Council on Medical Practice

Friday, April 12, 2024
2:30 – 4:30 p.m.
Location: San Antonio room at the Renaissance Austin Hotel
Zoom connection information: Meeting ID: **891 2090 9648** | Passcode: **811096**

AGENDA

1. Call to order by Tina Philip, DO, chair (Puja Sehgal, MD, vice chair)
2. Introductions
3. Approval of report – November 9, 2023
4. Current business
    a. Update on G2211 and TAFP/AAFP advocacy
    b. Discuss the problem of insurance patient attribution
    c. Discuss practice management resources offered by organizations such as Harris County Medical Society and the Ohio Academy of Family Physicians
    d. Should we host a "hassle factor log"?
    e. Potential TAFP CME topic on HIT or EHR best practices
    f. Artificial intelligence and family medicine: What's next?
5. Other business
6. Adjourn

Jonathan Nelson and Heather Osborne are the staff liaisons for this council.

COUNCIL ON MEDICAL PRACTICE

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COUNCIL ON MEDICAL PRACTICE REPORT

Author: Jonathan Nelson
Meeting date: November 9, 2023

The following members attended the meeting in person: Tina Philip, Triwanna Fisher-Wikoff, David Vaughan, Lara Gaines, Oscar Garza, Puja Sehgal, Nicole Lopez, Marian Allen, Tasaduq Hussain Mir, Richard Young

The following members attended the meeting virtually: Gabriella Hill, Roger Fowler, Elena Zamora, Jacob Coranado, Jennifer Greenblatt, Katia Jean Baptiste, Ernst Nicanord, Jennifer Liedtke, Serena Selli

The following members attended as guests: Fredricka Barr, Vicky Bakhos Webb, Lindsay Botsford, Justin Bartos

MINUTES

1. The meeting was called to order by Tina Philip, DO, chair at 2:35 p.m.
2. The council report from April 21, 2023 was approved.
3. The council reviewed TAFP web resources including a set on administrative simplification and a set on value-based care.
4. The council discussed the activity and recent meeting of the Task Force on Administrative Burdens and Managed Care.
    a. Various AI platforms were mentioned as a way of improving administrative burdens, including Freed AI, Abridge, DAX voice recognition, and Ursamin.
    b. The council expressed interest in continuing to monitor the AI space for opportunities to disseminate information to the membership.
    c. The council discussed the idea of proposing CME about best practices for major HIT platforms, something like “Top 10 Hacks for Your EHR”
5. The council discussed the new TAFP Strategic Plan, specifically the portion relevant to the Council on Medical Practice. The consensus of the group was that the plan was well designed and should provide appropriate guidance to the Academy in coming years. The group discussed ideas related to the strategic objectives, including:
    a. Hosting CME programs on administrative simplification and IT best practices
    b. Disseminating information to members regarding how to reduce uncompensated work, by both finding ways to bill for services currently not remunerated and by implementing practices that reassign or eliminate uncompensated work

c. Creating a TAFP Hassle Factor log, similar to what TMA has hosted, with which the Academy can gather information about specific administrative burdens

d. Providing members with best practices for their administrative staff – something similar to the orientation and support resources the Harris County Medical Society maintains for its members.

6. The meeting was adjourned at 4:10 p.m.

TAFP calls on insurers to provide payment for G2211 complexity add-on code

By Jonathan Nelson

February 29, 2024

The Centers for Medicare and Medicaid Services introduced a set of new codes to the Healthcare Common Procedure Coding System in the 2024 Medicare Physician Fee Schedule that are designed to compensate physicians for care coordination and other services necessary to provide comprehensive, longitudinal care to complex patients. However, many health insurance companies have not begun paying for the codes, the most important of which is the G2211 add-on code for visit complexity.

This week, TAFP and the Texas Pediatric Association **sent letters to the chief medical officers** of the five largest health insurance companies in Texas – Blue Cross Blue Shield of Texas, Aetna, United Healthcare, Cigna, and Humana – asking them to provide payment for the codes across all lines of business.

"Primary care is comprehensive, continuous, and coordinated team-based care that is not adequately described by the revised office/outpatient E/M visit code set and includes resources not reflected in the current relative values assigned to that code set," the associations said in the letter. "Payment for G2211 more appropriately values family medicine and pediatrics and will help stabilize the primary care workforce, especially community-based primary care practices patients rely on for their care. In turn, this will help prevent practice closures and consolidation, which can negatively impact patient access, care quality, and affordability."

Along with G2211, the associations advocated payment for the G0019 and G0022 Community Health Integration Services codes, the G00223 and G0024 Principal Illness Navigation Services codes, and G0136, which pays for the administration of a standardized, evidence-based social determinants of health risk assessment tool. Medicare pays $16.05 for G2211.

"AAFP and TAFP worked for years to get CMS to implement these codes to more appropriately compensate family doctors and other primary care physicians for the crucial work they do improving the health and the lives of their patients," TAFP CEO Tom Banning said. "Now we need to make sure the payers know that these codes aren't only for traditional Medicare, but they should be paying these codes in their Medicare Advantage plans, their Medicaid plans, and their fully insured and self-funded commercial plans as well."

For more information about how and when to use G2211, check out a recent article in Family Practice Management, **"G2211: Simply Getting Paid for Complexity."**

RELATED ARTICLES

AAFP: Tell Congress to implement Medicare add-on code G2211

New CMS regulations will streamline prior authorizations in some plans

THOMAS J. WEIDA, MD, FAAFP, AND JANE A. WEIDA, MD, FAAFP

G2211: Simply Getting Paid for Complexity

A majority of family medicine visits should qualify for the visit complexity add-on code. Here's how to start using it in your practice.

ABOUT THE AUTHORS

Dr. Thomas Weida is chief medical officer, associate dean for clinical affairs, and professor at the University of Alabama College of Community Health Sciences. He is also a member of the American Medical Association's Relative Value Scale Update Committee (RUC). Dr. Jane Weida is immediate past chair of the Department of Family, Internal, and Rural Medicine and professor at the University of Alabama College of Community Health Sciences. She is also a member of the Medical Association of the State of Alabama's Board of Censors, the Alabama Department of Public Health Board of Directors, and the Alabama Board of Medical Examiners. Author disclosures: no relevant financial relationships.

Editor's note: The Centers for Medicare & Medicaid Services has not yet provided written guidance for certain aspects of code G2211, as noted in the article. We will update the online version of this article as more details become available.

Primary care is unique in that it is based on an ongoing relationship with patients. Effective Jan. 1, 2024, traditional Medicare (and some Medicare Advantage plans) will recognize the value of that relationship by reimbursing for HCPCS code G2211, which clinicians can add on to an office/outpatient visit evaluation and management (E/M) code. G2211 documents that the longitudinal relationship has complexity beyond that captured in the work of standard E/M codes. This complexity exists for chronic care and even some acute care visits. The deciding factor is the continuing relationship between the clinician and the patient.

