will be in Washington, D.C. during the Annual House of Delegates and Legislative Conference. Both of these events are critical in terms of setting the direction of the APMA and advocating for policies that support the podiatric profession. Then in April, many IPMA members will be heading to Chicago for the Midwest Podiatry Conference. The MPC provides a fantastic opportunity to catch up with friends and colleagues from throughout the region. As a reminder, the IPMA receives a portion of all proceeds from IPMA member registrations.

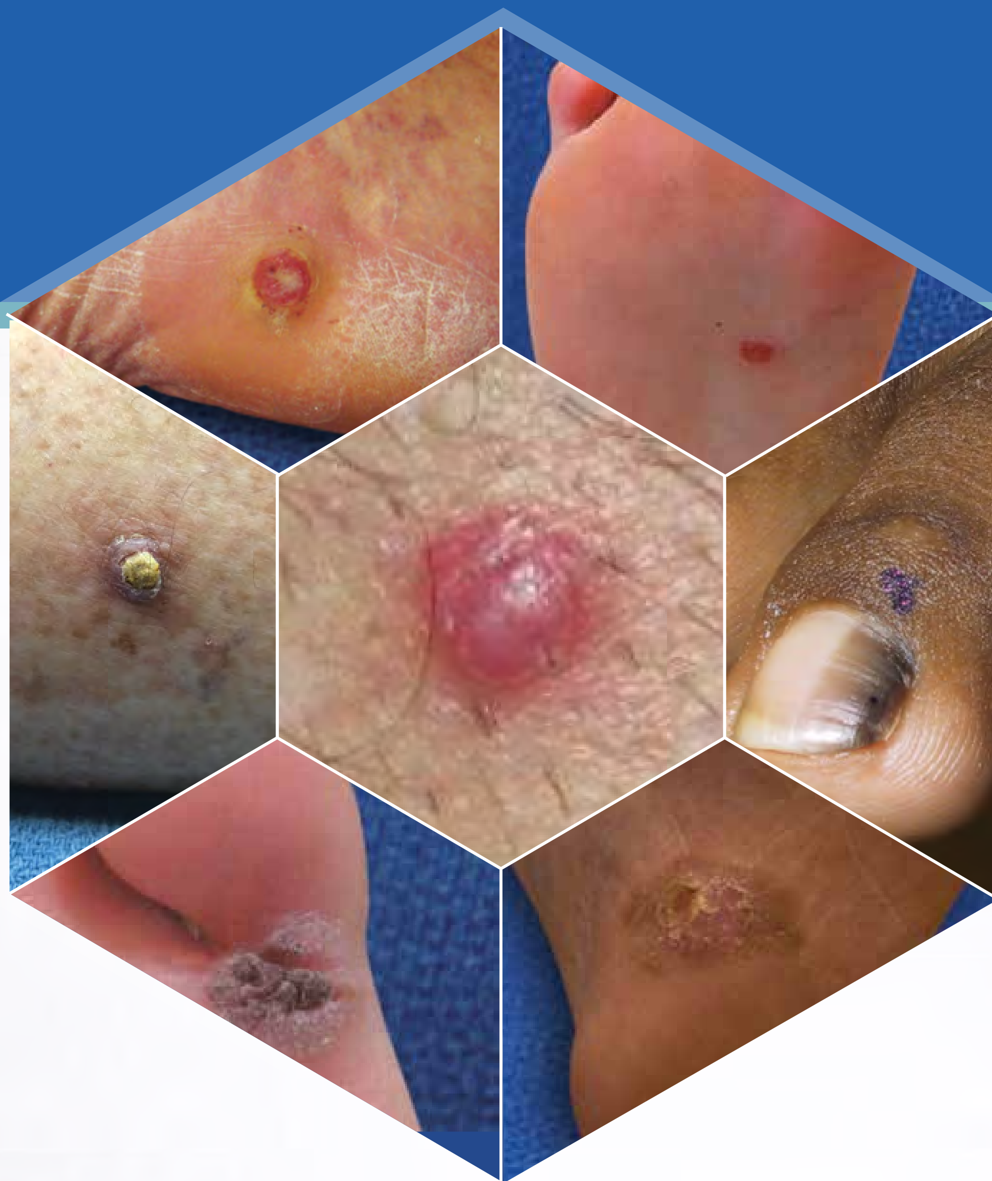
Please keep an eye out for a new webinar CME series that we will provide to members in 2024. We hope this will provide additional value and flexibility for IPMA members trying to complete their continuing education requirements.

Additionally, I ask you to continue to support the IPMA/APMA with your membership dues and participation. The IPMA needs you to be involved and engaged to make change happen for podiatrists, our patients and our practices.

Finally, please mark your calendars for the following events:

- APMA Annual Scientific Annual Meeting, Walter E. Washington Convention Center, Washington, DC – August 8 - 11, 2024
- IPMA Annual Convention, Renaissance Indianapolis North Hotel, Carmel, IN, September 20 – 21, 2024.

