The Affordable Care Act: Medical Home Provisions for the Obstetrician/Gynecologist

Ramon A. Suarez, MD, FACOG
Atlanta, GA

The Medical Care Home or Patient Centered Medical Care Home is a concept of medical practice first described in pediatric literature more than 40 years ago. It is a health care system that emphasizes primary care and manages all aspects of care across a patient’s life. It would include preventative care plus acute and chronic conditions. The assumption, by advocates of the concept, is it would improve the quality of care and lower costs.

The National Committee for Quality Assurance (NCQA) has established criteria that allow a Medical Home to be recognized and evaluated. According to Barbara Levy, vice president of ACOG Healthy Policy and Advocacy, at this time, the NCQA does not permit OBGyns’ practices to be certified as primary care medical homes! At present, internists, pediatricians, and family practice physicians are the only doctors classified as primary care providers by the Affordable Care Act (ACA). OBGyn physicians may be certified as “specialty” Medical Homes, but the criteria are not well developed and may not be advantageous.

For those of you who wish to be designated as Medical Homes for your patients, there are some limited options. The ACA contains several provisions that fund the state Medicaid programs (up to $25 million) to develop health homes for Medicaid enrollees. These “Health Homes” must provide “comprehensive case management, care coordination and health promotion, transitional care, patient and family support, referral to community services, and the use of health information technology”: OBGyn physicians may participate. This would be administered by the State of Georgia. The state Medicaid programs that are interested would submit a plan amendment to the Centers for Medicare and Medicaid Services and would have to provide 10% matching funds. To date, only North Carolina has a pilot program that includes OBGyn physicians. These take the form of “demonstration projects” that, if successful, would be incorporated into the framework of the plan.

On a separate but related note is the “Comprehensive Primary Care Initiative.” The ACA has funded this initiative in seven states (not Georgia) and about 500 practices. These 500 primary care practices (not OBGyn practices) were selected to apply if “eligible.” Those selected through “a competitive application process based on their use of health information technology, ability to demonstrate recognition of advanced primary care delivery by accreditation bodies, service to patients covered by participation payers, participation in practice transformation and improvement activities, and diversity in practice size, and ownership structure.” Yes, that is a direct quote! Payments would be provided in a typical fee-for-service format. In addition, management fees would be paid on a monthly basis per Medicare/Medicaid enrollee to average about $20 per month on year one, but would be reduced to about $15 for year three and onwards. The management fee would compensate the provider for administrative tasks related to the Medical Home.

Approximately 1,000 regulations will govern the practical effect of the Affordable Care Act. These, according to the ACA, will be established by the Secretary of Health. They have yet to be developed and/or published. ACOG has actively engaged the Secretary in an effort to protect the interests of our patients and fellows. We may not necessarily want to manage a Medical Home but due to “designation” we would not want what we do to be undervalued.

Dr. Ramon A. Suarez is a GOGS past president, a past chair of ACOG District IV and medical director of OB/GYN Graduate Education for Piedmont Hospital in Atlanta, and is president of Atlanta Women’s Healthcare Specialists LLC.

References
President’s Column

My Last Column: Introducing the Georgia OBGyn Foundation

As you read this, I will be preparing for the Annual Meeting and anticipating the inspirational practice pearls of knowledge I will gain from our amazing faculty guests. In addition, I will be preparing to pass the presidency of this wonderful Society on to our next president. Hopefully, you are planning to join us for this fantastic educational meeting.

In my final column, I wish to leave the membership with what I envision will allow the Georgia OBGyn Society to continue to enjoy the success of past decades as well as rise to new public health challenges: The creation of the Georgia Obstetrics and Gynecology Foundation (GOGF).

It has been well recognized among the leaders of GOGS that some of the funding our membership depends on is threatened in our future environment. Pharma and medical supply companies have tightening budgets and will be less generous with financial support of our educational programs. One concern is that these programs, held at attractive meeting locations, will not be possible without industry support unless additional funding is cultivated.