DEFINITION OF G2211

The Centers for Medicare & Medicaid Services (CMS) defines G2211 as follows:

Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal

point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established.)[1]

There are two aspects to this definition. The first part underscores that the basis for G2211 is *not* the patient's clinical condition but the clinician's continued responsibility for the patient. The second part acknowledges that an ongoing relationship may exist for a single, serious condition or a complex condition even if the clinician is not the focal point for *all* services; CMS provides the example of a patient with HIV who receives ongoing care from an infectious disease doctor.[2]

USING G2211

G2211 may only be added to a new or established patient office/outpatient visit E/M code (99202-99205 or 99211-99215). It may be added whether medical decision making or time is used to select the level of service. G2211 may be used for either chronic care visits (with no minimum number of chronic conditions needed to qualify) or acute visits as long as a longitudinal relationship exists or will exist with the patient. Therefore, a new patient visit can qualify when the patient will be establishing with the clinician as their medical home, and an acute care visit with an established patient can qualify if the clinician's practice serves as the continuing focal point for all needed health care services.

CMS has not required any additional documentation to support code G2211. However, if there might be any doubt about the longitudinal patient relationship (or intent to provide longitudinal care), it may be helpful to demonstrate it in the visit note. Particularly for acute problems, documenting the longitudinal relationship's impact on the acute visit could be helpful. For example, the assessment and plan could read as follows: *Influenza A, X prescribed, call if not improved in X days; make an appointment to return for influenza immunization in about 2 weeks; next visit as needed for new or worsening problem, already scheduled annual wellness visit.*

G2211 may also be used in instances where a "patient's overall, ongoing care is being managed, monitored, and/or observed by a specialist for a particular disease condition."[1] G2211 is an add-on code to the E/M visit, and modifier 25 does not need to be added to the E/M code. (In fact, G2211 cannot be billed if the visit requires modifier 25; see the exclusions section on page 8.) G2211 can be billed with an office visit E/M service provided via telehealth.

> The basis for G2211 is *not* the patient's clinical condition but the clinician's continued responsibility for the patient.

EXAMPLES WHERE G2211 WOULD QUALIFY

A 65-year-old established patient on Medicare whom you have been treating for diabetes, hypertension, and hyperlipidemia presents to your office for a routine check. You order an A1C, comprehensive metabolic panel, lipid panel, and urine for microalbumin, and you adjust the patient's blood pressure medication. This would qualify for a 99214 E/M code as well as the G2211 add-on code because you have an ongoing relationship with the patient.

A 72-year-old patient on Medicare who is new to the practice visits your office to establish ongoing care and also has sinus congestion. This would qualify for an appropriate E/M code as well as the G2211 add-on code. In this example, "the complexity that code G2211 captures isn't in the clinical condition — the sinus congestion.

KEY POINTS

- CMS created the new G2211 add-on code to recognize that the longitudinal relationship with a patient has complexity beyond that captured in the work of standard E/M codes.
- Code G2211 can be added to office/outpatient E/M visits (99202-99205 or 99211-99215) based on the clinician's continued responsibility for the patient, not based on the patient's clinical condition.
- Additionally, even if the clinician is not the focal point for *all* services for the patient, an ongoing relationship may exist for a "single, serious condition or a complex condition," justifying use of G2211.

The complexity is in the cognitive load of the continued responsibility of being the focal point for all needed services for this patient."[3] The intent to establish ongoing care for this new patient suffices.

A 68-year-old established patient who sees you yearly for a Medicare annual wellness visit and periodically for acute problems presents at this visit with complaint of a cough and concern for influenza. You order a rapid test for influenza and recommend influenza vaccination after the patient recovers from this illness and each season thereafter. This would qualify for an appropriate E/M code as well as the G2211 add-on code because you serve as the continuing focal point for all of the patient's health care.

An endocrinologist has been managing a Medicare patient's uncontrolled diabetes and complications for years, and the patient returns for a recheck. This would qualify for an appropriate E/M code as well as the G2211 add-on code because the physician has an ongoing relationship with the patient that involves care of a "single, serious condition or a complex condition" (diabetes, in this instance).

G2211 DOs AND DON'Ts

Do use G2211 for:

- ✓ Office/outpatient E/M visits (99202-99205 or 99211-99215) if you are the "continuing focal point for all needed health care services" for the patient, whether the condition is acute or chronic. (If you are not the continuing focal point, use G2211 only if you provide ongoing care for a serious or complex condition.)

Don't use G2211 for:

- ✗ Non-office E/M visits,
- ✗ Urgent care center visits (i.e., one-off visits),
- ✗ Transitional care management visits,
- ✗ Medicare annual wellness visits,
- ✗ Visits requiring modifier 25 (i.e., services that when reported on the same date as an office/outpatient E/M service necessitate adding modifier 25 to the E/M code). Examples:
  - Annual wellness visit (G0438-G0439),
  - Injection of medication (96372),
  - Spirometry, inhalation treatment, or other pulmonary function services (94010-94799),
  - Osteopathic manipulative therapy (98925-98929),
  - Annual alcohol misuse screening (G0442),
  - Annual depression screening (G0444),
  - High-intensity behavioral counseling to prevent sexually transmitted infection (G0445),
  - Annual, face-to-face intensive behavioral therapy for cardiovascular disease (G0446),
  - Face-to-face behavioral counseling for obesity (G0447).

EXCLUSIONS

CMS will not pay for G2211 when the E/M service is reported with modifier 25 (significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service).[4] The intent was to exclude G2211 from instances where minor procedures are performed on the same date as an office visit, which often occurs outside of primary care and does not reflect the visit complexity and ongoing relationship otherwise envisioned by G2211. In those instances, CMS considers the additional work and complexity to be part of the procedure code. Unfortunately, the unintended effect of CMS's decision is to exclude the use of G2211 in primary care when modifier 25 is applicable, such as medication administration (e.g., 96372) or spirometry (e.g., 94010 or 94060) in addition to an E/M service. CMS may make additional clarifications on this issue in upcoming rules as they monitor the use of G2211 and have further discussions with interested parties.

Because G2211 may only be reported in addition to office/outpatient E/M visits (99202-99215), it cannot be attached to Medicare annual wellness visits or transitional care management visits. Complexity is already factored into the work and codes for these visits. G2211 also cannot be added to any non-office-visit E/M codes, such as inpatient, emergency department, nursing home, or home visit codes. G2211 would not be appropriate for most urgent care center visits, given the one-off nature of those encounters.

Additionally, CMS considers G2211 to be inappropriate when the visit "is provided by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature; such as, but not limited to, a mole removal" — unless comorbidities are present or addressed, or unless the clinician has taken (or plans to take) responsibility

for ongoing care for the patient.[5]

CMS has not clarified in writing whether G2211 can be billed by a physician covering for a colleague who is the patient's ongoing source of care or by a nonphysician provider billing for an acute visit with a patient whose ongoing physician is in the same practice. However, based on statements from CMS staff at a Jan. 24, 2024, Open Door Forum, CMS seems inclined to think of clinicians in the same specialty and same group interchangeably for purposes of reporting G2211. (We will update the online version of this article when CMS publishes more guidance.)

