Idaho Medical Association

Table of Contents:
In this Issue...



# *IMAges*

## November 15, 2018

### Prop 2 Passed with 60.6 Percent Voter Approval!

That means Medicaid expansion is the law of the land in Idaho and will provide health coverage for 62,000 hardworking Idahoans. IMA is especially pleased with the large margin of victory because it sends a strong message to the Legislature that Idaho's citizens are staunchly supportive of this important initiative.

The efforts of Idaho's physicians really made a big impact in the success of the campaign. Thank you to the many IMA members who stepped up in so many ways to support the Idahoans for Healthcare campaign: your generous financial contributions, writing letters and op-eds, talking to friends and neighbors, volunteering your time, and finally for voting Yes for Prop 2. As an organization, IMA contributed $49,000 to the campaign, and in addition to that our individual physician members contributed over $100,000 to the effort.

After taking a moment to savor the victory, IMA will get back to work to ensure full implementation of Medicaid expansion, without undue requirements for patients or unnecessary and expensive administrative burdens. IMA is prepared to fight against any attempts to thwart the will of Idaho voters. We will continue to provide updates on next steps and how you can help shape the discussion in the Legislature over the next several months.

***[Back to Top]***

### CMS Moves on E/M: Three Things Physicians Should Know

There were major victories for physicians in the 2019 Medicare Physician Fee Schedule Final Rule, particularly when it comes to payment for evaluation-and-management (E/M) services. But with the document running nearly 2,400 pages, it could be difficult to sort them out. So here are three things physicians need to know about next year's fee schedule from the Centers for Medicare and Medicaid Services (CMS).

1. CMS has postponed the E/M coding "collapse" for at least two years. CMS will postpone its proposal to collapse payment rates for four E/M office visit services into a single blended rate. The American Medical Association (AMA) advised CMS that the proposal could create unintended consequences for specialties that treat the sickest patients and for physicians who provide comprehensive primary care. In revising E/M payments, CMS also announced it would take into consideration the recommendations of the AMA-convened Current Procedural Terminology (CPT®)/Relative Value Scale Update Committee (RUC) Workgroup. The workgroup has used a formal survey mechanism to solicit feedback throughout the process to ensure that maximum input is acquired to achieve consensus. More than 60 national specialty societies have responded to these surveys.

   The workgroup is also working to build consensus around modernizing the office and outpatient E/M CPT codes to simplify the documentation requirements and better focus code selection around medical decision-making and physician time. "The two-year delay in implementation will provide the opportunity for us to respond to the work done by the AMA and the CPT Editorial Panel, as well as other stakeholders," CMS said in the final rule. "We will consider any changes that are made to CPT coding for E/M services, and recommendations regarding appropriate valuation of new or revised codes, through our annual rulemaking process."

   2. Proposed same-day-service pay cut will not be implemented. CMS has dropped its proposal to chop in half payments for office visits that occur on the same day as a procedure furnished by the same physician or another physician in the same practice. Also dropped from consideration is a proposal to create a new indirect practice expense category for office visits. This proposal would have resulted in large changes in payments for some specialties - including a greater than ten percent pay cut for chemotherapy services.

   3. New documentation rules cut physician administrative burden. CMS followed suggestions provided by the AMA and some 170 other medical groups in a letter sent to CMS Administrator Seema Verma. Specifically, physicians will not have to redocument elements of a patient's medical history and physical exam. Instead, documentation will focus on patients' medical history during the interval since the previous visit. Also gone is a requirement that physicians redocument information recorded by their staff or by the patient. In addition, a requirement to document the medical necessity of furnishing a home visit rather than an office visit has been eliminated. [*AMA Advocacy Update*, 11/15]

***[Back to Top]***

## The Idaho Medical Association Welcomes New Members

A warm welcome to these physicians who have recently joined the IMA:

Autumn R. Bridger, DO, Urology, Caldwell

Kelly J. Bridges, MD, Neurological Surgery, Boise
Hannah Caulfield, MD, General Surgery, Pocatello
Susanne Choby, MD, Internal Medicine, Psychiatry, Hailey
Philip J. Dougherty, MD, Neuroradiology, Coeur d'Alene
Shawn Echols, MD, Anesthesiology, Boise
Tara L. Erbele, MD, Family Medicine, Boise
Clara Huntington, MD, General Surgery, Boise
Gregory A. Jeppesen, DO, FACEP, Emergency Medicine, Blackfoot
Jenny J. Jin, MD Orthopedic Surgery, Boise
Jonathan T. Klaucke, MD, Orthopedic Surgery, Sandpoint
Elisabeth M. Kuper, MD, Family Medicine, Eagle
Artur Narkiewicz-Jodko, MD, Vascular & Interventional Radiology, Idaho Falls
Dean A. Nelson, DO, Family Medicine, Jerome
Benjamin M. Perry, DO, Dermatology, Meridian
Finn B. Petersen, MD, Oncology, Boise
Richard A. Pierson, MD, Family Medicine, Jerome
S. Kathryn Potter, MD, Family Medicine, Boise
Katherine W. Quayle, MD, Pediatrics, Hailey
Nikhil P. Reddy, MD, Internal Medicine, Boise
Shanaz Sikder, MD, Internal Medicine, Boise
Joshua R. Smith, MD, Diagnostic Radiology, Coeur d'Alene
Alex M. Tanabe, MD, Internal Medicine, Boise
Jairus F. Taylor, MD, Anesthesiology, Boise
Taylor B. Turner, MD, Gynecological Oncology, Boise
Eric Varley, DO, Orthopedic Surgery, Meridian
Jacob P. Venesky, MD, Obstetrics & Gynecology, Idaho Falls
Rex E. Wortham, MD, Family Medicine, Jerome
Thomas H. Zepeda, MD, Family Medicine, Jerome

***[Back to Top]***

## IMA Online Fund Drive for the Idaho Foodbank

In 2016, the House of Delegates established IMA policy recognizing food insecurity as one of the most important social determinants that impacts the health status of Idahoans and directed IMA to partner with the Idaho Foodbank and its 230 non-profit partners to help decrease food insecurity in our communities.

As part of our partnership with the Idaho Foodbank and to celebrate the giving spirit of the holidays, the IMA has launched an online fund drive. We invite IMA members and others to join us in showing support for the important work of the Idaho Foodbank and its network of more than 230 non-profit partners largest throughout the state.

To donate, go to https://idahofoodbank.org/idaho-medical-association/

***[Back to Top]***

## Extortion Scam Targeting DEA Registrants

The Drug Enforcement Administration (DEA) is aware that registrants are receiving telephone calls and emails by criminals identifying themselves as DEA employees or other law enforcement personnel. The criminals have masked their telephone number on caller ID by showing the DEA Registration Support 800 number. Please be aware that a DEA employee would not contact a registrant and demand money or threaten to suspend a registrant's DEA registration.

If you are contacted by a person purporting to work for DEA and seeking money or threatening to suspend your DEA registration, submit the information through "Extortion Scam Online Reporting" posted on the DEA Diversion Control Division's website, www.DEADiversion.usdoj.gov.

For more information contact:
Locate DEA Field Office for your area - https://apps.deadiversion.usdoj.gov/contactDea/spring/fullSearch

Registration Service Center - 1-800-882-9539
Email - DEA.Registration.Help@usdoj.gov

***[Back to Top]***

## How Are Prescription Drug Prices Determined?

The U.S. spends nearly $330 billion a year on prescription drugs. In 1990, the share the nation spent for pharmaceuticals accounted for 5.6 percent of total healthcare spending, but grew to nearly 10 percent in 2016.

Prescription drug price increases can lead some patients to not be able to afford critical medicine, causing them to skip doses of their medications or split pills, or force them to abandon treatment altogether. Physicians and patients are often left in the dark about how and why prices fluctuate year after year when ingredients stay the same.