In addition, because of the need to promote quality women’s healthcare and support educational endeavors, GOGF, as supported by the GOGS Board, has been created. Although these concepts are important to the mission of the Society, a successful Foundation will allow other opportunities for funding that are not within the current Society budget. Such examples include outreach and support of our rural colleagues in technology, practice sustenance, and manpower recruitment. Other possibilities would allow us to develop mission outreach programs both in the United States and international locations. The potential of this Foundation is limitless.

The Board of GOGF includes past and present GOGS leaders with the aim of representing the entire state. Current charter members include myself and Drs. Cindy Mercer, Cathy Bonk, Schley Gatewood, Terry Pope, and Pam Gallup. GOGF is being established with the help of legal counsel. Ideally, this foundation will not solicit funds. Rather, it will serve as a place of receiving. The challenge is to make members aware of the Foundation and thus want to contribute based on its mission. We anticipate the Foundation will be an attractive option as there will be little operational expense. The Society itself is the “unpaid think tank” with its Board representing the state’s OBGyns and women’s health interests.

Lastly, the Foundation will serve no political function. It is hopeful GOGF, as well as other forward thinking ideas from our membership, will allow OBGyns in Georgia to survive as well as excel in our challenging medical climate.
She needed “cycle control.” I elected to do nucleic acid amplification STI tests with the pap smear, bong and NOT, of course, a pap smear. Chlamydia was positive, so I e-prescribed treatment (EPT) for both her and her partner. They said there would be no partner to consider and somehow I believed them. A few days later I got a call from the mother who was afraid to leave her daughter alone, not because of promiscuity, but because she was depressed and crying and talking about not wanting to live after getting this diagnosis.

Around here there’s not a good system for taking care ofygyns who are troubled because they don’t think they have the right psychological issues. I brought her in to try to meet her head on. The large, overweight, awkward teen sat next to her protective mother and cried silent tears as we reviewed what her situation was. She had contracted an STI from a person she did not care anything for and who they declared would not be back. There’s no telling what all else might be going on in their lives. But right then what she needed was something there is no billing code for.

She had discharged herself and her mother and had risked her health and her future, yes, but there had been no crime. Still, nothing a thin white lady doctor could say seemed enough to them. The quiet tears kept coming. “The culture gap is so wide,” I thought as I sat with them. My instincts took over and I could only think to tell her how wonderful she is and how much I care about her and her mother, who loves her, cooperating, getting treatment and facing it. How brave she is! I took her hands and told her she has a bright future, that this is how we learn best, by making mistakes, and that her mother and I have made so many of them. For at least a few moments, her eyes reflected comprehension and belief in what I was saying. I don’t hold my breath about her future. I know what the odds are, but the hug I gave and received that day meant a lot to me and most likely it meant something to her. I called later that afternoon to check on her, and her mother was definitely feeling better. 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Margaret D. Schaufler, MD
Editor Lagrange, Georgia

“Editor’s Column

As Powerful as Serena

I’ve figured out how I am like Serena. Not just the tennis ace, but the young woman who trains day and day out for a living, I take on whatever and whoever waits for me in my exam room day in and day out. Behind each door is someone who has made an appointment, kept that appointment and is waiting with at least a modicum of trepidation for whatever I decide to make of the occasion. It’s actually quite a powerful hand I’ve been dealt, to be her gynecologist. Of course, how I handle this power means everything. I’m seeing more teenagers and twenty something’s lately. I thought it would be the opposite — that my practice would evolve into mostly menopausal issues, seasoned women who know what they want or don’t want. But here I am seeing precious tender-aged and young women who are impressionable and vulnerable, and I have the opportunity to be the bomb (if I can) or bomb out, so-to-speak.

Will I have time to listen? Will I smile as I enter? Or will I go straight to the computer screen and stare at it while loads up the templates I’m going to start from? Will I look her in the eye for the appropriate length of time that tells her I care? Will I acknowledge the older lady who came with her, inject a little levity and self-effaceman enough to put her at ease? It all means so much to this youngster. Surely after so many years I have developed a rhythm and can size it all up and be what I need to be for her and get paid enough to keep me in business. On electronic health records will make us wonder these things.

