FAST Practice

Medical Practice Information at the Speed of Sound

Volume 7, Issue 7

Executive Editor: Timothy W. Boden, CMPE

Periodicals Reviewed for this Issue

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- *Group Practice Journal*
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- HealthLeaders Media
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- Physicians Practice Pearls
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SECTION 1
PRACTICE OPERATIONS

1. Three Neglected Steps Toward Optimized Revenue Cycles

Jim Akimchuk, *Group Practice Journal*, May 2013

ABSTRACT

In practice management circles, everyone's talking about revenue cycle management these days. Changes in the past two decades—not to mention the changes we can hardly anticipate in the near future—have created a huge challenge for physicians pursuing every dollar owed them.

However, several underlying principles haven't changed—they've just become more critical. For example, *faster* collections have always equaled *better* collections. Older debts are simply harder to collect. And, of course, patient-owed balances tend to be the hardest part of your accounts receivable to collect. Collecting the patient balance earlier in the revenue cycle can have a huge, positive effect on your collection ratio. You can get software now that does a pretty good job of looking at allowables and reimbursement amounts per payer contract, and estimate up front what the patient will owe for procedures you perform. You can arrange for payment *before* you perform the procedure.

For quite a while, practices have been using "claim-scrubbing" software—either integrated in their systems or from a third-party vendor—to boost performance by catching inappropriate codes and missing data *before* claims go to the insurance companies. But many practices don't take the "next step" to optimize their claim scrubbers.

You still see denials after the scrubber has pronounced the outgoing claims as "clean." Analyze all your denials, and look for patterns in the rejections. Good scrubber software will allow you to add edits that will improve its accuracy for predicting denials, allowing your billing department to fix those claims before submission.

Sometimes medical practices don't consider their "supply chains" as a part of the revenue cycle. (That's more of a "big business" concept.) But optimizing your supply chain, says author Jim Akimchuk, will improve your bottom-line profitability. He advises practices to rein in supply purchases. Don't continue to use multiple channels for procuring supplies (like multiple office supply stores, a physician's credit card, and your local Sam's Club). Multiple sources can be good, but when you allow the process to become fragmented, you lose control. Other tools

for improving your supply chain can include institutional or association purchasing organizations or competitive bidding among suppliers for more-or-less exclusive contracts.

EXPERT COMMENTARY

Most of the time, we find that practices with weak collections aren't paying attention to the fundamentals. But here are a couple ideas that might enhance the cash flow for practices already doing a good job with the basics.

Leveraging available technology can sometimes yield positive results that amount to a good return on your investment. Software that helps sort out the complex and diverse payment systems from multiple payers and provides reliable estimates for patient balances would easily improve your patient collections. Remember: Sick patients are more willing to pay than well patients. That may sound heartless, but it's still true. After a patient has recovered, his or her motivation to pay tends to wane.

Tweaking claim-scrubbing software can add real value to its functionality as well. Not only can you use the software to improve your billing in the first place, you can get a better handle on how your various payers treat the claims you submit. You can submit a claim that is generally "by the book" on a national average, but that doesn't guarantee that XYZ Insurance Company will accept it. Improve your game by analyzing and giving payers what they want—within reason, of course.

2. Reduce Medical Practice Embezzlement Risk by Implementing Cash Controls

Karen Zupko and Cheryl Toth, Physicians Practice Pearls, September 18, 2013 (e-newsletter; to subscribe, visit www.physicianspractice.com)

ABSTRACT

Front-desk embezzlement has plagued physician practices for years, and it's often the result of lax protocols and loose oversight. Veteran practice advisors Karen Zupko and Cheryl Toth offer seven proven policies and procedures to tighten cash controls and reduce your risk:

1. **Confirm *all* encounter tickets each day have been posted and "closed."** Nearly every practice management system has audit controls like a "missing ticket" report to run at the end of every day. Even paperless systems have a version of this useful tool. The day's work simply isn't done until every ticket is accounted for.
2. **Balance ticket totals against posted payments and actual money collected.** Any retailer or restaurant does this—or goes broke fast! A manager or supervisor must review and sign off on the calculations.
3. **Lock it up.** It's amazing how many small practices treat cash casually. You might find an unlocked cash box at the desk that serves for everything from a cash register to petty cash—often without formal controls. At night, the drawer should be balanced and locked up under the control of a supervisor.
4. **Separate the "change drawer" from petty cash.** A change fund is a constant amount of small bills used for making change. It should have the same total every night. Petty cash is a small, cash bank account you draw from for minor purchases. Require receipts for every transaction, and constantly monitor petty

FAST Practice: Medical Practice Information at the Speed of Sound (ISSN: 1936-5101) is an audio newsletter published monthly by Greenbranch Publishing, LLC, PO Box 208, Phoenix, MD 21131. Yearly subscription rate: $340. To subscribe, call (800) 933-3711 or visit www.mpmnetwork.com/.

Executive Editor: Timothy W. Boden, CMPE

cash so that the amount in the fund balances with receipts.

5. **Randomly audit no-shows and cancelled appointments.** Make sure an employee isn't pocketing cash and marking a patient as a missed appointment. If a receptionist tries this with insured patients, you can get cheated twice: Once from the missing copay, and again when the insurance isn't billed.
6. **Conduct background checks on every applicant for money-handling jobs.** A criminal record and overwhelming credit card debt can be red flags to make you think twice before hiring a person who touches your cash.
7. **Pay attention to staff members' personal situations.** Unfortunately, a staffer who is having trouble paying the mortgage or has other credit issues may become desperate and do things he or she wouldn't normally consider. (And be wary of a staff member clearly living above the expected living standards for his or her family. You may be helping to finance that new Jaguar.)

EXPERT COMMENTARY

"But we're like a big family!" protests the doctor in a small practice. We've known physicians and managers who worry that tighter cash controls might introduce an element of suspicion and distrust into their otherwise happy, mom-and-pop office culture. But it doesn't have to have a chilling effect—especially if you're smart about how you introduce the new policies. (Besides, tightening cash controls won't even come *close* to damaging your office culture like a theft by a trusted employee!)

Here are a few smart ways to introduce better cash controls at your place:

- **Look for specific opportunities.** Opening a new office, acquiring a new computer system, or revamping your business systems can provide an "excuse" for modifying and improving cash controls.
- **Blame someone else.** You can get a lot of mileage out of a statement like, "Our accountant insists that we start doing a better job in this area."
- **Appeal to a noble principle.** Try a tack that says, "You know, guys, we think it's about time we start acting a little more businesslike in some areas of our practice operations."

You can foster and maintain a good family-like atmosphere at your place without creating potentially irresistible temptation for employees who handle the cash. "Family" doesn't mean "careless" or "incomplete." A healthy family takes care of its responsibilities to each other.

Besides, even in the best of families, Little Brother sometimes steals his sister's candy.

SECTION 2
FINANCIAL MANAGEMENT

1. Bundling Services Saves Time, Money

Derek Kosiorek, CPEHR, CPHIT, *Medical Economics*, September 25, 2013

ABSTRACT

There's nothing much more frustrating than dealing with multiple outside vendors that spend their time blaming each other for your system failure. For example, offers Medical Group Management Association management consultant Derek Kosiorek: One of your remote offices loses access to your EHR system. You call the support people at the EHR vendor, and they blame the system server provided by another company. So you call server support, and they blame the data lines. The people at the telephone company report the lines are fine and blame the server. And around and around it goes.

You can reduce opportunities for vendors to blame each other by reducing the number of vendors you use. Consolidating related services can save time and headaches—and sometimes, *money*. Some obvious targets for consolidation include:

- Voice communications and data lines from a single telephone provider;
- EHR and practice management software from a single software vendor; and
- Offsite server providers that sometimes bundle in-office hardware at attractive prices.

Bundling doesn't come without challenges, however. First, when pricing bundled-service packages from competitors, it can be complicated to make comparisons. Be sure you always consider "apples to apples."