To expose the opaque process that pharmaceutical companies, pharmacy benefit managers and health insurers engage in when pricing prescription drugs, the American Medical Association (AMA) launched the TruthinRx (https://truthinrx.org/) campaign in 2016. This grassroots campaign provides opportunities for patients and physicians to share their experiences with prescription drug price and cost challenges and rallies grassroots support to call on lawmakers to demand drug price transparency.

Prescription drug price negotiations often happen behind closed doors, leaving patients and physicians out of the negotiating room despite the impact drug pricing has on the health and treatments of patients. To improve prescription drug price transparency, the TruthinRx campaign is focusing on three major market players who significantly impact drug prices:

Pharmaceutical companies. Pharmaceutical companies make and sell drugs, but don't explain pricing or why costs can greatly exceed research-and-development (R&D) expenses. Some even buy existing drugs, spend nothing on R&D, and still raise prices.

Pharmacy benefit managers (PBMs). Working on behalf of health insurance companies or employers, PBMs negotiate upfront discounts on the prices of prescription drugs with pharmaceutical companies, as well as rebates, which reward favorable coverage of a particular drug (and the resulting increase in utilization by a health plan's patients). These prescription drug agreements are kept secret, so it is unknown if savings ever reach the patients.

Health insurance companies. Health insurance companies approve treatments, set co-pays, and price out with PBMs how much patients pay for drugs. Often, they decide coverage options based on what maximizes company profits. [Berg, *AMA Wire*, 9/14]

***[Back to Top]***

## 93 Percent of MIPS-Eligible Clinicians to Get Positive Payment Adjustment

The vast majority of clinicians eligible for the Merit-based Incentive Payment System (MIPS) will get a positive payment adjustment for their participation in the 2017 Quality Payment Program (QPP).

That's according to the Centers for Medicare and Medicaid Services (CMS), which reported the new data on the QPP's inaugural year.

Writing in a blog, CMS Administrator Seema Verma revealed that 93 percent of clinicians eligible for MIPS received a positive payment adjustment for their 2017 QPP performance - to be received in 2019 - while 95 percent overall avoided a negative payment adjustment.

"Admittedly, the MIPS positive payment adjustments are modest," wrote Verma, referring to the fact that the maximum positive adjustment for exceptional performance was 1.88 percent.

"It is important to remember that the funds available for positive payment adjustments are limited by the budget neutrality requirements in MIPS, as established by law under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)," she added. "Moreover, 2017 served as a transition year to help

ease clinicians into the program and encourage robust participation."

Earlier this year, CMS released preliminary participation data on clinicians eligible to participate in MIPS under the QPP, reporting that 91 percent of all clinicians eligible for MIPS participated - slightly exceeding the agency's goal of 90 percent participation.

MIPS has an advancing care information (ACI) performance category with measures that support clinical effectiveness, information security and patient safety, patient engagement, as well as health information exchange.

Under MIPS, the ACI performance category score defines a meaningful electronic health record user as a MIPS eligible clinician who possesses certified EHR technology, uses the functionality of CEHRT, and reports on applicable objectives and measures.

Created through MACRA, the QPP offers clinicians two tracks to choose from: MIPS or the Advanced Alternate Payment Model.

"We calculated that 1,057,824 MIPS eligible clinicians will receive a MIPS payment adjustment, either positive, neutral or negative," noted Verma. "Of that population, 1,006,319 MIPS eligible clinicians reported data as either an individual, as a part of a group, or through an Alternative Payment Model (APM) and received a neutral payment adjustment or better. Additionally, under the Advanced APM track, 99,076 eligible clinicians earned Qualifying APM Participant (QP) status." [Slabodkin, *Health Data Management*, 11/9]

***[Back to Top]***

## Opioid Prescriptions Research Study at University of Texas

The Health Innovation Lab at the University of Texas at Austin's Dell Medical School (http://sites.utexas.edu/HealthInnovationLab/) is recruiting clinicians with prescribing privileges to participate in a brief and confidential online survey to increase the understanding of clinical decision-making processes regarding opioid prescriptions. The IRB-approved survey will take less than 30 minutes. Participation is voluntary and no compensation will be provided. Please go to http://j.mp/2CzVGmU to see if you are eligible to participate. Please contact projectoppp@austin.utexas.edu with any questions.