The other day, a 16 year old was brought in by her mother who looked suspiciously like her grandmother and
on June 13, radio talk show host Tanya Mack interviewed C. Anne Patterson, MD, for her radio talk show, The Doctors Roundtable. Dr. Patterson is a board-certified OB/GYN, for her radio broadcast. The Doctors Roundtable Discussion OB/Gyn NEWS, August 2013

Tanya Mack interviewed C. Anne Patterson, MD, MFM, for her radio broadcast. The Doctors Roundtable Discussion OB/Gyn NEWS, August 2013

Dr. Patterson: That is right.

Mack: What kind of transmission? What do you transmit?

Dr. Patterson: Absolutely. The stethoscopes are so sensitive and so precise, that it’s just like you were there. Not everyone’s telemedicine units are identical. Often the specialty or the doctors providing the care will recommend or require certain things to be on a “cart” as it’s often called. Those are then configured as you need them.

Mack: I read that one of the hindrances to telemedicine expanding is actually adopted from the patient and the provider getting used to how to work this stuff. As an engineer, you’re probably more comfortable with technology (than) some of other physicians, having worked with EMRs and ultrasound technology. How hard was this for you to learn and how did you do that?

Dr. Patterson: I’m not hard. Getting the people on the other side comfortable if they’ve never been exposed to a lot of technology sometimes takes a little time. I’ve actually had a harder time getting the mid-level providers that are going to be the other part of the team that can’t always be as comfortable with what they’re doing and the equipment more than the patient.

Mack: You bring up a good point; the problems can occur in the middle by themselves in front of a unit. They actually need a provider or a medical assistant who’s with the patient.

Dr. Patterson: You have a “presenter” and the presenter can be a mid-level provider. They can “guide” the physical exam if you and/or help facilitate any questions with the evaluations.

Mack: It’s very similar to an in-person visit. The patient responds to signs whether they are at an emergency room, a health department, a doctor’s office or wherever the telemedicine unit is. They’re put in the space. It’s just they’re sitting in front of the telemedicine cart.

Dr. Patterson: Correct. They may be on the ultrasound table and we’re looking at a high resolution scan. We can still see the patient. We just split the screen.

Mack: I know a lot of listeners out there are going to think, “Oh my gosh, it’s like ultrasound is heading into the ether for anybody to grab.” Talk about privacy.

Dr. Patterson: It’s not different from being in your doctor’s office. Everything is HIPAA compliant that we see. There’s nothing transmitted anybody could get, that the patient that I can hear on my end.

Mack: So, I could be in Jackson, Georgia, and you could hear me here in Atlanta.

Dr. Patterson: Absolutely. The province of technology is not going to be a problem. It’s a great opportunity. There is a “universal schedule.” There are two components to it, but my office keeps a schedule for me. I know how I’m scheduled, where the patient is going to be. Usually, the presenter knows what time and sends a message, “Am I ready?”, “Yes”, and they call it right in.

Mack: Do you ever have circumstances, since you deal with pregnancies, where you have to interface with children’s hospitals for things like fetal abnormalities? I know in your practice, before the baby’s born, there may be some kind of collaborative practice?

Dr. Patterson: I’ve had some very interesting experiences. Actually, I have a patient in the hospital here in Atlanta from many hours away today, being

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Dr. C. Anne Patterson, left, is interviewed by The Doctors Roundtable host Tanya Mack on June 13.

Mack: Tell us a little bit about what telemedicine is and how you got involved with it from your previous clinical practice background.

Dr. Patterson: It was very obvious from my previous experience and having patients transferred into me, that rural Georgia is very short on healthcare in some areas. There are actually about 40 counties in the state that do not have obstetrics and gynecology. I was a guest at Emory University after completing a master’s in engineering at Georgia Tech. She has practiced at Northside Hospital for the past 25 years. Most recently, she moved from private clinical practice to telemedicine and now is one of the state-of-the-art equipment. It was absolutely amazing for me to see first hand that this would be a very advantageous thing for the state of Georgia. It has functioned as a cost-for-profit organization, even a 24/7 network so you can see the patient anytime. It has been utilized by nurses in specialties in various fields. Actually, a patient, instance, telestroke is something that’s widely used in Georgia and different emergency rooms. If a patient has a stroke in a remote community and has a stroke, they can connect with someone who is an expert neurologist to get the right advice about what to do to minimize disability the cause.