What do all of these skin lesions have in common?



They are all **MALIGNANT.**

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LEGISLATIVE REPORT

BY RHONDA COOK
LEGISGROUP PUBLIC AFFAIRS, LLC

The 2024 Indiana General Assembly completed work for the first half of the session. All committee hearings and final votes in the chamber of origin have occurred. Any bill that failed to receive a committee hearing or failed to pass its chamber of origin is considered dead. However, in a few cases, language from the original bill can be inserted in a different bill in the second half of the session.

One disappointment so far is that SB 3 on Prior Authorization stopped moving forward due to its fiscal impact to the State of Indiana. This bill, with its low bill number, was a Senate Republican priority bill. It would have prohibited prior authorization when 80% of prior authorizations for the same service had been previously approved. This bill would have eliminated a lot of paperwork and time delay, but unfortunately, it looks like it won't be a reality this year.

Another highlight from the first half, SB 10 and SB 142, which compliment one another, are both moving forward. SB 10 sets up pilot program for mobile integrated health care programs and SB 142 requires an insurance plan to cover mobile integrated health care services.

APMA CORNER

APMA MAKES RECOMMENDATIONS FOR MIPS 2025 PY PODIATRY SPECIALTY MEASURE SET

On February 2, APMA submitted comments to CMS in response to its solicitation for recommendations related to the MIPS 2025 Performance Year Podiatry Measure Specialty Set. APMA recommended removing Measure #219: Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairment from the Podiatry Specialty Measure Set for 2025.

APMA requested this measure's removal due to the fact that very few physicians typically perform the actions described in this measure. This is underlined by the data—in 2021, more than 1,800 physical therapists reported Measure #219, compared to just three podiatrists in the same year. APMA is further concerned that by keeping the measure in the specialty measure set, DPMs may use it incorrectly, not fully understanding the requirements or the tool used, resulting in skewed data and results, potential misuse affecting patient care, as well as possibly poor scoring outcomes for those DPMs. To read this letter in full, as well as all other past comment letters, visit www.apma.org/commentletters. Contact MIPS@apma.org with any questions or concerns.

APMA REQUESTS HHS ENFORCE NETWORK ADEQUACY REQUIREMENTS FOR STATE EXCHANGES IN 2025

APMA submitted comments to HHS last week, responding to HHS' proposed rule, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program."

APMA focused its comments largely on HHS' proposal to not require State Exchanges and State-Based Exchanges on the Federal Platform (SBE-FPs) to enforce the appointment wait time standards and ensure that the provider network of each QHP (qualified health plan) meets applicable standards specified in 45 CFR §156.230(b) through (e), for 2025. APMA believes that strong network adequacy ensures that the most vulnerable patients, especially those living in rural and small communities, continue to receive access to the critical medically necessary foot and ankle care provided by a doctor of podiatric medicine, and as such, it is critical to require State Exchanges and SBE-FPs to adhere to these requirements.

Members can read this letter in full, as well as others, at www.apma.org/commentletters. If you have questions or concerns, contact the APMA Health Policy and Practice department at healthpolicy.hpp@apma.org.

APMA MEMBER INSIGHTS: 2024 PROFESSIONAL GOALS

Thank you to our members who shared their professional goals with us for the upcoming year! Here's a breakdown of what you told us:

- 27 percent of respondents want to advance in their current practice, while 16 percent are interested in expanding their clinical offerings by acquiring a new skill/technique.
- 15 percent of participants hope to retire, 6 percent are looking to become more involved in their profession, 2 percent are aiming to publish research, and another 2 percent looking to open their own practice in 2024.

Commented goals from members include: "I want to maximize profits of my practice;" "I want to make sure that podiatry is better understood by my patient base and medical colleagues in my facility;" "I want to start a residency program;" and "I want to retire or downsize where I work two days a week." How do your professional goals stack up?

APMA SUBMITS COMMENTS TO USPSTF REGARDING FALLS PREVENTION DRAFT EVIDENCE REVIEW AND RECOMMENDATION STATEMENT

APMA submitted comments to the United States Preventive Services Task Force (USPSTF) in response to the draft evidence review and draft recommendation statement regarding falls prevention in community-dwelling older adults on January 8. The evidence review process, conducted on behalf of USPSTF, was robust and complete. While APMA agrees with the identified needs and gaps for interventions to prevent falls in community-dwelling older adults, it strongly recommends further research on how footwear and amputation status influence falls.

Both letters are available at www.apma.org/commentletters. Continue to follow the APMA Weekly Focus and other APMA publications to learn more about falls prevention efforts, including www.apma.org/fallsprevention.

Support Your Industry!

