Fourth Quarter 2018

The Scope of Family Medicine

A Publication of the Alabama Academy of Family Physicians • www.alabamafamilyphysicians.org

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CANCER PREVENTION

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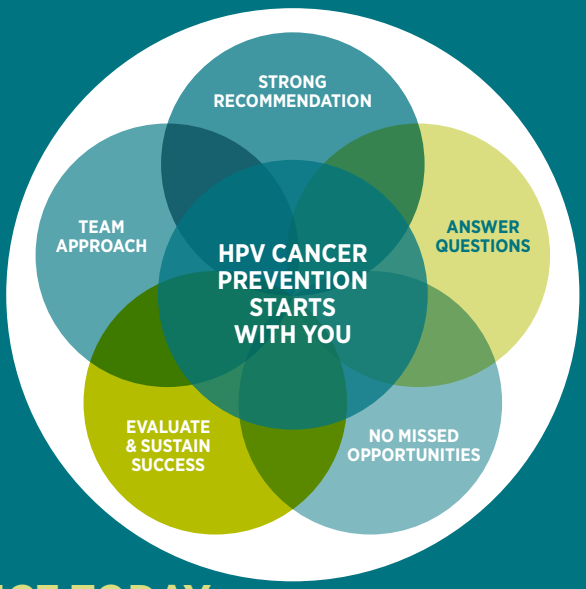
AN ACTION GUIDE FOR PHYSICIANS, PHYSICIAN ASSISTANTS, AND NURSE PRACTITIONERS

You have the power to reduce the incidence of human papillomavirus (HPV) cancers and pre-cancers among patients in your care. **HPV cancer prevention starts with you.**

Make it your goal for every patient you care for to be vaccinated against HPV before the age of 13. Every member of a practice plays a critical role in advocating for HPV vaccination as cancer prevention and should work together as a team.



TAKE THESE ACTIONS TO INCREASE HPV VACCINATION WITHIN YOUR PRACTICE TODAY.

Make a presumptive recommendation
Your recommendation is the #1 reason parents choose to vaccinate their children.

Answer parents' questions
Let parents know the vaccine is safe, effective and prevents cancers.

Minimize missed opportunities
Use every opportunity to vaccinate and keep patients up-to-date. Use EHR prompts to help.

Take the team approach
Empower every member of the team to be a HPV vaccination champion. Provide in-service training. Discuss vaccination status at huddles. Practice messaging "HPV vaccination is cancer prevention."

Evaluate and sustain success
Implement quality improvement strategies to drive up HPV vaccination rates to be on par with your Tdap and MenACWY rates.

ALABAMA PUBLIC HEALTH

IMM IMMUNIZATION DIVISION

alabamapublichealth.gov/imm

National HPV Vaccination Roundtable

Alabama Genomic HEALTH INITIATIVE

UAB – Alabama's leading provider of genomic and precision medicine – has launched the Alabama Genomic Health Initiative (AGHI) in partnership with the HudsonAlpha Institute for Biotechnology.

The statewide effort was funded with a $2 million award in the first year, with additional funding expected over the five-year project. With the goal of obtaining genetic information from 10,000 Alabamians, the AGHI is one of the most ambitious single-state initiatives of its kind ever undertaken. The program launched in spring 2017 in Birmingham and Huntsville, and recruitment will gradually be expanded to the entire state.

HERE'S HOW IT WILL WORK:

1. ENROLL
Participants are being recruited at sites across the state. They are asked to donate a small blood sample and provide a brief family health history.

2. TEST
DNA, extracted from that sample, will be analyzed with genotype arrays for participants upon their consent; individuals with indications of genetic disease will receive whole-genome sequencing.

3. COUNSEL
All participants will receive a findings report. Participants who have actionable findings (predicted to be 1–3 percent of participants) and those who have had whole-genome sequencing receive genetic counseling and referrals to appropriate medical care.

4. DISCOVER
Study data will create a statewide genomic database that could give researchers new insight into prevention and treatment of gene-related diseases. The AGHI also will help educate health providers statewide about genomic medicine and advance a genomics-ready population and health care workforce in Alabama.

To learn more about the AGHI, register for updates, or inquire about participating, contact us directly or visit our website.