EXAMPLES WHERE G2211 WOULD NOT QUALIFY

A 65-year-old established patient on Medicare whom you have been treating for diabetes, hypertension, and hyperlipidemia presents to your office for a routine check. You order an A1C, comprehensive metabolic panel, lipid panel, and urine for microalbumin, and you adjust the patient's blood pressure medication. You also order injection of a medication reported with 96372. This would qualify for a 99214 but would not qualify for G2211 because adding the injection code, 96372, requires that you add modifier 25 to the E/M code.

A 67-year-old Medicare patient sees you for a subsequent Medicare annual wellness visit. G2211 cannot be added because the proper code for this visit is G0439, a HCPCS code, which is not one of the applicable E/M codes. If you had provided the annual wellness visit in addition to an office/outpatient E/M service, modifier 25 would have been required, which would also disqualify the visit for code G2211.

A 70-year-old Medicare patient sees a gastroenterologist for a screening colonoscopy exam without expectation of an ongoing relationship. G2211 cannot be added as there is no ongoing relationship established (or expected to be established).

USE IN FAMILY MEDICINE RESIDENCY PROGRAMS

Unlike many other specialty residency programs, where patients may see different residents but the same attending physician who is established with the patient and bills for the visit, family medicine patients may see the same resident but have multiple attending physicians who bill for the visits. G2211 is not included in the primary care exception, so that would suggest that in order to use this code for visits that normally qualify for the primary care exception (straightforward and low complexity medical decision making), the attending physician would also need to see the patient. CMS has offered no written guidance in this area. However, at the Jan. 24 Open Door Forum, CMS staff suggested that guidance may be forthcoming allowing G2211 to be billed with E/M services on the primary care exception list if the resident is serving as the focal point for the patient's care.

> CMS will not pay for G2211 when the E/M service is reported with modifier 25.

Until specific guidance is released, given the intent of CMS to recognize the value of the longitudinal relationship between the physician and patient, the following billing practices seem appropriate. If the patient sees the resident who usually provides their care, then it would seem appropriate to use G2211. This would apply to continuity of care issues or acute issues where ongoing care influences the decision-making. If a resident doesn't usually see the patient for care but is seeing the patient for a continuity-type visit, it would seem appropriate to use G2211, as billing would be submitted under one Tax Identification Number (TIN) for the residency practice. Additionally, this would fulfill the intent of the longitudinal relationship for the practice. It would be important for the resident to document the ongoing relationship they have with the patient or the impact the patient's total health has on the current issue. The attending physician would also need to see the patient and document appropriately. Again, this is simply what seems appropriate given the intent of the code, but we look forward to guidance from CMS. ➤

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

PAYMENT

Medicare's national payment amount for G2211 is $16.05; the actual allowance will vary geographically. This value will be subject to the patient's deductible and coinsurance. A Medicare patient often has a 20% coinsurance; therefore, if this code reimburses $16, the patient will be responsible for $3.20. Practices should be prepared to explain to patients what this additional charge is.

CMS estimates that practices will use G2211 with more than half of office/outpatient E/M services once physicians become familiar with the code. So, assuming you provide 20 visits per day, 200 days per year, and half of your visits qualify for the new code, it could bring in $32,080 per year. Some Medicare Advantage plans may pay for this code, while others may consider the work to already be included in capitation rates or other services paid to the practice. Private insurers' coverage of G2211 will also vary because it is not a CPT code, but a Medicare HCPCS code. Each individual insurer sets its own payment policy, just as each state sets its own Medicaid payment policy.

OVERALL, IT'S A WIN

Although limited by legislative actions and budget neutrality, CMS is recognizing the contribution primary care (and other longitudinal care that consists primarily of E/M services) makes to the overall management of Medicare patients. The visit complexity add-on code, G2211, will be valuable for family physicians. Given that Medicare will be paying less per visit in 2024 because the Medicare RVU conversion factor has decreased by $1.14 per RVU, adding this new code will provide a positive net payment for office/outpatient E/M visits. Practices should check the payment policies of their Medicare Advantage plans and private insurers to determine whether they will be paying for this code. FPM

1. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. 88 FR 78970. https://www.federalregister.gov/d/2023-24184/p-1379

2. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. 88 FR 78974. https://www.federalregister.gov/d/2023-24184/p-1397

3. How to use the office & outpatient evaluation and management visit complexity add-on code G2211. *MLN Matters*, 13473. Jan. 18, 2024.

4. Current Procedural Terminology 2024 Professional Edition. American Medical Association. Appendix A:971.

5. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. 88 FR 78971. https://www.federalregister.gov/d/2023-24184/p-1385

G2211 Payer Matrix

Note: The table below should not be used to confirm coverage and payment for an individual. Final payment determination is always subject to a patient's individual plan benefits, code edits, and billing requirements, and the individual's plan document should be referenced. Moreover, in some cases, there may be differences in coverage and/or payment between hospitals and professional physicians and other health care professionals at the code level; the table below summarizes coverage for professional services only.

Aetna			
Line of Business	**Paying (Y/N)**	**Policy Links**	**Notes**
Medicare Advantage	Y	Not available	*See below
Commercial	N	Not available	No information at this time
Medicaid	Unknown	Not available	*See below

Anthem			
Line of Business	**Paying (Y/N)**	**Policy Links**	**Notes**
Medicare Advantage	Y	Not available	No information at this time
Commercial	Unknown	Not available	No information at this time
Medicaid	Unknown	Not available	No information at this time

Cigna			
Line of Business	**Paying (Y/N)**	**Policy Links**	**Notes**
Medicare Advantage	Y	Not available	*See below
Commercial	N	Not available	
Medicaid	Unknown		

Humana			
Line of Business	**Paying (Y/N)**	**Policy Links**	**Notes**
Medicaid Advantage	Y	Not available	Following Medicare's modifier –25 policy *See below for additional comments.
Commercial	Y	Not available	
Medicaid	Unknown	Not available	

UnitedHealthcare			
Line of Business	**Paying (Y/N)**	**Policy Links**	**Notes**
Medicare Advantage	Y	Add-on Codes Professional (MA)	Does not include 99211 as eligible for add-on
Commercial	Y	Add-on Codes Professional (Commercial)	Does not include 99211 as eligible for add-on
Individual Exchange	Y	Add-on Codes Professional (Exchange)	Does not include 99211 as eligible for add-on
Community (MCO)	Y	Add-on Codes Professional (Community Plans)	Does not include 99211 as eligible for add-on

Additional Payer Notes

Aetna	• **Medicare Advantage:** Aetna is following Medicare's payment policies as it relates to the covered services for Medicare Advantage. • Aetna indicated that physicians in value-based payment contracts may bill G2211 in Medicare Advantage. • **Medicaid:** Aetna indicated each state Medicaid program will advise on coverage of the HCPCS codes. Aetna is working closely with each of its state government partners to integrate these codes into Aetna's reimbursement systems.
Anthem	• Anthem indicated that it is paying G2211 for Medicare Advantage plans.
Cigna	• Unsure if Cigna has updated their system to pay G2211 in Medicare Advantage. • Seeking clarification whether G2211 is payable for Medicare Advantage if a physician or practice is in a value- based contract (partial or full-risk).