The IPMA Foot Support PAC is a nonprofit, bipartisan fundraising committee through which podiatrists support state candidates who support podiatric medicine's issues before the Indiana General Assembly.

The Foot Support PAC's role is to support candidates seeking office in the Indiana State Senate or Indiana House of Representatives.

Donate to the Foot Support PAC

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Make a difference for podiatry. Join TEAM APMAPAC today!

PURPOSE: The American Podiatric Medical Association Political Action Committee's purpose is to raise and disburse funds to candidates for federal office who support the legislative priorities and goals of the podiatric medical profession.

IMPORTANT: You may contribute or not contribute without concern of being favored or disadvantaged. Occupation/Employer information is required for aggregate annual contributions of more than $200.00 by the Federal Election Campaign Act. Federal election law does not permit corporate contributions to be used for donation to candidates for federal office. Political contributions are not deductible for income tax purposes.

WHAT IT TAKES TO HAVE AN "A" TEAM FOR YOUR MEDICAL PRACTICE

BY TINA DEL BUONO, PMAC
DIRECTOR TOP PRACTICES VIRTUAL PRACTICE MANAGEMENT INSTITUTE , CONSULTANT AND PERFORMANCE COACH

Teams of any kind, sports, work, family, or community-related take work and the process of keeping the team together and everyone on the same page is an ongoing task. There is no magic wand, or simple solution. But there is one thing that is necessary and that is all the staff members desire to be a great "A" Team.

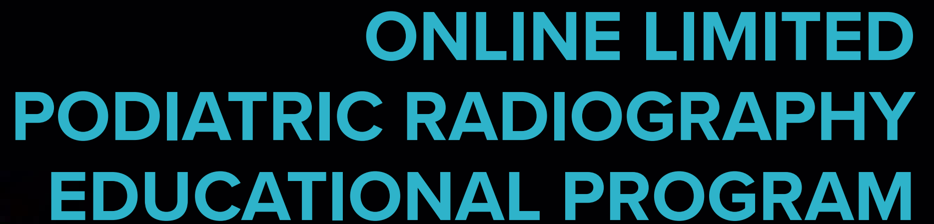
Over the years, I have found that there are a handful of key elements that need to be in the "mix" for an "A" Team to developed:

1. Everyone on the team must lead by example. Great team players do not wait to see how their team players perform, they jump in feet first and focus on their job tasks and do the best job they can so the team can be successful.
2. The team players build relationships and help one another. They can take the practice vision and goals and apply it, not only to the position they play on the team, but they know their strengths and look to see how they can help others on the team, so the goals of the practice are reached.
3. The players on the team hold one another accountable to do what is expected of them as a team player. Everyone makes errors and great team players recognize this, but they also recognize when someone is slacking off and needs encouragement to get back in the game and play by the rules.
4. Great team players have positive, contagious attitudes. They see what needs to be done; they work hard to make sure it gets done. Their attitude is Awesome. People are attracted to their positive energy and want to be their teammates.
5. Great team players are humble; they realize they are a player on the team just as the other players. No superstars allowed. They are open to learning and correction to make the team better and to reach the goals set before the team.

I have the wonderful opportunity to work on such a team. My teammates are amazing, and I feel privileged to work side-by-side with them.

If you noticed I said "work" with them. This is one of the most important key points of successful teams. They know it will take work to keep them moving forward and they are willing to put in what it takes to make their team an amazing one.

Tina Del Buono is a Performance Coach, Consultant and Mentor for physician and her fellow office managers/administrators and their staff. She has been a practice manager for over 25 years. Tina is the author of a National Indie Award Winning Book, "Truth from the Trenches" The Complete Guide to Creating A High-Performing, Inspired Medical Team. She lectures nationally on Practical Practice Management, specializing in Complete Practice Efficiencies, Team Building, Staffing Issues, Manager Training and Practice Building Protocols. She has also authored over 400 articles on practice management and has developed, GPS –Global Practice Systems, to create the road map to get your practice from where it is now to where you want it to be, in small practical, achievable steps.



ONLINE LIMITED PODIATRIC RADIOGRAPHY EDUCATIONAL PROGRAM

The Indiana State Department of Health (ISDH) requires all podiatric medical assistants who take x-rays to be licensed as a limited podiatric radiographer.

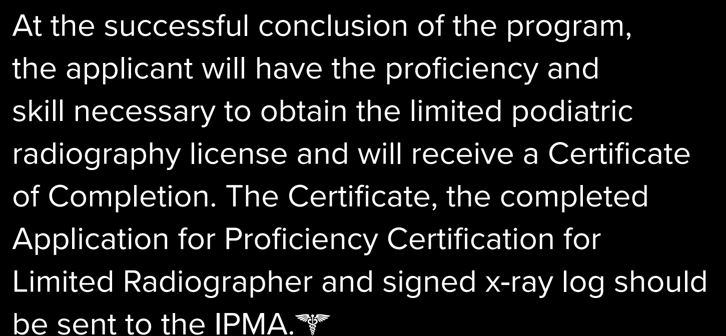
The IPMA wants to remind the membership of its new limited podiatric radiography program that meets the ISDH requirements and is designed to instruct the podiatry assistant in the safe and effective use of x-rays in the podiatric practice.