Phone: 855.462.6850 • Email: aghi@uab.edu • aghi.org

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THE SCOPE OF FAMILY MEDICINE

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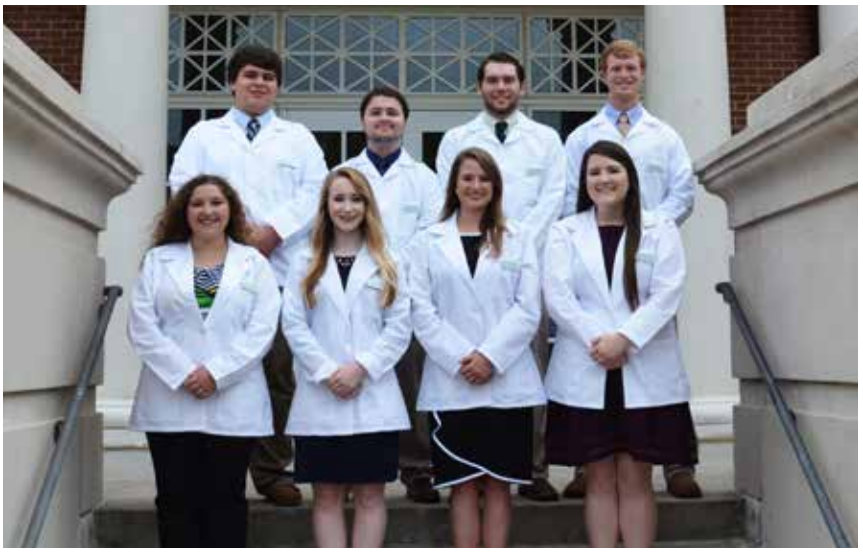

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Access to Medicaid Can Change and Save Lives

DO YOU HAVE A STORY TO TELL?

Medicaid is a vital health care program for individuals and families from all walks of life. The coverage provided through Medicaid makes it possible for low-income children and adults to get the care they need to go to work, school and care for their loved ones.

Yet, many people do not understand the program or know how important Medicaid is to individuals, families, the health system and communities across the state.

We can change that. The American Cancer Society Cancer Action Network (ACS CAN) is leading a public education campaign focused on communicating the value of the Medicaid program in an effort to build understanding and support for Medicaid.

We need your help. Through this campaign, ACS CAN wants to highlight the stories of individuals and families who rely on Medicaid for life-changing and lifesaving care. We also want to illustrate how important Medicaid is to Alabama's health care system and local economies.

Do you know the story of a someone who can describe how Medicaid has

- **Changed or improved their lives for the better?** This can be the story of a child with asthma who is able to play with his or her friends because Medicaid pays for his or her inhaler, or the story of a woman who accessed Medicaid for chemotherapy, surgery or radiation after being diagnosed with breast cancer.
- **Not been a source of care, because Alabama has not expanded its Medicaid program?** These could be stories of individuals or families in the coverage gap, like the story of a 59-year-old who had to quit his or her job to care for a spouse battling Parkinson's disease.
- **Affected providers' abilities to ensure that patients can get the care they need?** We want to demonstrate the impact of Medicaid on clinics, hospitals, health systems and communities from the provider perspective — as well as the impact that a lack of access to comprehensive care has impacted the health and well-being of your uninsured patients.

Will you share a story?

We would like to ask you to share your story with us, or engage your patients and ask if they would like to share their stories. If you are willing to help, please contact us.

- **Send an email to medicaidstory@cancer.org** with the storyteller's name, contact information and a few sentences about his or her story.
- **Visit www.fightcancer.org/medicaidstory** to fill out the short form with the storyteller.
- **Complete an ACS CAN Medicaid Story Card.** (Email medicaidstory@cancer.org to request them). You can scan a copy of it to the email address above or text a photo of it to 615-378-7823.

We would very much appreciate your support and assistance in this effort. If you would like more information about this project or have questions, please reach out to ACS CAN's Alabama Grassroots Manager Sarah Domm at sara.domm@cancer.org.

US Army
to come
####-#

Opportunities to Lead Are at Hand – *Seize Them!*

by John Meigs, MD, outgoing Board Chair of the AAFP

There's more to leadership than just showing up, but it's a start. As I've said in this space before, it's important for family physicians to say yes to leadership opportunities.

If you say yes once, more opportunities likely will follow. I urge you to take them.

I didn't have special leadership talents when I first got involved with my state chapter more than 35 years ago, but an appointment to a committee led to me later chairing that same committee, which led to a role on the chapter's board of directors.

Along the way, I developed the skills I needed, such as being an advocate and working with the media. You might be surprised by what leadership roles you enjoy and excel at it, and you won't know until you try.

For example, I was apprehensive about my first trip to Capitol Hill. I was a rural, small-town family physician. Would legislators and congressional staff listen to me? The answer was yes. In the years since, I've made numerous trips to Washington, D.C., to advocate on behalf of patients and physicians. What I discovered is that I enjoy meeting with the folks who have the power and influence to make necessary changes in our government. It's not easy, but our specialty needs people who will provide insights from the family physician's perspective and attempt to make an impact on health policy.

Once you dive in, you might find a niche. I had a keen interest in parliamentary procedure, having chaired my church's business meetings for years. The responsibilities were similar to those of a speaker, which is a role I held for the Medical Association of the State of Alabama from 2003 to 2009. I also served in the Alabama AFP's delegation to the AAFP Congress of Delegates (COD) for a decade. Those opportunities led to roles as the Academy's vice speaker (2008-2011) and speaker (2011-2015). I loved it. Presiding over the AAFP's policymaking body was one of the great privileges of my career.