Humana	• G2211 was incorrectly being denied due to Humana's system not being updated. Humana communicated with the AAFP on Feb. 19 that the issue had been identified, corrected, and incorrectly processed claims would be scheduled to be reprocessed. The AAFP was not made aware of the date the claims would be reprocessed. • Humana indicated they would pay G2211 for physicians in non-value-based payment and value-based payment arrangements. • The AAFP has asked for links to their policies that address G2211 but has not received them.
UnitedHealthcare	• UHC's payment policies support coverage for G2211, but the AAFP has been unable to verify it. • The AAFP is seeking clarification when UHC updated their system to pay G2211 across all business lines.

CME

Troy Fiesinger, MD, FAAFP

PATIENT ATTRIBUTION:
Why It Matters More Than Ever

How payers assign patients to you will affect how your practice is evaluated and paid for value in the future.

When Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, physicians hailed the demise of the sustainable growth rate formula, which had for many years threatened annual cuts in Medicare reimbursement. Now that MACRA regulations have been finalized, we are learning the extent to which Medicare payment will be transformed.[1] Our payments will now be directly connected to the quality and cost of the care we provide. Those of us who provide higher quality, lower cost care will be paid more, and those who do not will be paid less. To accomplish its stated goal of tying 90 percent of all Medicare payments to quality or value by 2018, the Centers for Medicare & Medicaid Services (CMS) must know exactly which Medicare patients are yours – and which are not.[2] ➤

About the Author

Dr. Fiesinger practices at Village Family Practice in Houston. He is the lead physician for population health and chairs the quality committee for a Next Generation Accountable Care Organization. Dr. Fiesinger currently represents the American Academy of Family Physicians on the National Quality Forum's Attribution Committee. Author disclosure: no relevant financial affiliations disclosed.

Understanding how attribution works is an important first step to succeeding in the new payment environment.

The Medicare Access and CHIP Reauthorization Act (MACRA) will tie physician payment more closely to high-quality care.

Attribution is the process Medicare and other payers use to assign patients to specific physicians.

Knowing which patients are attributed to you helps ensure your care is evaluated fairly.

The process that commercial and government payers use to assign patients to the physicians who are held accountable for their care is called *attribution.* Think of the patient lists that insurers send in the mail. If you review them at all, some names you recognize, some leave you scratching your head, and some are missing. Yet those lists will increasingly affect how much you are paid, regardless of whether the patients named on them are seen in your office. Understanding how attribution works is an important first step to succeeding in the new payment environment. Knowing which patients are attributed to you by each payer and how value-based payment programs affect different segments of your patient population will help you target your health care team's resources most effectively.

Which patients are yours?

When we think about whose patients are whose, many perspectives come into play. For example, I may see Mrs. Smith every fall and spring for her allergies, but she may see another physician every summer for her annual physical. Mrs. Smith may consider both of us "her doctor," but her insurance company may not see it that way. The insurer may attribute her to the physician who performed her most recent annual wellness visit or to the one who saw her most recently. Attribution approaches vary, but they share common elements:

Timing. Attribution can be *prospective*, meaning the payer tells you at the beginning of the measurement year what patients you will be responsible for over the next 12 to 24 months. It can also be *retrospective*, meaning you find out at the end of the year which patients are in your panel and payers measure your care by looking back at the previous 12 to 24 months. According to the National Quality Forum, two-thirds of implemented attribution models use retrospective timing.[3]

Type of attribution rule. Some payers attribute patients to the physician who provided the *majority* of the patient's care. If no physician provided more than 50 percent of the patient's care, they may attribute the patient to the physician who provided the most, or the *plurality,* of the patient's care. Other payers assign patients to the physician who provided the plurality of the patient's *primary care.* Since most payers rely on claims data to attribute patients, two fundamental questions must be answered:

- **How do payers define patient care?** Some use inpatient and outpatient evaluation and management (E/M) codes. Others use only outpatient E/M codes.
- **How do payers determine who provided patient care?** Some, such as Medicare, use allowed charges. Others use relative value units (RVUs) or even the number of patient visits.

Exclusivity. The majority of payers attribute each patient to only one doctor.[3] But some attribute patients to multiple doctors, meaning the same patient might be attributed to you, the family physician down the street who saw the patient once, and the patient's cardiologist.

Level of attribution. Some payers attribute patients to individual physicians, and others attribute patients to a group practice or even an accountable care organization (ACO), if the

ATTRIBUTION METHODS UNDER MACRA

The Medicare Access and CHIP Reauthorization Act describes the patient attribution method for the Merit-Based Incentive Payment System (MIPS). Advanced Alternative Payment Models (APMs) may decide their own methods. For comparison, this chart lists attribution methods for MIPS and two types of Medicare accountable care organizations (ACOs).

Category	Merit-Based Incentive Payment System (MIPS)	Medicare Shared Savings Program ACO	Next Generation ACO
Timing	Retrospective	• Retrospective (Tracks 1 and 2) • Prospective (Track 3)	Prospective
Measurement period	One year	Two years	Two years
Type of attribution rule	Plurality	Plurality	Plurality
Data used	Medicare Part B allowed charges for outpatient E/M codes (no inpatient or emergency department codes), Medicare wellness visits, transitional care management, and chronic care management codes.	Medicare Part B allowed charges for office visits, rest home visits, home visits, and Medicare wellness visits provided by primary care physicians and non-physician professionals (physician assistants, advanced practice nurses, and clinical nurse specialists).	Medicare Part B allowed charges for office visits, rest home visits, home visits, and Medicare wellness visits provided by primary care physicians and non-physician professionals (physician assistants, advanced practice nurses, and clinical nurse specialists). Patients can voluntarily align with ACO.
Exclusivity	Single physician	Single ACO	Single ACO
Level	Individual physician, but physicians can report and receive bonuses or penalties as a group or virtual group.	ACO	ACO
Basis	• National Provider Identifier (NPI) for individual physicians. • Taxpayer Identification Number (TIN) for group practices.	Unique APM participant identifier and combination of physician's NPI and TIN. ACO treated as collection of TINs.	Unique APM participant identifier and combination of physician's NPI and TIN. ACO treated as collection of TINs.
Tie breaker	Physician who provided most recent primary care service.	• ACO-affiliated physician who provided most recent primary care service. • ACO-affiliated primary care physician used in original patient assignment who provided most recent primary care service. • Patient assigned to ACO if he or she received at least one primary care service from ACO-affiliated specialist physician and a plurality of primary care from ACO-affiliated specialist physicians.	Primary care physician who provided most recent primary care service.
Patient exclusions	Not eligible for or not participating in Medicare Part B (for example, participating in a Medicare Advantage plan).	• Same as MIPS • Did not receive at least one primary care service from ACO-affiliated primary care provider during previous two years. • Did not receive plurality of primary care services from ACO-affiliated primary care physician during previous two years. • Attributed to different ACO during previous year.	• Same as Medicare Shared Savings Program ACO. • Has had Medicare as a secondary payer. • Lives outside of ACO's service area.

physician or group belongs to one. Whether patients should be assigned to individual clinicians or to groups or health systems is controversial. For physicians, it may feel unfair for payers to assign a patient's quality and cost measures to them when they do not control all of the factors that influence those measures.