Mack: Most commonly, you don’t have to be the IT department. You can utilize another provider’s broadband network, so the telemedicine unit is pretty low in terms of IT support.

Dr. Patterson: Correct. And Georgia is a leader in this in the nation, which is really great!

Mack: Talk a little bit about what hardware is required for telemedicine.

Dr. Patterson: Overall, it’s a telemedicine unit. The best is an integrated unit where the doctor can see the patient and the patient can see you and you, on the other side, can see the patient. The best would be a unit that can be used for electronic medical record as needed. Not only that, there’s good voice. There are stethoscopes that can be put on the patient. Those are then configured as you need them.

Mack: I’d like to talk a little bit about how telemedicine works. I know you integrate ultrasound, telemedicine and Bluetooth technology. My understanding is there are three big components of telemedicine. One would be some transmission network, either cellular, satellite or broadband network. Another component would be the hardware that needs to be with the patient and you

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Dr. Patterson: No, not at all. It’s billed just like you were present. In Georgia, you can bill insurance or Medicaid just like you are there. It pays exactly like you were a patient in the room with a doctor because you are the doctor “there.”

Mack: Let’s talk a little bit about some of the limitations of telemedicine. Are there licensure rules?

Dr. Patterson: I just have to have a license wherever I am. Every state is different about licensure, so you have to look through whatever their process is. Sometimes that’s pretty involved.

Mack: Do you have to be licensed where the patient’s sitting?

Dr. Patterson: Correct.

Mack: Do you do “urgent” telemedicine visits?

Dr. Patterson: I can.

Mack: That opens up instant access for the patient and the doctor to pretty much anything they need to know. It’s also convenient.

Dr. Patterson: Yes, we can. Let’s say a patient needs to be referred to a level-3 center or referred to a level-3 center where she needs to be delivered, or something like that. If we can try to expedite that, whether she comes by ambulance or she’s airlifted in.

Mack: Another big question I have is physical. It sounds like with all of this technology, I’m really going to pay for that? So who pays for telemedicine? Is it different than if I just came to see you as a patient?

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delivered because her baby will need surgery nearby. She could have elected to deliver near home and have the baby transported. But I think, wisely, most mothers would choose to be where their baby was. She came to Atlanta and will be delivered here.

We’ve also had a patient, or more that a special person, and we had the pediatric cardiologist online. The patient was being scanned, there was a ‘presenting site’ viewing the fetal echo, and the pediatric cardiologist was viewing the fetal echo all at the same time. We collaborated and the patient knew the diagnosis, the plan, before she ever left the doctor’s office. This is pretty nice because that means she doesn’t have to come to Atlanta, four hours away, and she can see and talk to me. I could see you at the same time. You both could see my ultrasound images and we, all three, could talk to each other at the same time?

Mack: It sounds "Star Trekky" to me. But in general, if I’m the patient, I could see the pediatric cardiologist on the screen from Children’s, and talk to him.

Prenatal Testing at EGL

**Rapid Screen: Chromosome:**

Chromosome Analysis: Conventional karyotype analysis detects abnormalities in chromosome number (aneuploidy), large deletions/duplications of chromosomes, and balanced chromosome rearrangements.

Chromosome Microarray Analysis: The EmArray Cyto Prenatal chromosome microarray is a 60K oligonucleotide array that detects copy number aberrations across the genome. With an increased detection rate over standard chromosome analysis, ACOG has endorsed microarray analysis for prenatal testing and recommends its use in pregnancies with abnormal ultrasound findings and normal G-banded chromosome analysis.

**Known Mutation Testing:**

When a familial mutation is identified, either a sequence mutation or whole or partial gene deletion/duplication, targeted molecular testing can be offered for the at-risk pregnancy.

**L1CAM & PKHD1 Full Gene Sequencing:**

EGL offers prenatal full gene sequencing and deletion/duplication analysis for L1CAM and PKHD1 when there is a prenatal indication of an L1 syndrome disorder or autosomal recessive polycystic kidney disease, respectively.