When Congress meets in New Orleans, it will mark the end of my unusual 10-year tenure on the AAFP Board. (The president track typically is a six-year commitment.) During that decade, the profile of family medicine and primary care has risen through efforts such as Health is Primary, the three-year campaign from Family Medicine for America's Health that demonstrated the value of primary care in delivering on the triple aim of better health, better care and lower costs.

The academy has become a trusted source of information for legislators, payers, policymakers and the press. It's not uncommon for the AAFP president to do more than 200 media interviews during a one-year term.

People inside the Beltway also are now more aware of the need for family medicine and primary care and the value we bring to the system. We know, based on a 2017 report of interviews with more than 2,000 administration officials, congressional staff and thought leaders, that the academy is viewed as one of the most influential and bipartisan organizations in Washington.

We know, based on a 2017 report of interviews with more than 2,000 administration officials, congressional staff and thought leaders, that the academy is viewed as one of the most influential and bipartisan organizations in Washington.

Still, change rarely happens quickly in Washington. Ridding ourselves of the dreaded Medicare sustainable growth rate, for example, took years, and much work still lies ahead on the issue of payment.

It's difficult for members to know everything the academy is doing to provide input to the Centers for Medicare and Medicaid Services (CMS), private payers, and others involved in issues related to payment and administrative burden. That's one reason I thoroughly enjoyed my many visits to our constituent chapters. It was an opportunity to share updates on the academy's efforts, as well as to hear directly from members about what was happening in your communities. Those stories help inform the academy's actions.

In 10 years, I visited more than 30 states and met hundreds of family physicians. It was, in fact, one of my favorite parts of serving on the AAFP Board. You can tell when you are in a room full of family physicians. There is an undeniable collegiality and a common sense of purpose. Thank you for always making me feel welcome, even when you had tough questions that needed answers.

Next week, the COD will select several new leaders, including a president-elect and three new directors. There is a misconception by some that the board is filled with only academics and medical administrators, but the reality is that the board — like the AAFP membership as a whole — encompasses family physicians from diverse backgrounds, including solo and small-practice docs like myself. It's important that family medicine leaders at the state and national levels continue to demonstrate diversity, not only in race and gender, but also in geography and practice type, so that our leadership represents our truly unique membership.

The breadth of our training and comprehensive nature of our specialty make family physicians experts in many areas, and our communities look to us as leaders. Are you ready to lead?

A wealth of such opportunities can be found not only in your state chapters but also in county medical societies and state medical associations. The AAFP has numerous leadership opportunities for active members, residents and students.

My time in this treasured role is winding down. Could yours be about to start?

Rural Medical Scholars • 2018-2019

Maggie Blevins is the daughter of Donald and Kathy Blevins of Harvest, Alabama. She graduated from Westminster Christian Academy in 2013 before attending The University of Alabama at Birmingham. At UAB, Blevins graduated *magna cum laude* with a BS in biomedical sciences and a nutrition minor. She was a part of the School of Health Professions Honors Program, which enabled her to research health policy in child care centers, and held a leadership position in the Biomedical Sciences Organization. She has volunteered with programs in the Birmingham area, including Birmingham AIDS Outreach, the Ronald McDonald House, Relay for Life and the Red Barn. The health care disparities in the area surrounding Eutaw, Alabama, which she experienced through a mission trip, sparked her interest in rural medicine and prompted her to shadow her family physician. She plans on returning to north Alabama to practice family medicine in a rural area near her family.

Chase Britt is the son of Chad and Vicki Britt of Pickensville, Alabama. He was a participant in the UA Rural Health Scholars program and graduated as the valedictorian of his class at Pickens Academy. From The University of Alabama (UA), he received a Bachelor of Science degree in chemistry with a minor in mathematics. As an undergraduate, he worked for three years at University Medical Center as a scribe. In addition, he volunteered with the UA Discovery Buddies mentoring program. Growing up in rural Alabama helped Britt to understand the impact rural physicians have on their communities, and he hopes to make a similar impact one day.

Jeb Cowen is the son of Dr. Gary and Julie Cowen of Jasper, Alabama. He graduated from Walker High school before attending Samford University in Birmingham, Alabama, where he earned his Bachelor of Science degree in sports medicine. While there, Cowen participated in Alpha Epsilon Delta, a premedical society, Gamma Sigma Alpha, an academic honor society, and the American Chemical Society. Cowen has volunteered with Hope for Women and Habitat for Humanity, along with a number of community churches and nursing homes. He received the Chemistry Academic Excellence Award his freshman year and the Most Outstanding Sports Medicine Student Award in his senior year at Samford. Cowen also participated in a medical mission trip to the Dominican Republic and spent a summer shadowing with an internal medicine physician in his hometown.