The fact that payers use different methods of attribution further complicates practices' efforts to identify and take care of their patient populations in the ways payers expect. For example, Aetna uses either a majority or a plurality of total charges. Blue Cross Blue Shield applies a more complex hierarchy that looks initially at which physician billed the plurality of RVUs, then who billed the plurality of the outpatient E/M codes, and finally who billed the plurality of total charges. United Healthcare, on the other hand, just looks at which primary care doctor billed the majority of the charges. Attribution is simplest in health maintenance organizations (HMOs) and Medicare Advantage (MA) plans, because patients typically must choose a physician from a list of approved providers when they enroll in the insurance plan, and future changes must be patient-initiated.[3]

Payers may attribute patients prospectively or retrospectively for a defined period of time.

Patients may be attributed to an individual physician, a group, or an accountable care organization.

MACRA defines two payment pathways, and each has its own attribution method.

The changing landscape of Medicare attribution

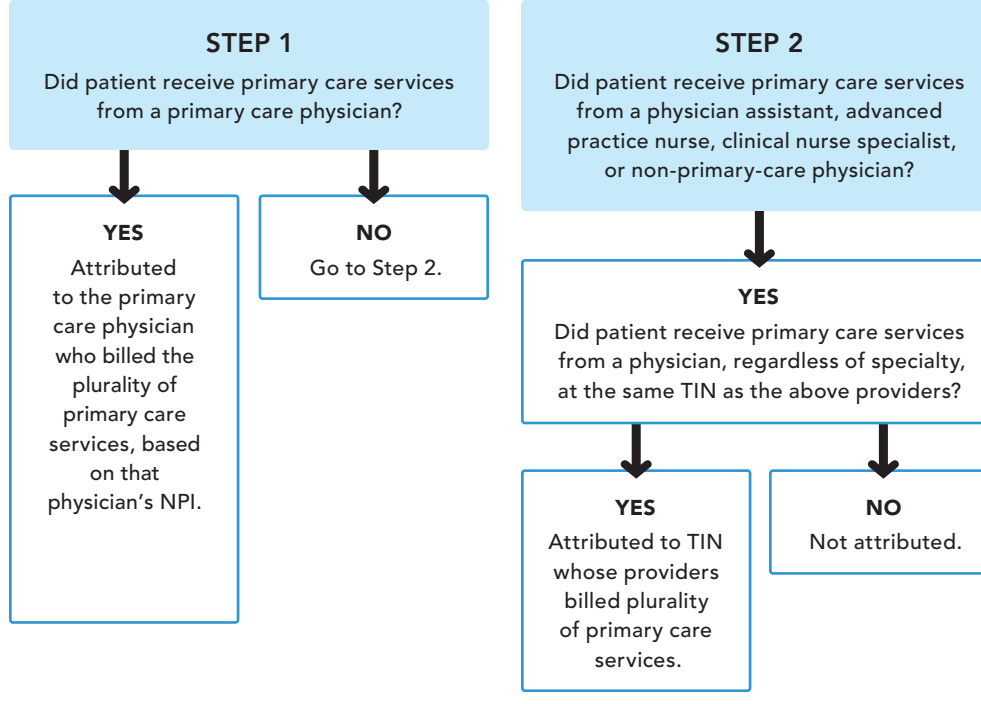
The burning question is how will attribution work under MACRA?

The MACRA final rule stipulates specific attribution methods for each of the two payment pathways defined in the regulations.[1] (See "Attribution methods under MACRA," page 27.) All physicians enrolled in Medicare must choose between these two payment pathways – the Merit-Based Incentive Payment System (MIPS) or the Advanced Alternative Payment Model (Advanced APM). Physicians seeing a small volume of Medicare patients are excluded. (See "Medicare Payment Reform: Making Sense of MACRA," *FPM*, March/April 2016, http://www.aafp.org/fpm/2016/0300/p12.html.)

The MIPS program will follow the attribution method currently used by Medicare's

MEDICARE'S TWO-STEP ATTRIBUTION METHOD

Medicare beneficiaries who do not receive any primary care services are not attributed. If they do receive primary care services from a physician, Medicare uses the following process to determine to whom the patient is attributed.



PATIENT ATTRIBUTION SCENARIOS

The following patient cases illustrate how attribution methods work now and under the Medicare Access and CHIP Reauthorization Act (MACRA):

Patient	History	Attribution (current Medicare)	Attribution (MACRA)
"TC"	Saw a local physician last year for a Medicare annual wellness visit, two chronic disease visits, and one acute visit. She has also seen her gynecologist for well-woman exams in the past two years. She saw her primary care physician twice this year for a chronic disease visit and an acute visit. After the physician disclosed his plans to retire, she established care with a new family physician. She has since come in for a cold and scheduled her annual wellness visit.	TC remains attributed to her prior primary care physician because he has billed the plurality of Medicare Part B allowed charges in the previous calendar year and billed the plurality of charges so far this year.	TC would remain attributed to her prior primary care physician under the Merit-Based Incentive Payment System (MIPS) because he has provided the plurality of Medicare Part B allowed charges. Once the claim for her most recent acute visit clears, however, the new practice gains plurality and attribution.
"KG"	Sees her family physician only when she is sick but periodically calls for health advice. She normally sees her gynecologist once a year for a well-woman exam but did not have a physical the last two years because of her schedule. Her most recent contact with any type of clinician was an urgent care visit for a urinary tract infection.	KG is not attributed to anyone because she has not received any primary care services besides one visit to an urgent care clinic, which does not count toward attribution.	KG still would not be attributed to anyone. However, she would be attributed to a physician she saw for a single acute visit.
"BW"	Has seen her family physician for seven years as part of a Medicare Advantage plan. During the previous calendar year, she visited her physician five times, including two acute visits, two chronic care visits, and an annual wellness visit. This year she has been seen four times, including one acute visit, two chronic care visits, and an annual wellness visit.	BW is attributed to her physician because she chose him as her primary care physician when she first selected a Medicare Advantage plan and selected the same plan for the current calendar year.	BW still would be attributed to her physician, but her care would be excluded from MIPS because she is enrolled in a Medicare Advantage plan.
"RJ"	Has for several years received care from a family medicine clinic whose physicians participate in a Medicare Shared Savings ACO. This year, he switched to a new clinic whose physicians participate in a Next Generation ACO. So far this calendar year, he has seen his new physician once for a chronic disease visit. Last year, RJ saw his previous primary care physician four times. He has not had an annual wellness visit this year or last, and was admitted to a hospital earlier this year for a stroke and discharged to a skilled nursing facility.	RJ remains attributed to his former practice because attribution to an existing Medicare ACO excludes him from attribution to a new Medicare ACO.	RJ would remain attributed to his former practice but under the Next Generation ACO rules could voluntarily assign his care to the new practice.
"CN"	Has been going to the county health clinic for primary care because of a lack of insurance. He turned 65 this year, enrolled in Medicare, and scheduled an appointment with his wife's primary care physician.	CN is not attributed to anyone because he is a new Medicare beneficiary this calendar year.	CN would be attributed to his new physician once he completes his initial visit and Medicare receives a claim with the physician's Taxpayer ID Number.