Finally, you carry some risk when you put all your services eggs in one bundled basket. You can feel "captive"—severing a relationship with a vendor that provides "mission-critical" hardware *and* software, for example, could be painful and pricey.

EXPERT COMMENTARY

As you try to stretch your overhead dollars, always be on the lookout for opportunities to cut costs through bundled services. This author focused on technology, but you might come up with some creative ideas in other areas as well.

Similarly, watch for opportunities to engender competition among suppliers. Let the vendors who want your business know that they have some work to do to earn a place in your Rolodex. When a new vendor comes with a proposal to expand its offerings through bundling, contact your existing providers and challenge them to sharpen their pencils and offer a competitive deal.

It's harder than ever to decrease supply costs—but even if you can keep them from increasing, you've scored one for the home team.

2. Public Shuns Co-Pays for E-mail Consultation: Survey

Joseph Goedert, *HealthData Management*, December 2013

ABSTRACT

C.S. Mott Children's Hospital at the University of Michigan commissioned a national research firm to survey parents this past June to gain insight into their attitudes toward electronic communications with their children's pediatricians. Key data indicated that 77% would indeed use online means to get medical advice from their doctors if it were available. *But 49% said they believed there should be **no** copay for such services.*

These attitudes didn't vary by parents' education level or their children's ages. The only real difference appeared among those who had children with chronic conditions: They showed a stronger opposition to copayments. In a way, the attitudes expressed by the public mirrored the concerns that providers have raised about e-mail consults.

Providers fear there is little appreciation for the additional workload that goes on behind the scenes in e-mail consults:

- Reviewing records;
- Documenting the exchange; and
- Raising patient expectations for 24/7 availability to answer e-mail.

They also worry about widely variable reimbursement rates for these services. No one has established any real standards yet. Finally, physicians and other providers have expressed concerns about the hassle, costs, and technical challenges associated with maintaining HIPAA-compliant security for e-mail transactions with patients.

Administrators at Children's Hospital pointed to one potential solution to consider. Some practices circumvent the payer system entirely by offering e-mail access to physicians as part of a larger "extra services" package that includes family conferences, texting, and Web-based chart access. Practices charge a monthly or annual subscription fee for these "extras."

EXPERT COMMENTARY

Somehow the old saw "Why buy the cow when you can get the milk for free?" comes to mind when we consider this e-mail consult conundrum. As long as physicians allow modern communication technology to keep raising the bar of patient expectations, there will be no end to the demand.

We see at least two strong dynamics at work here: First, society has completely redefined its perception of *reasonable availability*. Those of us who walked the earth before cell phones remember what it was like to be "out of reach." Even doctors had to rely on pagers to notify them to get to a land-line for an emergency call.

Why, we even remember archaic, one-way pagers without glowing LCD displays! We called them "beepers," because that's all they could do! Only the most successful physicians actually had "car phones" from which they could call the service to find out why their beepers were beeping.

But most fourth graders carry around smart phones these days, virtually allowing access anytime, anywhere. The 40-hour work week has been seriously expanded by mobile phones and Internet access. Bosses feel they can call employees almost anytime.

It's no wonder that patients and family members have dropped that new template over their relationship with physicians! That kind of access isn't "extra," it's expected.

A second dynamic makes patients reluctant to pay for e-access: Already stinging from astronomical premiums and larger-than-ever copayments, the average patient (or guarantor) wants nothing to do with any additional cost. Who couldn't see that coming? (Makes us wonder about hospitals paying thousands of dollars for a survey to tell them what common sense should have told them in the first place!)

We find just a bit of irony in the hospital's suggestion to consider adding a sort of *deluxe* physician-access package for an additional subscription fee. Wouldn't that be similar to what has been called ***concierge medicine***? Many hospital leaders have criticized concierge physicians—a business model we prefer to call ***direct-pay medicine***. (In fact, we won't be surprised to see more and more hospitals offering other concierge services as practice acquisition fever continues across the country.)

Snobbish satisfaction aside, however, we think the idea of offering premium services for a premium makes more sense than ever. Smart practices can see an opportunity in the current situation wherein the payer community can't seem to establish value standards and sensible reimbursement for e-consults. Perhaps this is one of the last few ways you can get paid a little extra for doing extra work—a concept that seems to grow more elusive for physicians every day.