Will Davis, son of William and Valerie Davis, grew up in Letohatchee, Alabama, where he graduated from Fort Dale Academy before attending The University of Alabama. While a student, Davis volunteered and shadowed extensively. In addition, he volunteered at the Rise Center, Good Samaritan clinic, and he went on two mission trips to Costa Rica with the Fellowship of Christian Athletes before graduating from UA.

Chelsey Deloney, of Gardendale, Alabama, is the daughter of Chris and Lori Deloney. She graduated from Gardendale High School before graduating from Belmont University. Deloney is a member of Psi Chi, the International Honor Society in Psychology, and was named the President Scholar-Athlete of the Year (2016-2017). She graduated *cum laude* with a BS in psychology, and she hopes to pursue medical missions and to work within underserved communities.

William Fagan, of Equality, Alabama, graduated from Benjamin Russell High School and Central Alabama Community College. He continued his education at Jacksonville State University and earned a Bachelor of Science degree and went on to complete a second BS from The University of Alabama at Birmingham. During this time, he acted as a teaching assistant (TA) and researcher in the biology department for three years before completing two Master of Science degrees in biomedical health sciences and lifestyle management and disease prevention from UAB. His research focused on the effects of high-dose vitamins on breast cancer cells, and as a TA, he taught advanced anatomy and human dissection, advanced histology and microscopy, and neuroanatomy to both undergraduate and graduate students. He worked as an emergency room technician for six years at UAB. His volunteer experience at the Community of Hope Health Clinic helped to guide him in his efforts to bring all of his experience and dedication, one day, to a rural area in desperate need of health care.

Rex Farris is the son of Gary and Lea Farris of Muscle Shoals, Alabama. He graduated from Leighton's Colbert County High School and attended the University of North Alabama before transferring to the University of Alabama at Birmingham (UAB) for his sophomore year. While at UAB, Farris was a member of the pre-health honors society, Alpha Epsilon Delta, along with Circle K International. He went on to participate in the Huntsville Rural Pre-Medical Internship (HRPI), during which time he shadowed family medicine physicians in hospital and clinical settings. In addition, he volunteered at Spirit of Luke, a free clinic set up once a month in south Alabama to service individuals without insurance. He hopes to return home one day to practice family medicine.

Bradford Lepik, of Jasper, Alabama, graduated from Walker High School before attending The University of the South in Sewanee, Tennessee, where he graduated *magna cum laude* with a BS in biochemistry. At Sewanee, Lepik was a member of Alpha Epsilon Delta, Honor Council, Omicron Delta Kappa, Order of the Gownsmen and Chemistry Club. Lepik assisted prolactin and growth-hormone research at The University of Alabama at Birmingham, the fndings of which were published in Endocrinology. In addition, he conducted genetic research in autism and Dravet syndrome at Yale School of Medicine. Bradford then returned home to shadow rural physicians and volunteer with Walker County Children's Advocacy Center while working as a medical assistant.

Paris Long is the daughter of Gilbert and Te'Sha Long of Coosada, Alabama. Long graduated from Stanhope Elmore High School before attending Auburn University in Auburn, Alabama, where she received a Bachelor of Science degree in biomedical science. During her time in Auburn, Long volunteered with the Red Cross in Opelika, Alabama, and participated in the PASS Mentoring Program, through which she acted as a mentor to newly arriving freshmen. She actively seeks opportunities to gain the knowledge needed to help, as a health care professional, small-town communities like her own, where her family has lived for generations.

Emily Sutton is the daughter of Patrick and Amy Sutton of Hamilton, Alabama. She was a University of Alabama Rural Health Scholar prior to graduating from Hamilton High School. Sutton then attended The University of Alabama, from which she graduated with university honors with a Bachelor of Science degree in Biology. For three summers during college, Sutton mentored students as a counselor for the Rural Health Scholars and also volunteered as an after school tutor for elementary school students at the Brown House community in Northport. Sutton recently traveled to Haiti on a weeklong mission trip, where she served at a local orphanage. Since shadowing physicians in her hometown, her goal has been to practice medicine as a pediatrician in a rural community in Alabama.

New Contract Review Program for Residents

The academy is pleased to announce that it has negotiated an arrangement with The Sanders Law Firm, P.C. in Birmingham that will benefit resident and fellow members of the academy. Specifically, The Sanders Law Firm will review a draft employment agreement for any academy member, discuss the draft employment agreement with the member and recommend changes where necessary, for a flat fee of $500. Rich Sanders, the firm's president, has spoken at the summer and fall forum meetings of AAFP since the late 1990s, and he has previously assisted academy members with HIPAA and corporate compliance programs. If you have any questions about this new contract review program, please call Rich Sanders at 205-930-4289 or via email at rsanders@southernhealthlawyers.com.

RURAL MEDICINE PROGRAM

My name is Adam Bonner, and I am from Toxey, Alabama. I graduated from Stillman College in May 2018 with a Bachelor of Science in biology. I played shortstop on the baseball team while at Stillman College, earning All-SIAC academic team honors my first three years and Scholar-Athlete of The Year my junior year. Upon completion of medical school, I plan to return to a rural area to provide superior health care and be a leader in the community, helping mentor the next generation of students who are pursuing careers in the health sciences.