***[Back to Top]***

## Idaho CCHD Screening Educational Website

As previously reported, effective July 1, 2018, all newborns in Idaho are screened for critical congenital heart defects (CCHD). This new screening requirement was a result of IMA's efforts in partnership with the Idaho State Department of Health and Welfare.

The IMA House of Delegates adopted policy supporting CCHD screening in 2016 and directed IMA to advocate for mandatory screening and reporting in Idaho. Research shows that states with mandatory screening policies have significantly fewer infant cardiac deaths.

The Idaho State Department of Health and Welfare is currently working to provide education to the community about the screening requirement. As part of their efforts an educational website has been developed. Access this resource at https://healthandwelfare.idaho.gov/Children/CriticalCongenitalHeartDisease(CCHD)/tabid/4392/Default.aspx

***[Back to Top]***

## Reducing Clinician Burden

On November 8, the Centers for Medicare and Medicaid Services (CMS) released a letter to clinicians outlining how the agency is reducing burden through reform of documentation and coding requirements.

The letter from CMS Administrator Seema Verma outlines the "Patients over Paperwork" initiative that

updates policies in Medicare and Medicaid that are outdated, duplicative or overly burdensome.

Information is provided in the letter regarding CMS' efforts to update documentation requirements and propose a new model of payment of payment for E/M services which was included in the 2019 proposed rule for the Physician Fee Schedule. In response to more than 15,000 comments CMS received regarding these proposals, many of the changes will not be implemented until January 1, 2021 to allow clinicians more time to integrate changes in workflow that may be required.

The letter is available at https://www.cms.gov/About-CMS/Story-Page/Clinician-Letter-Reducing-Burden-Documentation-and-Coding-Reform-.pdf

***[Back to Top]***

## *Gifts to Patients and Referring Providers*

Kim C. Stanger, Holland & Hart

At this time of year, healthcare providers may want to give gifts to patients, referring providers, or other sources of business, but such gifts may violate federal and state fraud and abuse laws and result in civil or criminal fines for both the giver and receiver.

1. Gifts to Referring Providers and Other Referral Sources. The federal Anti-Kickback Statute ("AKS") prohibits soliciting, offering, giving, or receiving remuneration (e.g., gifts) in exchange for referrals for items or services covered by Medicare, Medicaid, or other federal healthcare programs unless the arrangement fits within a regulatory exception. (42 U.S.C. § 1320a-7b(b)). AKS violations are felonies, automatic False Claims Act violations, and may result in an obligation to repay the federal government, criminal and civil penalties, and exclusion from Medicare and Medicaid programs. The AKS is violated if "one purpose" of the remuneration is to induce federal program referrals, including gifts to referring practitioners or program beneficiaries to encourage or reward their business. (OIG Adv. Op. 12-14). Significantly, the AKS applies to both the giver and recipient; thus, soliciting or receiving gifts from vendors or other providers may expose the recipient to liability. The OIG has suggested that "nominal" gifts would not create much AKS risk, but offers no guidance as to what is "nominal". (65 F.R. 59441). The AKS does not expressly apply to referrals for private pay business, but the OIG has warned that offering remuneration to obtain private pay referrals may also induce federal program business and thereby violate the AKS. (OIG Adv. Op. 12-06). In addition, offering gifts to induce or reward private pay business may violate state laws, including state laws prohibiting kickbacks, rebates, or fee splitting. (See, e.g., Idaho Code 41-348 and 54-1814). In short, providers should not give gifts to referral sources and should not accept gifts from vendors or others to whom the receiving provider refers business unless the gift is truly nominal, is clearly and completely unrelated to past or future referrals, or is very unlikely to influence referrals.