Content includes:

- History of the x-ray
- Risks and safety measures associated with radiography
- Image production and film development
- Principles of CT Scan, MRI, and Bone Scan
- Anatomy of the foot and ankle
- Positioning and x-ray machine placement

PROGRAM STRUCTURE

The program consists of four online content modules, each with a final exam, one attestation module, a student manual, and an x-ray log. A Certifying Physician must guide the applicant in the clinical portion of the program and the completion of the x-ray log. The podiatry assistant must document competency by demonstrating the proper performance of 60 x-ray views in the podiatrist's office.



At the successful conclusion of the program, the applicant will have the proficiency and skill necessary to obtain the limited podiatric radiography license and will receive a Certificate of Completion. The Certificate, the completed Application for Proficiency Certification for Limited Radiographer and signed x-ray log should be sent to the IPMA.

To learn more about this program or to register, click here.

CMS'S NEW FEDERAL PRIOR AUTHORIZATION RULE: AN EVENTUAL STEP IN THE RIGHT DIRECTION

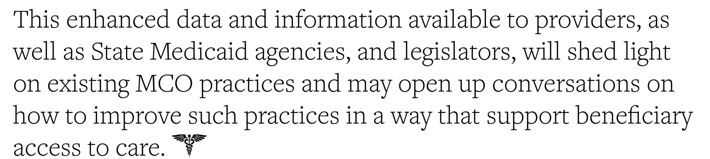
BY MEGHAN M. LINVILL MCNAB AND BRANDON W. SHIRLEY

CMS published a final rule, effective January 1, 2026, implementing additional processes to advance interoperability as well as to improve prior authorization processes. The changes to prior authorization will require: (1) Medicare Advantage, Medicaid Fee-for-Service ("FFS") and Medicaid Managed Care Organizations (collectively, "Payers") to send prior authorization decisions within 72 hours for expedited (urgent) requests and within 7 calendar days for standard (non-urgent) requests; (2) Payers to provide a specific reason for denied prior authorization decisions (except decisions for drugs); and (3) Payers to publicly report certain prior authorization metrics annually on their website. While CMS notes that Medicare FFS is not directly affected by this final rule, it indicates it will evaluate opportunities to improve prior authorization processes in Medicare FFS, as feasible. These changes will not significantly impact Indiana Medicaid and Medicaid Managed Care Organization ("MCO") processes, but the final rule's transparency elements could be prompt prior authorization reform in the future.

The final rule is not likely to significantly impact Indiana Medicaid providers. While federal rule currently requires Medicaid Managed Care Organizations ("MCO") to send prior authorization decisions within 14 calendar days for standard requests,[1] Indiana Medicaid proactively adopted a 7-calendar day timeframe.[2] So the existing 7-day requirement will be status quo. Furthermore, for expedited or urgent requests, the 72-hour timeframe is already in effect, although in the final rule CMS is eliminating the opportunity for MCOs to extend the 72-hour time period where the MCO justifies a need for additional information.

However, the new requirements will improve transparency in Indiana by requiring the Medicaid MCOs to report annually:

1. A list of all items and services that require prior authorization.
2. The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
3. The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
4. The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services. kriegdevault.com
5. The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
6. The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
7. The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
8. The average and median time that elapsed between the submission of a request and a determination by the MCO, for standard prior authorizations, aggregated for all items and services.
9. The average and median time that elapsed between the submission of a request and a decision by the MCO, for expedited prior authorizations, aggregated for all items and services.[3]



This enhanced data and information available to providers, as well as State Medicaid agencies, and legislators, will shed light on existing MCO practices and may open up conversations on how to improve such practices in a way that support beneficiary access to care.

For questions on the new federal rule, how interacts with State prior authorization requirements and what it means for providers, please contact Meghan M. Linvill McNab or Brandon W. Shirley.

Disclaimer. The contents of this article should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general informational purposes only, and you are urged to consult with counsel concerning your situation and specific legal questions you may have.

1. *CMS's New Federal Prior Authorization Rule: An Eventual Step In the Right 42 CFR 438.210(d).*
2. *405 IAC 5-3-14.*
3. *See new language at 42 CFR 438.210(f).*

WHAT IS HAPPENING FOR MIPS 2024?

BY MICHAEL BRODY, DPM, CEO REGISTRY CLEARINGHOUSE

There have not been many changes for MIPS 2024. However, one of the biggest changes for 2024 is the exemptions. The public health emergency is now over. Therefore, all COVID-related exemptions are gone. Many doctors who attempted to claim an exemption in 2023 were denied. Which means that many offices that didn't need to report for 2022 need to report for 2023.