SECTION 3
GROUP DYNAMICS

1. Brainstorming *Is* Dead: Three More-Effective Approaches to Generating Ideas

Peter Valenzuela, MD, MBA, *MGMA Connexion*, November/December 2013

ABSTRACT

An old tradition for medical groups—whether in the board room or at the physicians' retreat—has been declared "dead" by a growing number of organizational gurus and management consultants. *Brainstorming* has fallen on hard times these days. Brainstorming was more-or-less legitimized back in the 1950s, and it has been characterized by these key components:

- Focusing on the quantity of ideas;
- Withholding criticism;
- Welcoming unusual ideas; and
- Combining and improving ideas.

The hope is that such an approach will yield a "Eureka!" moment, in which solutions will arise from the sea of (sometimes crazy) ideas. Trouble is, says current thinking, it seldom works. Some alternatives that show promise can stretch physicians and administrators and take them out of their comfort zones. Here are three:

- **Kill a stupid rule.** Gather employees or physicians into two- or three-person teams, and challenge them to come up with a list of stupid rules in your organization that keep them from performing their jobs optimally. Ask, "If you had the power, what stupid rule would you kill or change—and how would you go about it?"
- **View the problem through a different lens.** Perhaps using role-playing, challenge group members to work through one of your pernicious problems playing a role other than their usual job. Have a doctor act the part of a patient or a receptionist!

- **Activate a blocker.** Often lauded, the phenomenon known as "groupthink" can have devastating effects. The infamous Challenger explosion in 1986 was caused by faulty group thinking—even in the face of many individuals aware of the faulty parts that ultimately failed. Assign a person to be the *voice of dissent* in a problem-solving discussion. Adventurous (and successful) corporations have empowered a designated blocker to disagree with the top-ranking people in the room—even the CEO. The resultant deeper conversations and multiple perspectives have enriched their problem-solving skills.

EXPERT COMMENTARY

One of the problems with traditional brainstorming rises from the way humans tend to acquiesce to authority figures. Multiple studies have confirmed that participants in a brainstorming session often do little more than echo the ideas forwarded by the most vocal or highest-ranking person in the room.

A second problem entails the "no-criticism" rule. To get lots of ideas on the table, brainstormers are forbidden to criticize anyone's suggestion. You can end up with a table full of worthless ideas that way. And it squelches critical thinking.

These ideas offered by Sutter Medical Group's chief medical officer could interrupt some of the unproductive thought process cycles that have stymied many medical groups. Give one of these ideas a try at your next planning or problem-solving meeting. You might want to try the techniques with staff members first—you have a little control there. When it comes to getting your doctors to role-play in front of each other, all we can say is, "Good luck!"

2. What Differentiates a CEO from Other C-Levels?

Young Entrepreneur Council, SmartBlog on Leadership, December 1, 2013; http://smartblogs.com/leadership/2013/12/01/what-differentiates-a-ceo-from-other-c-levels/?utm_source=brief

ABSTRACT

Individual members of the Young Entrepreneur Council, an invitation-only organization made up of some of the world's most promising young business leaders, offered their respective thoughts on a question posed by SmartBlog's editors: ***"What differentiates a CEO from other C-level executives, and how do you choose a CEO from among a company's co-founders?*** Their answers included:

- **Public and private responsibility:** Rather than crowning the biggest extrovert on your team, choose the one with the best proven track record. Anyone with good communication skills can become the company's public face.
- **People, direction, and money:** Different companies' CEOs can have widely varying responsibilities, but for a startup to be successful, the CEO must do three things well: oversee hiring and firing, set the company's long-term strategy, and make sure everyone gets paid.
- **Perception:** Insiders understand the important roles of all c-suite executives, but the public perceives the CEO as ultimately responsible and accountable for the company's success.
- **Ultimate responsibility:** Choose the cofounder who is already leading in the areas of sales and marketing, operations, and human resources. Choose the one who has been paying particular attention to the growth strategy.
- **Inspiration and communication:** The CEO's top roles include setting the company's vision and strategy (inspiration), and designing the company's communication infrastructure (communication). Communication responsibilities include being the voice of the vision and mission.
- **Disturbance management:** Internal and external situations can often interfere with key people getting productive work done. The CEO must handle these issues in a way that minimizes disturbance and protects productivity.
- **Stress management:** The CEO must manage a variety of relationships both inside and outside the company. It's his or her job to maintain those relationships—whether with

a team member, an investor, or a client—in a way that engenders calm and confidence, minimizing stress.