2. Gifts to Referring Physicians. In addition to the AKS, gifts to referring physicians or their family members may also implicate the Ethics in Patient Referrals Act ("Stark"). Gifts create a financial relationship under Stark; accordingly, Stark would prohibit the physician from referring patients to the giver for certain designated health services payable by Medicare or Medicaid, and would prohibit the giver from billing for those services, unless a regulatory exception applies. (42 U.S.C. 1935nn; 42 C.F.R. 411.353). Stark violations may result in civil penalties, repayments, and False Claims Act liability. Unlike the AKS, Stark is a strict liability statute: your intent does not matter. Stark does contain a limited exception that allows an entity to give unsolicited non-monetary gifts (not cash or cash equivalents) of up to approximately $400 per calendar year if the gift does not take into account the business generated by the physician and otherwise does not violate the AKS (i.e., not one purpose of the gift is to generate or reward referrals). (42 C.F.R. 411.357(k)). In addition, entities with formal medical staffs may provide one local medical staff appreciation event for the entire medical staff per year. (Id. at 411.357(k)(4)). Any gifts or gratuities provided in connection with the annual appreciation event are subject to the annual $400+ aggregate limit. In short, unless you are certain that the physician will not refer designated health services to you or you will not bill Medicare or Medicaid for such services, or you fit squarely within a Stark exception, you should not give gifts to or accept gifts from referring physicians or their family members. In addition, some state laws may contain mini-Stark laws that prohibit similar actions.

3. Gifts to Patients. Gifts to federal healthcare program beneficiaries trigger the AKS if one purpose is

to induce the patient to receive services. In addition, the federal Civil Monetary Penalties Law ("CMPL") prohibits offering or transferring remuneration to Medicare or Medicaid beneficiaries if you know or should know that the remuneration is likely to influence the beneficiary to order or receive items or services payable by federal or state programs from a particular provider unless certain conditions are satisfied. (42 U.S.C. 1320a-7a). CMPL violations may also result in civil penalties, False Claims Act liability, and exclusion from federal programs. Unlike the AKS, the OIG has approved nominal gifts if they are not cash or cash equivalents, and they have a retail value of less than $15 individually or an aggregate value of $75 per year per patient. (OIG Bulletin, Offering Gifts and Inducements to Beneficiaries (8/02); 66 FR 24410-11). As with the AKS, the CMPL does not apply to private pay patients, although state kickback, rebate or fee splitting statutes may apply. As a practical matter, providers are likely safe if they fit within the $15/$75 limits for gifts to patients.

4. Gifts from Vendors. The AKS may also apply to gifts offered by vendors: it prohibits providers from soliciting or receiving such gifts as a reward or in exchange for referring federal program business to the vendors. (See OIG Compliance Program Guidance for Pharmaceutical Manufacturers, 68 FR 23738). As with other gifts between referral sources, you should not accept gifts of more than nominal value if you have referred or may refer federal program business to the vendor. In addition, such gifts may also trigger reporting requirements under the Sunshine Act regulations. (42 CFR part 403).

Conclusion. Well-intentioned gifts between referral sources may have unintended consequences. Healthcare professionals should ensure that they and their staff comply with the rules cited above along with additional relevant state laws. If you have not done so recently, it may be a good time to review your compliance plan and these guidelines with your staff.

***[Back to Top]***

## New Free Webinar: Dealing with ERISA Claims

ERISA, the Employee Retirement Income Security Act of 1974, affects self-insured health plans. Claims payments and denials with ERISA plans are becoming increasingly problematic for physician practices. In years past, only very large companies took on self-insured health care coverage; now, insurers are marketing third-party administrator/ “administrative services only” to companies as small as 50-100 employees. As the employers bear full financial risk, these arrangements are not “insurance” products regulated by the state Department of Insurance, meaning the Department cannot intervene to protect those patients. However, the U.S. Department of Labor does have oversight of ERISA arrangements.

The IMA is collaborating with the Seattle office of the U.S. Department of Labor to offer a new webinar, ERISA and Payment of Healthcare Claims, to be held on Wednesday, November 28 from 1:00 – 2:00 PM (Mountain Time). Register at https://register.gotowebinar.com/register/4782950741761434882 for this free event. This presentation will provide an overview of ERISA Title I, as well as explain fully insured vs. self-insured health plans, claims procedures and participants’ rights.