Regarding exemptions moving forward, you can expect that there will not be exemptions available to your office unless there has been a natural disaster in your area and your area has been designated a federal disaster area. If you do not report MIPS for 2024 and you are required to report, you will experience a 9% cut in Medicare fees. Go to https://qpp.cms.gov to check if you are required.

At this point, there are only a few weeks left to submit MIPS data for 2023. The deadline to submit with Registry Clearinghouse is February 28. If you still need support, email info@registry-clearinghouse.com or use this link to set up a meeting. If you are required to report for 2023 and do not you will experience a 9% pay cut in Medicare fees starting January 1, 2025. Following outlines 4 components still for MIPS.

COST

Cost is something that is in flux, that that it is something that is calculated by Medicare based upon your billing and looking at certain diseased states. Medicare was able to assign costs for a small number of podiatrists for 2022. Many of these offices did not find out about this until after the fact and some of these assignments weren't necessarily appropriate. Starting in August when the final scores are being published, it is important that you check your account at the QPP website on a regular basis.

If anything seems out of the ordinary or if you do not think the score is correct, you need to contact CMS and request a targeted review. If they assign a cost to you that you do not believe is appropriate and you do not object, you may end up with a lower MIPS score than you are expecting. You only have a short time frame to appeal their decision, so it is important to review your account regularly.

As of today, there aren't any cost measures that work well in podiatry, but that is expected to change relatively soon. The APMA is working with CMS to develop a cost measure that is applicable to podiatry. In fact, I have received an email from APMA asking if I would be a beta tester for cost measures. If you also receive a similar email, please respond to the email. Participate to help ourselves and our profession. This will help to prevent cost measures that are not applicable to podiatry from being assigned to you in the future.

If Cost has not been assigned for your office, the value of Cost will be reweighted to other categories.

PROMOTING INTEROPERABILITY

This is how you use your EHR system to communicate with other doctors and patients. It is important to recall that if you are a small practice (15 or fewer clinicians) your office is automatically exempt from Promoting Interoperability. If you report for Promoting Interoperability, it will account for 25% of your MIPS score. If you are exempt (and do not file) it will account for 0% of your score and the value will be reassigned to other categories.

For 2024, Promoting Interoperability has increased from 90 days to 1 year. This means that your office must use the EHR for the full year. The Prescription Drug Monitoring Program Exclusion now accommodates clinicians who do not electronically prescribe Schedule II opioids. Looking ahead, in 2024, if you participate in a APM, you must use a certified EHR.

QUALITY REPORTING

In 2023, we needed a data completeness of 70%. For 2024, we will need data completeness of 75%. It is important to note that CMS initially proposed moving the data completeness threshold to avoid a penalty to 82%. While they decided to delay this change, we can expect this threshold to continue to increase for future years making it more difficult to avoid a penalty.

- 11 Quality Measures have been removed
- 59 Quality Measures have been modified
- 11 Quality Measures have been added
- A measure that many podiatrists used, Measure 128 – Preventative Care and Screening BMI is no longer available for 2024.

IMPROVEMENT ACTIVITIES

There were minor changes in improvement activities:

- 3 Measures have been removed
- 5 Measures have been added
- These changes will not likely affect podiatrists.

KEY TAKEAWAYS:

- Check if you are required to report for MIPS at https://qpp.cms.gov/. Know that if you got an exemption previously, it is likely that your exemption will be denied for 2023.
- The deadline to submit with Registry Clearinghouse is February 28, 2024. Email info@registryclearinghouse.com or schedule a meeting for assistance to submit.
- Starting in August, check your account in QPP to ensure that no inappropriate costs were assigned to your office
- Data completeness metrics are getting more stringent. Get set up early with monthly check-ins with Registry Clearinghouse to get the best possible MIPS score for 2024

23RD ANNUAL JOINT NATIONAL PODIATRIC CAC-PIAC REPRESENTATIVES' MEETING

I recently attended the 23rd Annual Joint National Podiatric Carrier Advisory Committee (CAC)- Private Insurance Advisory Committee (PIAC) Representatives' Meeting, held in-person on November 10, 2023, in Alexandria, VA, on behalf of our state association. The meeting featured experts and leaders on both private and public insurance issues, as well as the opportunity to hear from our colleagues around the country and discuss new and ongoing trends and challenges that might impact our members.