My name is Josh Bush. I grew up in the town of Eufaula, Alabama. I went to Auburn University for my undergraduate years, where I earned a degree in exercise science. I was involved with the Tiger Host organization along with leading in the Oaks Retreat. I originally was seeking to attend physical therapy school, but these plans changed the summer before my senior year. I was working at the physical therapy clinic in my hometown and fell in love with the relationships I built with the patients there. I was led to pursue family medicine, as I felt I would be able to establish more long-term relationships with my patients and fill the gap I realized many of the patients had with the shortage of family practice doctors in small towns.

My name is Jayci Hamrick, and I grew up in Haleyville, Alabama. I received my undergraduate degree from The University of Alabama at Birmingham, where I received a bachelor's degree in biomedical engineering. While at UAB, I worked for three years as a teaching assistant for a computer programming class. I was involved with Spirit of Luke Charitable Foundation, an organization serving rural communities throughout the Black Belt of Alabama, and Alpha Epsilon Delta. During my junior year, I participated in the Huntsville Rural Pre-Medical Internship, which solidified my decision to become a family physician. Upon graduation from medical school and completion of my residency training, I plan to return to a rural area to practice family medicine.

My name is Mallory Jones, and I am from Luverne, Alabama. I received my undergraduate degree in biomedical sciences from Troy University. I was involved in Alpha Epsilon Delta, the Alabama Student Rural Health Association, Tri-Beta, and Chi Omega Fraternity. While studying at Troy, I worked as an emergency room technician in a rural hospital. This experience, along with shadowing a family physician in my hometown, made me realize that I wanted to pursue a career as a family medicine doctor in a rural area. Upon graduating from medical school, I plan to return to a rural area like Luverne and serve as a family medicine doctor. I hope to make an impact on rural Alabama by providing health care to those who would otherwise be medically underserved.

My name is Trey Kidd, and I grew up in Alexander City, Alabama. After graduating from Benjamin Russell High School, I furthered my education at Central Alabama Community College and at Auburn University, where I obtained my bachelor's degree in biomedical sciences. While studying at Auburn, I volunteered at Russell Medical Center and completed my undergraduate research under Dr. Armbruster, the professor and director of the Auburn University Museum of Natural History. Following my completion of medical school and residency, my intentions are to practice family medicine in rural Alabama. My goal is to use my services to give back to small communities that lack appropriate medical care and resources.

My name is Alyssa Luckie. I am from Lowndesboro, Alabama. I received my undergraduate degree from Troy University, where I received a Bachelor of Science in biology with a concentration in biomedical science. While at Troy, I worked for the Palladium Yearbook as a photographer and then as a photography editor. I also worked for physician assistant as a scribe in the emergency department during my senior year. During my sophomore year, I participated in the Huntsville Rural Pre-Medical Internship, which introduced me to the Rural Medicine Program and the need for rural physicians in Alabama. After graduating from medical school and completing my residency training, I plan to return to a rural area near my hometown to practice.

My name is Luke Stone, and I am from Groveoak, Alabama. I received my undergraduate degree in history from the University of Alabama (UA). During my time at UA, I was involved in Alabama Student Rural Health Association (ASRHA), Alpha Epsilon Delta and the Blount Scholars Program. I participated in the Huntsville Rural Pre-Medical Internship the summer prior to my junior year, which helped solidify my decision to one day pursue a career in rural medicine. Upon graduating from medical school, I hope to one day return to my hometown in northeast Alabama and give back to the people who gave me so much.

My name is Carly Westmoreland, and I am from Addison, Alabama. I am in my senior year of my undergraduate degree in biomedical sciences from Auburn University. I am involved in tutoring honors organic chemistry, playing intramural volleyball, officiating high school volleyball for the Alabama High School Athletic Association (AHSAA) and volunteering around the city of Auburn. The summer after my sophomore year, I participated in the Huntsville Rural Pre-Medical Internship, which solidified my desire to be a part of the Rural Medicine Program. Through shadowing the doctor in my hometown, I learned more about the wide scope of services that family medicine doctors provide, as well as how they are interwoven in their communities. This is the reason I want to return to a small town like my own and serve it with medical care.

RURAL/PRIMARY CARE HYPERTENSION STUDY

Southeastern Collaboration to Improve Blood Pressure Control

Please consider joining us in an important regional initiative to improve blood pressure control among African-Americans in Alabama and North Carolina. Led by faculty from the University of Alabama at Birmingham (UAB), the University of North Carolina (UNC) and East Carolina University (ECU), this study aims to help practices and African-American patients improve care and self-management for uncontrolled hypertension.