***[Back to Top]***

## FDA Approves a Powerful New Opioid Amid Criticism

The Food and Drug Administration (FDA) approved a powerful new opioid on November 2 for use in healthcare settings, rejecting criticism from some of its own advisors that it would inevitably be diverted to illicit use and cause more overdose deaths.

At the same time, FDA Commissioner Scott Gottlieb issued an unusual statement saying he would seek more authority for the agency to consider whether there are too many similar drugs on the market. That might allow the agency to turn down future applications for new opioid approvals if the drugs are not filling an unmet need.

“We need to address the question that I believe underlies the criticism raised in advance of this approval,”

Gottlieb wrote. “To what extent should we evaluate each opioid solely on its own merits, and to what extent should we also consider … the epidemic of opioid misuse and abuse that’s gripping our nation?”

As the worst drug crisis in U.S. history has accelerated, agency critics and some public officials have clamored for that holistic approach to narcotic painkillers, instead of the FDA’s practice of ruling on each opioid application on its own.

Gottlieb has pledged that the FDA would do more to balance efforts to curb the epidemic – which killed a record 49,000 users in 2017, according to preliminary data – with the needs of people in need of strong pain relief. But Friday’s statement is the first detailed indication of how the FDA might use its drug-review process to tackle the overall problem.

Gottlieb said he would bring a plan to the FDA’s Opioid Policy Steering Committee and perhaps Congress. The guidelines would allow the agency to consider a narcotic’s benefit to public health, its risk of being diverted for inappropriate use or abuse and its unique benefits to groups of people in pain before deciding to approve an opioid.

The drug that was approved is a tiny, 30-microgram pill form of sufentanil, a powerful, 34-year-old opioid commonly used after surgery and in emergency rooms. Each pill, placed under the tongue for quick absorption, would have the same impact as five milligrams of intravenous morphine. Each pill would come in a plastic applicator that looks like a syringe.

The drug is intended for use within healthcare settings and perhaps on the battlefield. It would not be available to retail consumers.

The manufacturer, a California company called AcelRx, will market the drug under the name Dsuvia at a wholesale price of $50 to $60 per dose. A spokeswoman said the company is not providing information on expected sales.

AcelRx already has approval for 15- and 30-microgram versions of the drug in Europe. [Bernstein, *Washington Post*, 11/2]

***[Back to Top]***

## Medical Practice Opportunities

### Office Space Share

Medical office space sharing opportunity on Eagle Road across from St. Luke’s available.

Email medspaceshare1@gmail.com

---

### Physician - Nampa

Family Medicine Residency of Idaho Nampa is a new program recruiting for an experienced physician to join our faculty group. We are developing a 6-6-6 program in a Teaching Health Center and small community hospital. Our program will focus on preparing residents for rural practice and care of the underserved. We are looking for a physician interested in broad scope in-patient work with adults, OB (ability to do CS if fellowship trained) and adolescent care. Outpatient work will be in a Teaching Health Center (FQHC) that is also a level 3 PCMH. We are supported by a clinical care team of a psychologist, dietician, clinical pharmacist, care coordinators and community health workers. We believe in team based, patient focused care and community engagement. Our community is approximately 35 percent Spanish speaking and so Spanish language skills are appreciated.

The Family Medicine Residency of Idaho is the sponsoring institution and they have an over 40 year history of producing strong, rural physicians in the Boise core program and 2 rural training tracks. The position is open now with a start date as soon as possible. Employees are eligible to participate in a comprehensive benefits package. Interested parties should contact Kim Stutzman, MD, kim.stutzman@fmridaho.org

---

Large, Independent Multi-Specialty Group Looking to Grow
Nampa, Meridian, Boise and Caldwell, Idaho
Full-Time

Saltzer Medical Group (SMG) is seeking growth opportunities with other like-minded physicians interested in joining an independent, multi-specialty practice in Idaho's Treasure Valley. Current specialties include Family Practice, Internal Medicine, OB/GYN, Pediatrics, Neurology, Ophthalmology, Orthopedics, Pulmonology, Rheumatology, Sleep Medicine and Urgent Care. Opportunities exist for Primary Care and Specialty Physicians, as well as Advanced Practice Providers, to join a well-established group of 50 plus providers.