To start the day, APMA President Sylvia Virbulis, DPM, provided an APMA strategic and priority update to attendees, addressing upcoming member education opportunities and new member benefits and resources. Following Dr. Virbulis, Cindy Moon, MPP, MPH, vice president at Hart Health Strategies and APMA Health Policy and Practice provided her annual Medicare Physician Fee Schedule update, which included upcoming changes for 2024. She discussed the overall payment impacts, noting that while the finalized conversion factor is 32.7442 (-3.37% compared to 2023), the estimated impact on podiatrists for 2024 not including scheduled payment reductions is 0 percent. This is subject to change before the start of the new year based on potential Congressional action. She also reviewed the finalized G2211 code which will be implemented in 2024. This is a code that may be added to certain established office and other outpatient evaluation and management services to represent inherently complex visits. Also reviewed were extended flexibilities to telehealth through the end of 2024, as well as CMS' decision to abandon the appropriate use criteria (AUC) program. This last finalized proposal was a major victory for members, and something APMA spent several years advocating against.

Jeffrey Lehrman, DPM, next provided updates on participating successfully in the 2024 Merit-Based Incentive Payment System (MIPS). Given the official end of the COVID-19 public health emergency in May 2023, Dr. Lehrman highlighted the unlikelihood of CMS offering another automatic exception related to COVID-19 for 2024. APMA staff is working to create an updated MIPS resource page for 2024, but webinars are already scheduled and can be found at www.apma.org/MIPSWebinars.

The morning presentations wrapped up with a joint presentation from Paul Kesselman, DPM, Chair, DME Workgroup, and Michael Hanna, MPA, CDME; DME Provider Outreach, CGS, discussing

UPCOMING APMA EVENTS

RECORDING NOW AVAILABLE MIPS PY 2024: PROMOTING INTEROPERABILITY PERFORMANCE CATEGORY

On February 6, 2024, APMA Health Policy and Practice hosted the third webinar in its 2024 MIPS Performance Year Webinar Series, "Promoting Interoperability Performance Category." Jeffrey Lehrman, DPM, APMA health policy consultant, and Rachel Groman, MPH, vice president, Hart Health Strategies, presented.
Click here for the Recording (01:00:36)
Click here for the Presentation (PDF; 2MB)

AVOID THESE PITFALLS FOR FOREFOOT SURGICAL CODING

March 21, 2024
8:00 p.m. ET
Online Webinar
On March 21, 2024, APMA will host the fifth installment of its Coding Refreshers Webinar Series, "Avoid These Pitfalls of Forefoot Surgical Coding." Jeffrey Petty, DPM, and Michael King, DPM, will present. Materials will be posted on this page closer to the event date.
Click here to Register

APMA 2024 CODING AND CLINICAL EDUCATION SEMINAR

April 27–28, 2024
10:00 a.m.-3:00 p.m. ET
Click here for more information
Earn up to 8.0 CECH from home! This live virtual event provides 4.0 CECH of coding education and 4.0 CECH of clinical education.
Click here to Register

enrollment issues, audit examples, and DME documentation recommendations. They also recommended various CMS-approved resources and tools to assist members in submitting claims related to DME.

During the lunch hour, attendees heard a legislative advocacy update from Ben Wallner, Senior Director, Legislative Advocacy. In his brief update, Mr. Wallner highlighted numerous bills and actions that APMA is supporting at the federal level, including but not limited to:

- The APMA-led HELLPP Act, which will recognize podiatrists as physicians under Medicaid.
- The Student Loan Refinancing Act, which creates a pathway for students to refinance loans while maintaining public borrower status.
- Pursuing a MATE Act legislative fix via the Support Act, which would recognize APMA and CPME as approved providers of DEA MATE education.

Additionally, Ed Prikaszczikow, DPM, Health Policy and Practice Committee (HPPC) Chair, conducted the CAC Chair elections and Theresa Hughes, DPM was elected to be CAC Chair for another year. Dr. Prikaszczikow also announced the 2023 Franklin Kase, DPM, CAC PIAC Representative of the Year Award recipient, Brent Harwood, DPM. Serving in the Alabama CAC/PIAC role for almost 20 years, Dr. Harwood has been a vocal and passionate advocate for the podiatric profession both locally and nationally. He was also instrumental along with his Alabama colleagues in adding Alabama to the now extensive list of states that include ankle in their scope.

Following lunch, APMA private insurance consultant Kelli Back, Esq., provided attendees an update on ongoing issues and trends for Medicare Advantage (MA) and commercial plans. In 2023 – approximately half of Medicare-eligible patients were enrolled in MA plans. There is a major final rule update taking effect in 2024, with numerous changes, but of most interest to physicians will be the changes to utilization management and prior authorization. Regarding prior authorization, MA organizations may only require prior authorization for very specific and defined purposes. Under the new rule, a decision to deny a prior authorization or pre-determination request must be reviewed by a physician or other appropriate health care professional with a current and unrestricted US license and "expertise in the field of medicine or health care that is appropriate for the services at issue." Additionally, to ensure prior authorization policies and utilization management procedures are consistent with applicable requirements, the new rules require MA organizations to have a Utilization Management Committee.