The study started in 2017, and will continue to enroll and randomize a total of 80 practices (50 in Alabama, 30 in North Carolina) to receive *one of four interventions* as an adjunct to your already excellent care:

1. A free online patient education program, accessible to all patients
2. Education *plus* free peer coach (PC)[A] services for 25 patients who enroll in the study
3. Education *plus* free practice facilitator (PF)[B] services for practice staff
4. Education both free peer coach and practice facilitator services

UAB is actively engaged in 26 practice sites in Alabama, with more than 420 patients enrolled, and all study interventions currently being implemented.

For evaluation, each practice only needs to identify 25 African-American patients with uncontrolled hypertension and follow them as usual for one year. In addition to the intervention(s), each practice will receive $4,000 and a computer workstation, and 25 enrolled patients will receive home blood pressure monitors plus a monetary incentive. A research assistant will provide all informed consent and data collection, without burdening your staff.

The only requirement is that your practice has internet access and can refer at least 25 adult African-American patients with uncontrolled hypertension within a two- or three-month period. Your participation and that of your patients is completely voluntary.

If you would like to participate or have questions, please contact Muna Anabtawi at 205-934-7157 or manabtawi@uabmc.edu.

[A]PC – a local resident with hypertension who provides support for patients and links to resources that promote good self-management
[B]PF – an individual who works with practices to meet meaningful use of EHR, create registries, and provide better population health

Stisher Elected to American Academy of Family Physicians Board of Directors

Chandler Stisher, a fourth-year medical student at the University of Alabama School of Medicine and Master of Public Health student at The University of Alabama at Birmingham School of Public Health, serves on the Board of Directors of the American Academy of Family Physicians (AAFP). The AAFP represents 131,400 physicians and medical students nationwide. Stisher was elected to a one-year term by the National Conference of Medical Students and was confirmed by the governing body of the AAFP, the Congress of Delegates.

As the student member of the board of directors, Stisher represents the interests and opinions of the National Conference of Students to the AAFP Board of Directors and Congress of Delegates. In addition, he advocates on behalf of family physicians and patients nationwide to inspire positive change in the U.S. health care system.

Throughout his medical school career, Stisher has taken on leadership roles with the AAFP. He currently serves as national coordinator for the AAFP Family Medicine Interest Group (FMIG) Network, established by the AAFP to strengthen the on-campus FMIG Networks that focus on promoting family medicine as a career. He also serves as the student member to the AAFP Commission on Education, the Subcommittee on National Conference Planning, and the Subcommittee on Resident and Student Issues.

As the student member of the board of directors, Stisher represents the interests and opinions of the National Conference of Students to the AAFP Board of Directors and Congress of Delegates.

In 2015, Stisher was named to the UAB Primary Care Scholars program and received the Smith Foundation Graduate Scholarship. In 2017, he was awarded the UASOM Comer Foundation Medical Scholarship. He was named an AAFP Family Medicine Leads Emerging Leader Institute scholar in 2016.

Stisher graduated *summa cum laude* with a bachelor of science degree in biology from the University of Alabama at Birmingham in 2014. He entered the Rural Medicine Program at Auburn University in 2015, and he transferred to The University of Alabama School of Medicine, where he anticipates completing his medical degree in 2019.

EVALUATING AND MANAGING THE E/M CODES FOR 2019 AND BEYOND

by Christopher L. Richard and Gilpin Givhan, PC

This article is the first in a series of articles about notable changes in the 2019 Physician Fee Schedule Final Rule.

In the 2019 Physician Fee Schedule (PFS) Proposed Rule, the Centers for Medicare and Medicaid Services (CMS) proposed some major changes to the PFS, including changes to the way evaluation and management (E/M) services are reimbursed. The PFS Final Rule[1] contains some good news and bad news. The good news: CMS isn't making any of the major changes it proposed in 2019. The bad news: They plan on making some big changes over the next few years.

Proposal: CMS proposed to collapse several levels of E/M codes into one reimbursement level with add-on codes for certain prolonged or complex visits.

Final Rule: CMS is reducing some documentation redundancies for 2019, but it is not finalizing most of the payment proposals described above until 2021.

The Details

Currently, there are 3-5 levels of E/M codes depending on the practice setting (three to four in facility settings and five for outpatient or office settings). These codes are billed based on the relative complexity of the E/M service provided, as determined in accordance with either the 1995 or 1997 guidelines issued by CMS.[2] The higher the level of E/M service (and associated relative time and resources required to deliver those services), the higher the reimbursement. According to CMS, E/M codes represent approximately 40 percent of allowed charges for PFS services, and outpatient/office visit E/M codes represent about 20 percent of total PFS allowed charges. Despite the frequency with which E/M services are performed and billed, there are a number of complexities surrounding how they are billed and the documentation required for each level of E/M code.

In an effort to alleviate this burden, CMS proposed to collapse the reimbursement for E/M level 2 through level 5 codes into a single reimbursement amount. In addition, CMS proposed to allow two new add-on codes to represent prolonged services and services with a relatively high degree of complexity. Noting the extensive time and resources that will be needed to adjust to the new coding regime, CMS has delayed the effective date of these rules until 2021. There's time to prepare for the new E/M coding regime, and it may be altered some between now and 2021, but below is a brief overview of the finalized changes for 2021.