SMG is an independent physician-led, professionally managed, large multi-specialty practice with six locations in Nampa, Meridian, Boise and Caldwell, Idaho. SMG was established in 1961 by Dr. Joseph Saltzer and the friendly, patient-oriented approach that characterized his practice is still faithfully adhered to, even in these technologically advanced times.

Contact: Vicki Tyler at 208-463-3158 or vdtyler@saltzermed.com for additional information.

---

BC/BE Clinical Gastroenterologist
Nampa, Idaho
Full-Time

Saltzer Medical Group (SMG) is an independent physician-led, professionally managed, large multi-specialty practice with six locations in Nampa, Meridian, Boise, and Caldwell, Idaho. SMG was established in 1961 by Dr. Joseph Saltzer and the friendly patient-oriented approach that characterized his practice is still faithfully adhered to, even in these technologically advanced times.

SMG in seeking a BE/BC Gastroenterologist to work in our on-site Endoscopy Suite. Candidate would be assuming a mature practice and join a well-established, multi-specialty independent practice in Idaho's Treasure Valley. The practice offers a competitive salary with incentive and comprehensive benefits, along with a strong referral base within the practice.

Contact: Vicki Tyler at 208-463-3158 or vdtyler@saltzermed.com for additional information.

---

Primary Health Medical Group, Boise

Primary Health Medical Group (PHMG) is hiring full-time board certified/eligible FAMILY PHYSICIANS for OUTPATIENT FAMILY MEDICINE positions in Boise, Nampa, and Meridian, Idaho. Our clinics are based on a patient centered medical home model that gives the family doctor the support and time that encourages trusting relationships with their patients. Family physicians work 4-4.5 days per week and hospital call is 1 out of every 20 nights consisting of nurse triaged phone calls with no visits to the hospital.

URGENT CARE positions are also available for FAMILY PHYSICIANS, PHYSICIAN ASSISTANTS or NURSE PRACTITIONERS – Our ideal candidate would be board certified/eligible. Urgent care positions require the provider to work approximately 14 twelve-hour shifts per month and be comfortable with the fast paced environment of an urgent care clinic. Our clinics are based on a combination clinic that has urgent care and appointment family medicine practice at the same site. Urgent care and appointment providers work together to address the patients' episodic and chronic care problems. Must be willing to work some weekends and twelve hour shifts.

Primary Health is an independent, predominantly primary care medical group with 15 clinics (soon to be 17) and more than 300,000 patient visits per year. A leader in implementing quality programs, PHMG has been using electronic health records since 2007. Physicians follow evidence-based guidelines and engage with patients in innovative ways to promote wellness. PHMG has received local and national recognition for providing efficient, quality care. Primary Health has been voted among the top 10 Best Places to Work in Idaho, and employee turnover is low. The group provides a supportive environment where family doctors develop lasting relationships with patients and enjoy a schedule that allows time to experience the many

activities Idaho has to offer. Providers also have the opportunity to invest in the medical group and become an owner.

PHMG offers the following benefits to all full time physicians: – Medical and dental insurance with PHMG covering roughly 95% of the premium. – Group life insurance with options to voluntarily buy-up – A generous own occupation/own specialty long term disability policy – $500 worth of free services in our own clinics for the physician and his/her family (per year) – A 401(k) plan with a guaranteed match – Payment for malpractice insurance, licensing fees, professional memberships and CME. PHMG offers a strong benefits package and very competitive salaries. A detailed summary of our benefits may be found on our website www.primaryhealth.com.

---

To place a Medical Practice Opportunities Classified Advertisement, please contact:
Margy Leach, Director of Communications at 208-344-7888 or by email margy@idmed.org.

***[Back to Top]***

Idaho Medical Association
P.O. Box 2668, 305 West Jefferson, Boise, ID 83701
Phone: (208) 344-7888 - Fax: (208) 344-7903 - Email: mail@idmed.org