After Ms. Back's MA updates, Coding Committee Chair David Freedman, DPM, and Dr. Prikaszczikow, alongside Andrew Pavelescu, DPM, and Mark Block, DPM, presented the early progress of the HPPC and Coding Committee Joint workgroups on the -25 Modifier and Medically Unlikely Edits (MUE) and MUE Adjudication Indicator (MAI). The -25 Modifier Workgroup was formed to address ongoing denials that members have encountered in using this modifier, as well as review and update educational resources that APMA has for member use. The MUE-MAI Workgroup's goals include identifying coding anomalies and addressing MUE inconsistencies that CMS has created which affect reporting options for DPMs, as well as addressing and correcting inconsistencies between CPT and NCCI. The panel also collectively addressed a recent source of frustration and concern for members – recoupments related to incorrect facility (POS 31) versus non-facility (POS 32) place of service codes in nursing homes. APMA has created a resource page for members to use in correctly coding place of service for patients in these settings, which can be found at www.apma.org/RFCPOS. If members receive these recoupment notices, the advice is to adhere to the deadlines set in the notice, seek repayment schedule flexibility if necessary, contact their medical malpractice carriers to inquire about administrative defense coverage, and seek the services of an attorney if you believe you require legal assistance.

Finally, as in years past, attendees spent time discussing regional concerns in both the public and private insurance spheres. This key meeting feature allows representatives to share experiences and collaborate on solutions to common issues. In the public insurance arena, the biggest areas of concern are the continued DME same and similar denials, coverage for wound care, and amniotic injections/skin substitutes. For private payers, bundling and reimbursement issues for Medicare Advantage versus Original Medicare, denials or reimbursement reduction for claims billed with the -59 or -25 modifiers, DME audits, prior authorizations, and record requests.

To view more information about the 2023 Joint Annual National CAC-PIAC Meeting, including recordings, presentations, and notes, visit www.apma.org/CACPIAC2023.

3 STEPS TO MAKE MEANINGFUL, LASTING PHYSICIAN WELL-BEING CHANGES

BY TANYA ALBERT HENRY, AMA CONTRIBUTING NEWS WRITER
THE ORIGINAL ARTICLE WAS PUBLISHED IN AMA NEWS WIRE

With a chief wellness officer in place, physician well-being prioritized and an understanding that changes will take more than words, it's time to make meaningful, sustainable changes in each work unit. There are three key ways to make that happen and have a positive impact on physician well-being. They are: reduce tasks, engage front line physicians and tackle the easy changes first, explains an AMA STEPS Forward® playbook on wellness-centered leadership.

FIGHTING PHYSICIAN BURNOUT

Reducing burnout is essential to high-quality patient care and a sustainable health system. The AMA measures and responds to physician burnout, helping drive solutions and interventions. Click here to learn more.

The playbook presents the reasons why physician well-being is so important and offers concrete things leaders can do to get started on developing a culture of well-being across their organization. It also contains links to numerous sources to help create an environment that establishes the organizational foundation for joy in medicine.

"Wellness-centered leadership is imperative for any industry but is particularly powerful in health care, where the well-being of your workforce directly impacts patient care and the wellness of the community at large," the playbook explains.

TAKE AWAY TASKS, DON'T ADD THEM

Physicians and other clinicians have seen an overinterpretation of regulatory compliance. And in recent years, there's been an increase in the pressure to meet or exceed quality metrics. They're facing more checklists with items they need to cross off and an EHR that has added rules, clicks and protocols to their days. That only names a few of the items that are part of the already too-heavy administrative burden on physicians.

Health care leaders looking to improve physician well-being—and in turn improve patient care—need to ask, "What can we take off physicians' plates?" instead of asking, "What else do physicians need that I can provide?" Finding a way to remove 100 EHR clicks per day will do more for physician well-being in the long term than free food, yoga or massages.

"Ultimately, eliminating burdensome requirements will free up time for physicians to use for their own preferred activities that contribute to well-being," the playbook notes.

Reducing physician burnout is a critical component of the AMA Recovery Plan for America's Physicians. Far too many American physicians experience burnout. That's why the AMA develops resources that prioritize well-being and highlight workflow changes so physicians can focus on what matters—patient care.

The AMA's "De-implementation Checklist" and the "Stop This, Start That Checklist" can help leaders get started with examples of unnecessary work. Meanwhile, the AMA STEPS Forward "Getting Rid of Stupid Stuff" toolkit goes into even deeper detail on how practices or organizations can make changes.

ENGAGE FRONT LINE PHYSICIANS

Although the physicians who spend the most time seeing patients are the ones who will likely see the greatest well-being benefits from changes that an organization makes, they are also the least likely to have time and energy to spend on management initiatives. But they are the ones that leaders need to listen to first. It's up to leaders to find a way to involve these front-line physicians who are the ones most likely to be burned out in the organization.