Collapsing Reimbursement for Levels 2-4. Importantly, CMS decided not to change the E/M codes themselves but instead chose to pay the same base reimbursement for E/M code levels 2 through 4.[3] In theory, this will reduce the level of documentation required because physicians will only need to meet the documentation requirements for a level 2 E/M code. However, it will also result in a reduction of reimbursement for many physicians who ordinarily bill higher level E/M codes, unless they also bill for one of the new add-on codes discussed below. Despite the changes in reimbursement levels, physicians do not necessarily have to change how they perform and document E/M services. In fact, CMS expects that physicians will continue to document and bill as they normally would. Noting that other government and private payors (including Medicaid, Anthem Blue Cross Blue Shield, etc.) may continue to use the existing coding structure — or would at least need time to adjust to new coding regimes — CMS decided to retain the existing coding structure, changing the reimbursement only.

Add-On Codes. To account for the reduction in reimbursement associated with the new combined reimbursement rate for E/M levels 2 through 4 and to better align reimbursement with the resources utilized in providing E/M services, CMS decided to add two new add-on codes (again, effective 2021) that can be billed with E/M levels 2 through 4. The first is an add-on code for E/M visits for primary care and certain types of specialized medical care. The second is an add-on code to account for additional resources utilized when physicians have extended visits with patients. Despite the addition of these new codes, CMS indicated there should not be any additional documentation requirements for E/M services.

Reducing Redundant Data Recording (effective 2019). In response to stakeholder feedback, CMS decided to remove the requirement that physicians document the medical necessity of conducting a visit in the patient's home instead of in the physician's office.[4] CMS also decided to streamline documentation requirements by allowing physicians to review information already contained in the medical record (review of systems and past, family and/or social history) and update it as needed, rather than re-recording all of the information.

Proposals Not Adopted. CMS decided not to adopt some of its proposals, including proposals to: (1) reduce reimbursement when E/M services are provided on the same day as a procedure; (2) establish separate podiatric E/M codes; and (3) standardize the amounts of practice expense RVUs for E/M codes.

Conclusion

Overall, there are some changes going into effect in just over a month, and others will likely be reshaped and refined over the next two years before they are implemented in 2021. For now, all physicians need to know is that they can continue to document and bill E/M codes as they always have, but in theory with less redundancy in documentation requirements.

[1]CMS-1693-F, available at http://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf.

[2]1995 Documentation Guidelines for Evaluation and Management Services, available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf; 1997 Guidelines for Evaluation and Management Services, available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf.

[3]CMS decided to combine levels 2 through 4 instead of 2 through 5, as originally proposed. CMS-1693-F, available at http://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf.

[4]CMS reasoned that this decision is best left to the physician and patient, without applying additional payment rules.

Infant Mortality Rate in Alabama Is Lowest Ever in 2017; Decrease Seen in Both Black and White Infant Deaths

The Alabama Department of Public Health announces that the infant mortality rate of 7.4 deaths per 1,000 live births in 2017 is the lowest in Alabama history and is an improvement over the 2016 rate of 9.1. A total of 435 infants born in Alabama died before reaching 1 year of age in 2017; 537 infants died in 2016.

While there is a longstanding disparity between birth outcomes for black and white infants, the infant mortality rate for black infants declined to an all-time low in 2017, and the infant mortality rate for white infants was the second lowest. The rate of 11.2 for black infants was an improvement over the 15.1 rate in 2016, and the rate of 5.5 for white infants was a drop over the 6.5 rate for whites in 2016.

Alabama enjoyed many positive indicators. Teen births and smoking during pregnancy are risk factors that contribute to infant mortality, and both are continuing to decline. The percentage of births to teens (7.3) and the percentage of births to mothers who smoked (9.6) are the lowest ever recorded in Alabama, with the largest decrease among teen mothers. There was also a decline in the number of infants born weighing less than 1,000 grams and infant deaths to those small infants.

While there was a significant decline in infant mortality, the percent of low weight births and births at less than 37 weeks gestation remained the same. Statisticians look at average infant mortality rates for three-year periods. Between the years 2015 through 2017, the combined rate of 8.3 was tied with the years 2009 through 2011 as the two lowest three-year rates of infant mortality in Alabama.

"Due to the sharp decline in the infant mortality rate for 2017, the Alabama Center for Health Statistics worked diligently to ensure all infant deaths were reported," Center Director Nicole Rushing said. "A decrease in the number of infant deaths reported was seen at almost all hospitals."

We must continue our efforts to reduce the number of families who experience the profound sadness of infant deaths.

State Health Officer Dr. Scott Harris said, "We are encouraged with the progress in improved pregnancy outcomes we are seeing, but many challenges remain such as addressing persistent racial disparities, the opioid epidemic and ensuring access to health care."