One responding entrepreneur noted that he doesn't particularly like being a CEO. He prefers to focus on partnership negotiations, business development, and a range of behind-the-scenes responsibilities. The CEO has too much public responsibility to dive deeply into the kind of work he likes to do best.

EXPERT COMMENTARY

Physician-owned group practices follow different patterns in choosing their leaders—whether they call them *managing partner, CEO, president,* or something else. Some practices just defer to the senior-most partner, or perhaps one of the founders. Others more-or-less take turns sitting in the president's chair every year or two. Some groups seriously nominate and vote for leaders a la *Robert's Rules of Order*.

Some groups take the role very seriously, relieving their presidents of some clinical responsibilities so they can dedicate time to practice leadership. Groups that pay on productivity often pay an executive stipend to the doctor who takes time away from generating income.

We've noticed that more mature medical groups generally have a more practical approach to practice leadership. The maturity we speak of isn't about the age or emotional intelligence of the physicians, but the developmental stages of the business. As a business wends its way along the path from birth to maturity, the "make-it-up-as-you-go" policies and procedures eventually defer to formal systems, clear lines of authority and delegation, and carefully designed and managed processes. (There's an excellent *Harvard Business Review* article, "The Five Stages of Small Business Growth," at www.tameer.org.pk/images/The_Five_Stages_Of_Small_Business_Growth.pdf.)

When we were actively involved in practice management, our best work was with groups with a carefully chosen CEO who was paid to spend a full day each week working with the administrator. In those practices, the shareholder-physicians felt well represented by their colleague as he worked with the administrator. The administrator could work productively, because the CEO trusted him, and they worked in sync. Except for major decisions, the CEO and administrator could act with authority in day-to-day operations.

The physician-administrator team brings together the best of the professional manager's acumen and the wisdom and direction of the owners. (And we didn't have to wait till the next partner meeting to decide whether to buy a box of light bulbs!)

SECTION 4
HUMAN RESOURCES

1. Companies Shift Strategies to Retain Employees

Suzanne Bowness, *The Globe and Mail*, July 23, 2013

ABSTRACT

When new employees arrive at Environics Communications, Inc., in Toronto, they find clear indications of a warm welcome, like new business cards waiting at their desks. A few days before day one, a welcome packet arrives by mail at their homes, including a "family tree" that features staff photos and a map of the office. At LoyaltyOne, a customer strategy and insight firm, new employees get a personal phone call from the boss and a welcome packet full of information.

Smart companies have started paying attention to ways they can make new hires feel comfortable and confidant as quickly as possible. From "welcome" details to thorough orientation training and buddy-style mentoring, these employers are making smart investments toward retention.

LoyaltyOne's "onboarding" program stretches over the first six months of employment, and includes training and online resources to help get newbies up to speed quickly. Similarly, Home Depot uses a two-day orientation program for

new hires and some 35 to 40 hours of training about specific products in their departments. Home Depot demonstrates its commitment to front-line sales associates by requiring support staff in its offices to work 24 hours (including at least one four-hour shift) on the sales floor so they will know what it's really like.

Companies like these have discovered another strategy: early feedback from management. New employees especially need reassurance and guidance about how they're doing early on. Home Depot discovered that its "90-day check-in" with new hires reduced turnover by 15% in one year.

EXPERT COMMENTARY

Across a wide spectrum of industries, experts generally agree that replacing an employee costs about one-and-a-half times his or her annual salary. A $12-per-hour staff member may seem almost "disposable," but recruiting and training a replacement (and the associated lost productivity during the first months) could cost your practice some $37,000 in additional overhead. Want to calculate the cost of replacing a $25-per-hour nurse? How about a physician?