Value-Based Payment Modifier Program with a slight modification. It is retrospective, looking back one to two years for a plurality of allowed charges for outpatient services only. Under MIPS each Medicare beneficiary will be attributed to a single physician based on the National Provider Identifier (NPI). The patients of physicians of physicians who are members of group practices will be attributed first to the individual physician using the NPI and then to the group practice based on its taxpayer ID number (TIN). The Value-based Payment Modifier Program used only the TIN, but the authors of the MACRA final rule incorporated the NPI to more accurately attribute patients within group practices, especially those with multiple locations and large numbers of physicians and other clinicians. Medicare uses a two-step algorithm to determine attribution. (See "Medicare's two-step attribution method," page 28.) MIPS will also use common definitions for outpatient primary care (E/M codes are specified) and primary care providers (physicians, physician assistants, advanced practice nurses, clinical nurse specialists, and certified registered anesthetists).

MACRA's Merit-Based Incentive Payment System follows attribution rules of the Medicare Value-Based Payment Modifier Program.

If you are participating in an Advanced APM such as a Medicare ACO or a patient-centered medical home, your Medicare patients will be attributed to you based on the attribution method used by the APM. The attribution methods used by Medicare ACO programs share common elements with those used by MIPS. Medicare tends to use the same models repeatedly, which gives both it and physicians the benefit of consistency and means you are likely to see these methods used in other programs in the future. (For examples of patient attribution under current rules and MACRA, see "Patient attribution scenarios," page 29.)

Alternative Payment Models will set their own attribution rules.

What if you think CMS is wrong?

Attribution is based on claims data, which can take months to be fully adjudicated. Even under the best circumstances, CMS can make mistakes, attributing to you patients you have rarely or never seen, and attributing to others patients to whom you have provided extensive services. Under MACRA, erroneous determinations about the quality and cost of your care will affect your Medicare payment rate.

If you think CMS has made attribution or other errors, you may appeal by requesting a "targeted review." However, these reviews are allowed only under certain circumstances. Specifically, you have to believe that 1) the measures or activities submitted to CMS and used to determine your bonus under MIPS have "calculation errors" or "data quality issues;" 2) performance category scores were incorrectly assigned to you; or 3) you should have been excluded from part or all of MIPS because you treat too few Medicare patients to participate. The final rule released in October does not specifically state that you can appeal incorrect patient attribution, but it also does not specifically exclude attribution of patients as grounds for an appeal.

Physicians who disagree with patient attribution under MACRA can ask Medicare for a "targeted review" for clarification.

The best way to deal with attribution problems is to identify and avoid them in the first place by asking your payers these key questions:

- Do they measure prospectively or retrospectively? How far back?
- How much patient care do you have to provide to meet the threshold of attribution?
- What data do they use to measure care?
- Do they attribute patients exclusively to a single physician or multiple ones?
- Do they identify providers by TIN or NPI?
- Do they attribute to an individual provider, the provider's group, or the group's ACO?

Ultimately, attribution is a confusing and wonky policy that exists in the background of your dealings with Medicare and other payers – that is, until a payer reduces your payment rate after evaluating your attributed panel and finding areas where your care is lacking. Taking time to understand attribution can help you understand the patient population you are accountable for and maximize reimbursement for the care you provide. FPM

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2. Better, smarter, healthier: in historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value. Health and Human Services website. http://bit.ly/1QhLv5b. Published Jan. 26, 2015. Accessed Oct. 20, 2016.

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Send comments to **fpmedit@aafp.org**, or add your comments to the article at **http://www.aafp.org/fpm/2016/1100/p25.html**.

Potential Learning Objectives for Administrative Burden CME

Identify (or define) key topics (issues) in administrative burden

Administrative burden specifically refers to documentation and administrative reporting duties imposed on clinicians due to organizational policies as well as governmental and oversight reporting requirements.

Upon completion of this CME activity, you should be able to:

- Identify key topics in administrative burden through current research
- Evaluate potential AI solutions and other software models to optimize time and reduce burdens
- Improve administrative processes, resulting in greater efficiency and enhanced patient care for primary care physicians and their staff

EXAMPLE - This is a course offered by AAFP:

https://www.aafp.org/cme/all/practice-management/solutions-to-administrative-burden-inbox.html

- Apply findings from current research on reducing EHR inbox burden.
- Recognize the potential of AI solutions, payment models, and process optimization in reducing administrative burdens for family physicians.
- Evaluate and select suitable tools for their specific practice needs.
- Optimize administrative processes, resulting in improved efficiency and enhanced patient care.

Additional Back-up Materials on Administrative Burden

1. From the National Library of Medicine:

More Evidence That the Healthcare Administrative Burden Is Real, Widespread and Has Serious Consequences Comment on "Perceived Burden Due to Registrations for Quality Monitoring and Improvement in Hospitals: A Mixed Methods Study"

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9309957/

2. AMA article on Reducing Administrative Burden

https://www.ama-assn.org/practice-management/reducing-administrative-burden

3. AMA offers a boot camp on saving time in your practice

This two-day boot camp Sept. 23-24, 2024, is designed for clinical and operational change agents looking to eliminate unnecessary work and free up more time to focus on what matters most–patient care.

https://www.ama-assn.org/about/events/saving-time-practice-innovation-boot-camp

4. Article from The Office of the National Coordinator for Health Information Technology - Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

https://www.healthit.gov/sites/default/files/page/2020-02/BurdenReport_0.pdf

5. America College of Physicians offers this toolkit:
   Toolkit: Addressing the Administrative Burden of Prior Authorization

https://www.acponline.org/advocacy/state-health-policy/toolkit-addressing-the-administrative-burden-of-prior-authorization