The AMA's "Listening Campaign" toolkit can help leaders engage physicians in conversations to uncover the sources of burnout. Additionally, the AMA STEPS Forward "Scholars of Wellness" toolkit can help organizations create a formal training program for frontline physicians who want to develop skills to effect change at a system level.

CAPITALIZE ON EASY WINS

Some changes may seem small—even trivial—to people not experiencing a day-to-day problem, and they may seem like the ones that can be easily implemented. Those "high feasibility, high impact changes" are among the ones leaders should look to implement first. When those problems are delt with, it can have a huge impact when they are multiplied across the many people who are experiencing the problem.

"These changes can dramatically reduce burnout and increase goodwill and trust between physicians, other clinicians, and leaders," the playbook says.

The AMA's "Listen-Sort-Empower" toolkit can help leaders engage with physicians and determine what local problems need to be fixed. AMA STEPS Forward open-access toolkits offer innovative strategies that allow physicians and their staff to thrive in the new health care environment. These resources can help you prevent, create the organizational foundation for joy in medicine and improve practice efficiency.

THE CONSEQUENCES OF ADMINISTRATIVE BURDENS: DOCTORS IN PRIVATE PRACTICE CONTINUES TO DWINDLE

BY JEFF BENDIX

THIS ARTICLE WAS ORIGINALLY PUBLISHED IN THE FEBRUARY 2024 EDITION OF THE MEDICAL ECONOMICS JOURNAL

Doctors are continuing to abandon private practice in favor of direct or indirect hospital employment, according to an American Medical Association (AMA) study of physician practice arrangements.

The association's biennial Physician Practice Benchmark Survey found that in 2022 46.7% of doctors worked in wholly-owned physician practices, down from 49% in 2020 and 60% in 2012, the first year of the survey.

Conversely, 31.3% of doctors worked in practices that were wholly or partially hospital-owned, up from 30.5% in 2020 and 23.4% in 2012. The percentage of doctors employed directly by hospitals or working as contractors increased to 9.6% from 9.3% in 2020 and 5.6% in 2012.

Respondents cited the ability to negotiate higher payment rates as the biggest reason for joining a hospital, with 79.5% calling it "important" or "very important." That was followed by the need to better manage payers' regulatory and administrative requirements (71.4%) and wanting to obtain better access to costly resources (69%).

"The AMA analysis shows that the shift away from independent practices is emblematic of the fiscal uncertainty and economic stress many physicians face due to statutory payment cuts in Medicare, rising practice costs, and intrusive administrative burdens," AMA President Jesse M. Ehrenfeld, M.D., M.P.H., said in an accompanying news release.

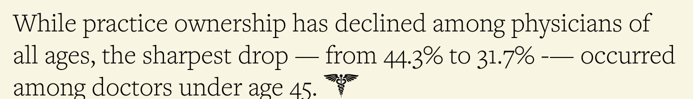
The survey also revealed significant differences between private and hospital-owned practices in their incorporation of primary care. Among physicians in hospital-owned practices, 61% were affiliated with practices that include primary care, compared to 44.9% of those in private practice.

Among hospital-owned practices, 39% of physicians were in multispecialty groups that offer primary care services. By contrast, primary care in private practice is more often offered in solo or single specialty practices. About 31% of private practice physicians work in a solo or single specialty primary care practice, and 13.7% are part of a multispecialty practice that includes primary care.

The study also found:

- An ongoing migration from smaller to larger practices, with the percentage of doctors in practices with five or fewer physicians declining from 40% to 32.8% between 2012 and 2022, while the percentage in practices with 50 or more physicians grew from 12.2% to 18.3%
- A decline in the number of self-employed physicians and corresponding growth in employed physicians. In 2012 53.2% of doctors were self-employed, compared to 41.8% who were employed. In 2022, the percentages were 44.0% and 49.7%, respectively.

While practice ownership has declined among physicians of all ages, the sharpest drop — from 44.3% to 31.7% -— occurred among doctors under age 45.



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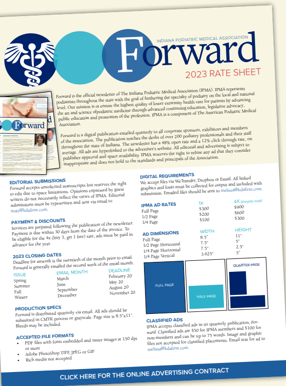

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ISSUE	EMAIL MONTH	AD DEADLINE
Spring	February	January 15
Summer	May	April 15
Fall	August	July 15
Winter	November	October 15

INDUSTRY EVENTS

Midwest Podiatry Conference
April 11-14, 2024
Marriott Chicago
Chicago, Illinois

APMA The National
August 8–11, 2024
Washington DC Convention Center
Washington, DC

IPMA Annual Convention
September 20-21, 2024
Renaissance Indianapolis North Hotel
Carmel, Indiana

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