Even if the experts are off by half, do you have an extra $18,000 lying around? Better to invest in some comparatively inexpensive onboarding techniques. Consider the positive emotional impact of strategies like these:

- An information packet mailed to the home before the first day, including a staff directory with photos;
- An informative employee section on your practice Web site featuring an orientation section for new staffers;
- A new-employee luncheon during the first week, including all the staff in a small office or the whole department in a larger practice *and* a doctor or two;
- Personal "welcome" phone calls from a physician and the top manager;
- Thoughtful touches waiting at the new employee's desk on the first day: flowers or a plant, printed business cards, name plate, ID tag, and other tokens of welcome;
- Pairing every new hire with an experienced staffer to serve as mentor and "go-to" person for questions and concerns;
- Periodic "check-in" meetings at 30, 60, and 90 days to answer questions, provide feedback, and check on progress; and
- Orientation training that includes a thorough look at the employee manual and staff benefits.

The list could go on and on. And the new employee could stay "on and on" with just a little more sincere effort to help him or her feel comfortable and confident in the new job.

2. Pushed Out of a Job Early

Michael Winerip, *New York Times*, December 6, 2013

ABSTRACT

Older Americans have a significant fear of being pushed out of their jobs during these economic hard times. In March 2013, Richard L. White, a 22-year veteran director of career services at Rutgers University, lost his job. The 63-year-old had a string of successes, a Fulbright grant, and glowing performance reviews to back him up, but his new boss, the president's chief of staff, gave him a terrible review the year before.

Shortly before leaving, White filed an age-discrimination lawsuit against the university. Three other employees in similar situations joined the suit, and the school found itself awash in a very unfavorable light.

This story is just a prominent example of something going on across the nation. As wave after wave of baby boomers approach retirement age, discrimination suits are—well—booming. Age-related complaints at the EEOC rose some 38% from 2006 to 2012—from 16,548 to 22,857.

The plaintiffs in the Rutgers case have unearthed a series of decisions and actions taken by the school's administration that could look very bad to the Commission—or to a jury. And the fact that White and his colleagues have not been able to secure comparable full-time work since their dismissals will strike a sympathy chord, to be sure.

Winning an age-discrimination suit has become especially difficult since a 2009 Supreme Court ruling resulted in a requirement for the plaintiff to prove that age was the *determining* factor in a lay-off. States like New Jersey, however, have retained a lower standard of proof, requiring the plaintiff to show only that age was *one of* the factors.

EXPERT COMMENTARY

Employment law tends to feature somewhat cyclical "hot-button" issues for the experts to write about. Age discrimination has been around for quite a while, but the significant rise in EEOC complaints over the past several years should get the attention of every employer—including *you*.

Our rapidly changing medical practice environment of the last two decades has forced physicians and their administrators to rethink how they staff their offices. Narrowing profit margins require us to do more with less in every aspect—including support staff. Not only are we trying to find ways to cut staff, we're also struggling to make the remaining ones more efficient. In other words, we want fewer people to do more work—sometimes *much* more work—individually and collectively.

In the midst of this firestorm sits long-time, aging worker Miss Suzie. It took her a long time to trade her typewriter and HCFA-1500s for a computer and electronic billing. Now she does her best to avoid touching the new EHR system, often longing verbally for her old manila file folders. Her breaks are too long, her casual conversations last too long, and her personal phone calls are too frequent. She also happens to be 64 years old.

Suzie earns one of the highest hourly wages among the nonclinical staff, and don't even mention the number of sick days and other PTO days she has accrued! Under any business analysis, Suzie should be at the front of the line when it's time for a reduction in workforce. But this isn't simply about a business calculation. If Suzie is a pleasant, loveable office matriarch, you'd have a hard time dropping the axe on her. If, however, Suzie is a crotchety pain in the office's collective posterior, you probably fear what she might do if you were to let her go.