6. AAFP Video: 10 ways to reduce your administrative and documentation burden

https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/reduce-administrative-burden.html

VIDEO to share regarding reducing and eliminating prior authorizations

This includes hacks

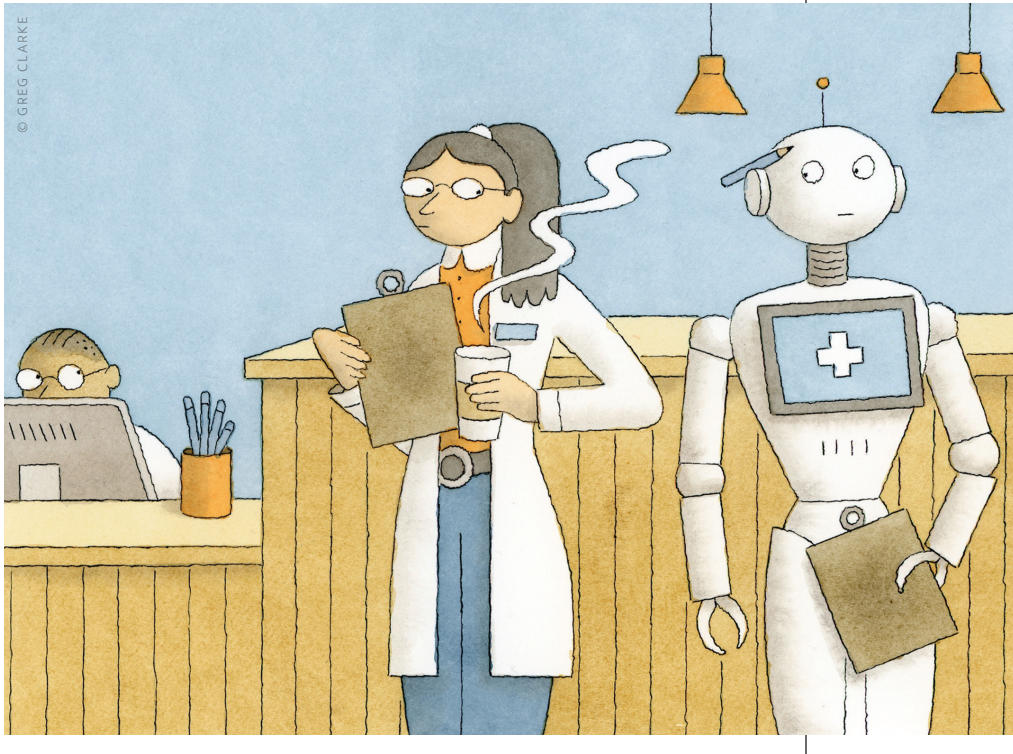
STEVEN E. WALDREN, MD, MS

CME

The Promise and Pitfalls of AI in Primary Care

Programs like ChatGPT have the potential to greatly diminish your administrative burden. But how do you get started — and can you trust them?

Near the end of 2022, a group called OpenAI launched ChatGPT, a large language model (LLM) artificial intelligence (AI) chatbot. It may have seemed like a novelty at first (e.g., "Write a poem about Medicare in the style of *Hamilton*"), but it soon became apparent that ChatGPT and AI models like it could have huge implications for education, business, and even medicine.



By January 2023, ChatGPT had become the fastest-growing consumer software application in history, reaching 100 million users in just two months (TikTok held the previous record at nine months).[1] Before the end of the year, other companies launched similar products, such as Google's Bard and Microsoft's Bing Chat (now Copilot).

AI is here to stay and will likely become more embedded in our daily lives in the coming years. If used properly, it could be a

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tremendous boon to primary care physicians, potentially ridding us of administrative tasks that are a leading source of burnout.[2] But, as with any new technology, there are downsides. This article seeks to illuminate some of the ways AI can help primary care practices now and in the near future — and some of the ways AI could be downright dangerous.

> AI models are always learning, but it's not advisable to use the current models to guide clinical decision-making.

WHAT IS AI?

At its most basic, AI is when computers try to mimic how the human brain works, learning from the information (data) they take in and becoming progressively more capable.

AI has existed in various forms for decades, but what's different about ChatGPT and other LLMs is the sheer amount of data they are able to process and their ability to be "generative." Generative AI can take a prompt from a user (an input as text, image, etc.) and can output almost instantly a novel response based on what it has learned from a massive corpus of existing data. Using Google or another traditional search engine is like looking through books in a library yourself and copying down what one author wrote. But using a generative AI program is like having an assistant who can look through all the books in the library and synthesize all of that information into a brand new answer.

LLMs are generative AI models trained on enormous volumes of text. The training process allows the model to learn statistical relationships between words and phrases. It then uses these relationships to predict the most likely next word given the user's prompt (and the prior words it just generated). In its most simplistic sense, it is a fancy autocomplete model like you see in smartphone texting applications, where the phone predicts what you may want to type next based on phrases you've used in the past.

One of the reasons AI researchers are so interested in LLMs is the potential for "emergence," which is when an AI model can accomplish tasks that it was not explicitly trained to perform. There is some debate among academics about whether the current models have achieved true emergence, but there is no denying that LLMs can generate responses far beyond what people assumed they could accomplish.

What does that mean for health care? It's not entirely clear yet, but the technology is moving fast. Early LLMs could barely pass the U.S. Medical Licensing Examination, but more recent models, such as Google's medically focused Med-PaLM 2, have achieved relatively high scores.[3,4] Some of the leading EHR companies are also testing ways to integrate generative AI within their programs.[5]

USER BEWARE

Before we get to how the new generative AI models can help, we should understand how they could harm. First, it is important to remember that these models were trained to generate the best next word (probabilistically speaking) — not to understand logic, the scientific method, or medical questions. Second, their learning is only as good as the data used to train the model (a common maxim in computer science is "garbage in, garbage out," which means that any shortcomings in the data used to create a program will manifest themselves in the program's execution). This leads to two of the biggest problems with current generative AI products: bias and hallucinations.

Any significant biases in the data can be learned by the model. Then the model's

KEY POINTS

- New artificial intelligence (AI) systems such as ChatGPT can reduce administrative burden, but their current shortcomings make it inadvisable to use them to aid clinical decision making.
- Tasks AI can help with now include drafting prior authorization requests, rewriting medicolegal forms in more patient-friendly language, and explaining normal test results.
- Proprietary or HIPAA-protected information should only be submitted to closed, private AI systems, not open systems such as ChatGPT.

responses will be informed by these same biases, which is why you may have read reports of chatbots producing conversations that are racist, sexist, homophobic, or otherwise awful.[6] Bias in medicine is well-documented, even in clinical guidelines.[7] Therefore it would not be surprising for generative AI models trained on existing scientific literature to perpetuate these biases. AI developers are designing and implementing tactics to confront this challenge, but AI users should be conscious of the potential for bias in the responses.