Gov. Kay Ivey said, "We must continue our efforts to reduce the number of families who experience the profound sadness of infant deaths. Alabama has developed an infant mortality reduction plan that includes a pilot project to reduce infant mortality by 20 percent in five years."

Components of the pilot project being conducted in Macon, Montgomery and Russell counties include home visitation, preconception and interconception health care, screening for substance use, domestic violence and depression, safe sleep education, and breastfeeding promotion.

The top three leading causes of infant deaths in 2017 that accounted for 43.4 percent of infant deaths were as follows:

- Congenital malformations, deformations and chromosomal abnormalities
- Disorders related to short gestation and low birth weight
- Sudden infant death syndrome

These top causes of infant deaths parallel those for the U.S. as a whole in 2016.

County health departments throughout Alabama provide a wide range of confidential and professional services. Call 800-545-1098 or contact your local county health department for additional information.

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CAN I GET A WITNESS?

Chaperones in the Exam Room

by William T. Ashley III, JD, Risk Resource Advisor, ProAssurance

In 2018, the world of sports was rocked with the revelation that Larry Nassar, a physician for USA Gymnastics, used medical examinations as a pretext to molest nearly 300 female gymnasts over a 20-year period. Many of these young athletes were abused while their parents were in the examination room. News coverage of the scandal caused many physicians to reexamine the professional safeguards that exist to protect a patient during one of his or her most intimate and vulnerable experiences, the physical examination.

In fact, the medical community addressed this concern long before the Larry Nassar scandal brought the issue to the public consciousness. The American Medical Association (AMA) promotes the use of chaperones to provide a comfortable and considerate atmosphere for the patient and physician to respect a patient's dignity. Am. Med. Ass'n Code of Med. Ethics, Op. 1.2.4 (1998). While Alabama has yet to act legislatively to require the use of chaperones during a physical examination, many states have. For instance, the Georgia Composite Medical Board defines "unprofessional conduct" to include "conducting a physical examination of the breast and/or genitalia of a patient of the opposite sex without a chaperone present." Ga. Comp. R. & Regs. 360-3-.02(12). While adopting a chaperone policy in your practice is not yet obligatory in Alabama, there are many reasons why doing so is in the physician's best interest.

First, the presence of a chaperone during a sensitive examination can help put the patient at ease. Patients who have had very few interactions with a physician may not yet fully trust the physician. Offering the patient a chaperone may ease any patient anxiety arising from unfamiliarity with the physician, and it helps demonstrate the physician's respect for cultural or personal sensitivities.

Second, a chaperone may serve as a deterrent to improper patient behavior. The presence of a disinterested third party can help prevent false claims of sexual assault by the patient. In some cases, boundary violations may be initiated by patients. For example, patients may initiate boundary violations in order to gain an advantage over the physician. The manipulative patient may use the threat of a medical board complaint or a lawsuit to demand controlled substances or other special treatment. Thus, having a chaperone present can help protect the physician and other medical staff by discouraging abusive patient behavior.

Third, a chaperone serves as a witness to events occurring during the patient interaction. As a defendant in a malpractice suit, the physician will benefit from an additional witness to the physician-patient exchange. The chaperone can serve to corroborate

The American Medical Association (AMA) promotes the use of chaperones to provide a comfortable and considerate atmosphere for the patient and physician to respect a patient's dignity.

the physician's testimony, rendering the physician's version of events more believable to a jury.

Before undertaking any sensitive examination or procedure, the physician should explain the specific components of the physical exam, and offer the patient the option of having a trained chaperone of the gender of the patient's choice present. Document clearly in the patient's chart whether the patient consented to the examination, and whether he or she elected to have a chaperone present. Write a note in the chart identifying all individuals present during the exam. Ideally, a practice should train at least one male and one female staff member to serve as a chaperone; however, patients often decline a chaperone when the physician and patient are of the same gender. As the Nassar scandal revealed, lay chaperones, such as family members, are not trained to observe the examination in a way that best protects the physician and the patient. Additionally, it may be awkward and uncomfortable for a patient to have a family member present during a physical exam. Thus, the presence of a trained, uninterested observer is the most effective means of ensuring a safe and respectful physical examination.

Occasionally, it will not be possible to accommodate a patient's desire to have a chaperone present. If your practice does not have a chaperone available on the date of the examination, consider rescheduling the patient's routine physical examination for a date when one will be available. If your practice lacks the capability to accommodate the patient's chaperone request, discuss transferring the patient's care to a physician better suited to make those accommodations.

Physician boundary violations portrayed in the media are increasing calls for mandatory use of chaperones. Rather than viewing this procedure as an unnecessary regulatory response to a few bad actors, physicians should embrace the protections provided by a chaperone policy. An effectively implemented chaperone policy helps physicians to become more responsive to patients' sensitivities, ultimately strengthening the physician-patient relationship.

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