**Coming Soon to EGL**

EGL is excited to announce the addition of non-invasive prenatal screening with the ability to detect multiple fetal chromosomal aneuploidies using a single maternal blood draw. This screen is intended for patients at 10+ weeks gestation with singleton pregnancies.

Also coming soon is the Pan Ethnic Carrier Screening (PECS) Panel, which simultaneously detects 464 common mutations in 93 genes via a targeted sequencing assay. This assay tests for disorders on the recommended newborn screening panel, as well as other metabolic and lysosomal storage disorders. The mutations were chosen based on their prevalence in diverse ethnic populations.

**Telemedicine: The Doctors Roundtable Discussion**

Carrie Gann, DPH Communications

**Telemedicine**

The Georgia Department of Public Health (DPH) plans to transform its statewide telemedicine program into one of the most comprehensive in the nation, driven by DPH Commissioner Dr. Brenda Fitzgerald’s vision to expand the network to all of the state’s health districts and county health departments.

In January, DPH began distributing 13 telemedicine carts to health districts around the state, each equipped with a smartphone, endoscope and a basic exam camera. The department also will pursue case finishing touches on the videoconferencing infrastructure it has been consolidating, updating and expanding over the past year.

Dr. Kathryn Cheek, a member of the Board of Public Health, said eventually people will be able to visit the telemedicine hubs in their local health districts to get everything from a dental checkup to a pulmonary exam or an autism evaluation. The goal is to remove barriers so all patients can be seen and get care they need,” Cheek said in a Dec. 11 Board of Public Health meeting. She noted the technology will also make follow-up care more reliable and improve health outcomes for rural patients.

The need for increased access to health care is great. According to the Georgia Board for Physician Workforce, 52 percent of Georgia’s physicians are located in five areas that serve just 38 percent of the state’s population. The state also ranks 40th in the nation when it comes to adequate distribution of doctors by specialty and geographic location.

Telemedicine plans to establish telemedicine hubs across Georgia.

Many patients travel for hours to visit doctors across the state, and some providers visit rural areas to treat underserved patients. Cheek noted that in the time these doctors spend traveling, they could see dozens of patients through telemedicine.

The video conferencing systems have been in place in some rural districts for nearly a year, and the use of those systems has been steadily increasing. In the first quarter of 2012, an average of 15 sites used the system each month. By the end of 2012, that number tripled.

"I think that’s pretty impressive for one year," Cheek said. "We have really only propelled this forward to get where we are.

To expand the network, DPH is recruiting doctors and dentists in the Georgia Volunteer Health Care Program to enroll them in the telemedicine program and get them the necessary audio and video equipment to start seeing patients. The department also hopes to expand the telemedicine network to include doctors in the 80 clinics in the Georgia Free Clinic network.

When seeing a patient in the emergency room, you have a few options to consider before billing your face-to-face service. This will be based on the reason for the visit, the results of the visit, and on the patient's insurance.

Example 1:
If you meet your established patient in the ER as a courtesy to the patient and not because it is a true emergency, you should bill the service as an initial hospital visit (99261-99262) with the place of service for the emergency room (23) (regardless of insurance).

Example 2:
If you see a true emergency patient in the ER and later admit the patient to your service from the ER and you document an admitting H&P, you should bill an outpatient code and not because it is a true emergency, in the ER as a courtesy to the patient and the patient in the ER and later admits the patient to your service from the ER and you document an admitting H&P, you should bill an outpatient code (regardless of insurance).

Example 3:
If you are asked to see the patient in the ER and the patient's insurance company accepts consultation codes and you do not admit the patient to your service, you can bill the service as an outpatient consultation visit. Outpatient consultation codes are 99241-99245, (This is normally for commercial carriers.)

Example 4:
If you see the patient in the ER at the request of another provider and the provider's insurance company does not accept the outpatient consultation codes and you do not admit the patient to your service, you can bill the service as a 99281-99285. (This is normally Medicare and Medicaid.)

Example 5:
If you see the patient in the ER and admit them to the hospitals' service, you would not bill an initial hospital visit 99221-99223, because you are not the admitting provider of record.

(You therefore will have to refer back to example 3 or 4.)