The second shortcoming is when LLMs make up something that is not true. AI literature calls this a "hallucination," which conveys the concept that the AI does not seem to "know" it is being untruthful (i.e., lying). If confronted by the user (with a subsequent prompt), the model is likely to continue to respond as if the hallucination were true, or respond like a toddler and deny it did anything wrong. This type of behavior makes sense. The model was trained to predict the next best word and learned from the vast amount of human text, not all of which adds up. But hallucinations are a very serious obstacle for being able to use LLMs in medicine. For example, in one high-profile instance, ChatGPT created an entire fake data set to support a hypothesis about ophthalmologic care.[8]

Generative AI models are always learning, and each iteration is generally more capable than the last, but it's not advisable to use the current models to guide clinical decision making. You must be able to carefully double-check the AI's answers, and after doing that you've likely wasted more time than you saved. Plus, surveys show most patients are uncomfortable with the idea of doctors using AI to inform treatment decisions.[9] Fortunately, surveys also show most doctors are similarly wary of it.[10]

COMMON USES IN PRIMARY CARE

Now that we've provided the necessary caveats about AI in medicine, it's time to get to the fun part: how generative AI can help family physicians with some of the tasks they most despise. (If you want to experiment with generative AI as you read this article, you can create a free account at https://chat.openai.com or https://bard.google.com, but make sure to follow the safeguards described in the box below.)

With a quick browse through the web, we can find news stories, journal articles, blog posts, and forums that discuss the possible uses of LLMs in health care.[11-15] These range from performing administrative tasks to generating communications for patients to translating medical jargon. Here are some of the use cases.

- **Rewriting medical or legal forms** in patient-friendly language. For example, you might ask the AI program to "Rewrite this informed consent form for those who read at an eighth-grade level: [insert text]" or "Create a new informed consent form for those with low health literacy."
- **Summarizing information** such as a

THREE SAFEGUARDS FOR USING AI IN MEDICAL PRACTICE

1. Use artificial intelligence (AI) large language models (LLMs) when the physician or other user is able to easily verify the accuracy of the AI output. For example, it is easy for a physician to look at an AI-generated office visit note and quickly verify whether it is accurate and complete. But when using LLMs to generate initial drafts of messages to patients about lab results or post-diagnosis/post-procedure instructions, first ask, "Can I independently verify the accuracy of the AI response?" and "Does verifying it take less effort and time than generating the output myself?"

2. Do not enter any protected health information or private organizational information into open online LLMs, such as ChatGPT and Google's Bard. For those cases, instead use an LLM embedded in a company focused on health care solutions, such as an EHR vendor, that will operate under a HIPAA business associate agreement. Do your due diligence on the company by asking them questions about the safety of their solution, including their processes to ensure accuracy. You should also plan to verify the output because you are still liable for the safety of your patients. It is essential to protect patient privacy and organizational security. The information entered into an AI model is not safeguarded from public view unless specifically noted, as in a proprietary model.

3. Use the LLM only in low-risk situations. Clinical uses are not recommended in primary care at this point. But independent physicians or physicians in leadership positions could consider leveraging LLMs for administrative functions, for example, creating employee policy documents or generating newsletters for teams. Verification of the information is still needed in these cases. Consider the LLM response a first draft that you must edit, which is still usually much faster than creating a document from scratch.

patient's medical record, a report, insurer policies and regulations, and journal articles. An example would be asking an AI embedded in your EHR to "Give me all the information on [patient X] pertaining to diabetes" or asking ChatGPT to "Summarize this journal article: [insert text]."

• **Generating initial drafts of patient communications** such as responding to portal questions, explaining test results, providing general education on chronic disease care, or explaining new diagnoses. Researchers have found that ChatGPT often responds to patient questions with more empathy than physicians (the machines don't have the same time constraints as us).[16] Still, when it comes to test results, you might want to explain abnormal results yourself and reserve AI for explaining normal results ("Explain normal results for an electrocardiogram").

• **Searching for information within a trusted source** such as the medical record ("Has the patient had a colonoscopy in the last 10 years?") or an evidence-based guideline ("Using the following guideline, what is best course of treatment for a patient with [condition]? The guideline is [text of the guideline]"). While this might seem like using AI to aid clinical decision making, it's actually using AI to search and curate the trusted guideline that is aiding your decision making.

AI models can produce "hallucinations." The consequences may not be as dire for administrative tasks versus clinical ones, but it's something to be alert to.

• **Populating clinical registries**. AI programs within EHRs can increasingly take on this data entry task, using medical records to find and place the appropriate patients on the registry ("Find all patients who have billed for services involving [insert ICD-10 codes] in the past two years and put them in a spreadsheet").

• **Generating initial drafts of referral letters, prior authorization requests, insurance appeals, etc.** For example, "Write a letter to [insurance company] requesting authorization for a patient to get an MRI of the left knee." To strengthen your prior authorization request, ask the AI program to reference scientific literature that supports it (but remember to double-check for AI hallucinations), or paste in the insurance company's template or copies of similar requests that were successful in the past and tell the program to use them as models.

• **Generating documentation from an audio recording of an office visit**. There are already AI products on the market that act as virtual scribes, recording the appointment, transcribing it in its entirety, creating a summary, and placing it in the patient's record.[17]

Even the uses described above require safeguards (see page 29), such as considering the AI-generated text to be a draft that you must review for accuracy. I would not recommend just firing up ChatGPT, for instance, and using it immediately in practice. Although its makers have added options to keep your chat history private, conversations with ChatGPT are still recorded temporarily and the program has suffered privacy breaches in the past.[18] So, while it might be fine for rewriting generic informed consent forms, any information that is proprietary to your organization or HIPAA-protected should go through an AI platform covered under a HIPAA business associate agreement. And, as noted, current AI models can produce "hallucinations." The consequences may not be as dire for administrative tasks versus clinical ones, but it's still something to be alert to.

LOOKING FORWARD

In my mind, there is no question LLMs will have a prominent position in medicine over the next several years. We are already at a place where there is too much information for humans to manage in health care. Having AI that can summarize and review every piece of information and never forget a single data point can significantly improve health outcomes and decrease the cognitive burden on physicians. Having AI that can handle administrative tasks will free physicians from the EHR and paperwork and allow them to focus on the patient and care delivery. At least one

university is already offering a combined doctor of medicine/master of science in artificial intelligence degree to help prepare physicians for this future.[19]

Yet, I also think AI presents significant peril. As long as the financial incentives of medicine are misaligned, there are market pressures to leverage innovations such as LLMs to do things that are not in the best interest of patients and primary care (such as insurers allegedly denying claims based on AI algorithms).[20] Because of AI's promise and peril, I believe primary care physicians must become educated about it and its application in medicine. Family physicians should weigh in on the design, development, and deployment of AI in medicine to ensure it is more helpful than harmful to patients, primary care physicians, and practices. FPM

Family physicians should weigh in on the design, development, and deployment of AI in medicine to ensure it is more helpful than harmful.

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