Remember this too:
If you see the patient in the ER as a consultation service and decide the patient needs surgery and the patient is sent to the operating room, don't forget to append your modifier 25 if the global period for the surgery is 0-10 days, or use the modifier 57 if the surgery on the same day or next day is major surgery and has a global period of 90 days. The modifier 25 and/or 57 would be appended to the Evaluation and Management Codes described above depending upon the service you provided.

Update ICD-10 Information
Webinars
Need some help preparing for ICD-10? The Georgia Department of Child Health is providing free ICD-10 webinars through its web site to help with ICD-10 transition. Webinars may be view live or as on-demand after the initial presentation. Visit www.dch.georgia.gov/events for more information or to register.

Upcoming 2013 ICD-10 Webinars:
• August 15 – 10:30 a.m. Topic: ICD-10 Clinical Close-up – Part 1
• August 22 – 10:30 a.m. Topic: ICD-10 Clinical Close-up – Part 2
• September 10 – 10:30 a.m. ICD-10 Testing Readiness with DCH (for Trading Partners, Billing Firms)
• September 25 – 10:30 a.m. ICD-10 Testing Readiness with DCH (for Providers)
• October 15 – 10:30 a.m. ICD-10 Pre-Testing Readiness & Troubleshooting
• October 29 – 10:30 a.m. ICD-10 Open Discussion

Georgia Obstetrical and Gynecological Society
First Annual Practice Administrators Meeting
Saturday, August 24, 2013, 8 am - 3 pm

Meet, Greet, and Learn . . .
Meet other practice administrators from around the state while learning more about topics relevant to improving your profession:
• Affordable Care Act and its impact on OBGyn practices
• Updates for navigating Medicare
• Future uses and advanced applications for Electronic Medical Records
• Compliance and coding information

In addition, tour the Society’s Annual Meeting Exhibition Hall and interact with all attending vendors.

ACOG’s District IV Annual Meeting
The 2013 Annual ACOG District IV Meeting will be a joint meeting with Districts I and III, October 11 - 13, at the Wyndham Rio Mar Beach Resort, Rio Grande, Puerto Rico. The meeting offers 14 AMA PRA Category 1 Credits and will include topics such as LARC, Robotic Surgery, MOC, Patient Safety, Antibiotic Resistance, Gyn Ultrasound and much more! For registration and hotel information, visit http://www.acog.org/About_ACOG/ACOG_Districts/District_IV/2013_Annual_District_Meeting.

News from Around the State

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The 2013 Annual ACOG District IV Meeting will be a joint meeting with Districts I and III, October 11 - 13, at the Wyndham Rio Mar Beach Resort, Rio Grande, Puerto Rico. The meeting offers 14 AMA PRA Category 1 Credits and will include topics such as LARC, Robotic Surgery, MOC, Patient Safety, Antibiotic Resistance, Gyn Ultrasound and much more! For registration and hotel information, visit http://www.acog.org/About_ACOG/ACOG_Districts/District_IV/2013_Annual_District_Meeting.

STD Treatment App
CDC’s Division of STD Prevention has launched the STD Treatment (Tx) Guidelines mobile app, which helps health care providers easily access diagnostic information and the current STD Treatment Guidelines. Providers who use this app will have quick access to information about diagnosing and treating 21 STDs as well as the booklet “A Guide to Taking a Sexual History.” The app is available for Apple and Android devices and can be downloaded for free from the iTunes and Google Play stores. For more information about the app, visit the http://www.cdc.gov/std/STD-Tx-app.htm?s_CID=govd-std-017.

Asian Americans and Hepatitis B Campaign
CDC’s Division of Viral Hepatitis has launched a “Know Hepatitis B” campaign to raise awareness about the disease among Asian Americans and Pacific Islanders (AAPIs) and encouraging AAPIs to be tested. Hepatitis B affects 1 in 12 Asian Americans and most don’t know they have it. A Know Hepatitis B is especially common in many Asian and Pacific island countries. While AAPIs make up less than 5% of the total U.S. population, they account for more than 50% of Americans living with chronic hepatitis B. For additional information, visit the http://www.cdc.gov/features/AAPICampaign/.
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