Statistically speaking, you *should* fear the potential consequences of letting a baby boomer go. If like most offices, you haven't had a realistic, consistent performance review system, you probably don't have any objective records to fall back on when a plaintiff attorney accuses you of discrimination. Instead, you have evidence of a great worker with a clean disciplinary slate and a long history of pay raises and promotions.

The only advice we can offer is this: Proceed with extreme caution. You may simply be stuck waiting for Suzie to retire on her own terms. If you do want to send her on her way, make sure that you avoid every possible appearance of discrimination. Plaintiff attorneys are famously creative in twisting even the smallest business decision into a devious plot against their client.

SECTION 5
RISK MANAGEMENT/MED MAL

1. Defective Devices

Jerrald R. Goldman, MD, and Victoria H. Rollins, MHA, RN, *The Doctor's Advocate*, Fourth Quarter 2013

ABSTRACT

Implantable device manufacturers may contact physicians who use their devices for a number of reasons, including:

- Product efficacy;
- Defects;
- Sterility issues;
- Public health risks;
- Regulatory violations; and
- Recalls.

Manufacturers usually issue recalls when necessary, but if the company fails to act, the FDA may step in and request a recall in one of three classifications. The most serious, Class I, means the FDA has determined that continued use of the product brings a high probability of serious

adverse health effects or death. Classes II and III indicate lower probabilities.

The authors tell about an orthopedic surgeon who replaced a knee for a 58-year-old woman who subsequently reported instability and clicking noises. The surgeon performed an arthroscopy to inspect the joint and found some wear in the joint's plastic post. She replaced it, even though it had not failed.

A year later, the patient called to report a fall. The surgeon's office directed the patient to the emergency department, where she was eventually examined and evaluated by another orthopedist. Soon the patient claimed the original orthopedist had implanted a defective knee and concealed the fact. It wasn't until the patient filed a lawsuit that the surgeon learned that the manufacturer had indeed identified a defect—although it wasn't serious enough to warrant an FDA recall.

Had the doctor known about the defect earlier—***and*** made full disclosure to the patient—the lawsuit might not have ever happened.

EXPERT COMMENTARY

Malpractice cases usually develop over a pretty good stretch of time. This one unfolded over the years following a total knee replacement. We don't know all the facts, of course, but on the surface this appears to be one of those cases that could have avoided litigation—it looks like it snowballed out of control.

We see a surgeon who followed her natural instinct to trust her own experiences with this type of knee replacement. That's a comparatively small sample when it comes to clinical data. Now we know that on a broader basis, there was a problem with this product. It wasn't a big enough problem to make much news—even the FDA didn't see it meeting the need for a recall at that time.

But the critical moment probably happened when the patient fell a year later and—thanks to a referral to the emergency department—received a "second opinion" by a doctor who was perhaps more up-to-date on information about that particular knee replacement. The patient learned about the identified defect before her own surgeon did.

This case is full of "if only's." *If only* the original surgeon had known about the manufacturer's admission . . . *if only* she had looked a little further after identifying and replacing the worn plastic post . . . *if only* she had seen the patient after the fall instead of simply referring the patient to the emergency department.

The article's authors advise doctors who deal with medical devices—especially implants of all kinds—to review their internal policies and beef up their procedures for managing implants with strategies like these:

- Review your informed consent documents and policies. Do all you can to involve the patient in the decision-making process.
- Dictate the device's serial number (or newly required unique device identifier [UDI]) in the post-op report and all patient records.
- Assign a specific individual in the practice to receive and act on all manufacturer notices and recall information that comes into the practice.
- Make sure physicians review and evaluate all manufacturer or FDA information gathered by that person.
- Create a system for notifying patients immediately of recalls (or other adverse information), and follow up in accordance with FDA guidelines.
- Document thoroughly every step as you follow these processes.
- Work closely with hospitals and surgery centers involved.
- Notify your malpractice carrier immediately whenever you receive a patient complaint about a device, or whenever an incident occurs that you think might lead to a lawsuit.

2. Sunshine Law: Don't Be Surprised by What Is Reported about Your Practice

MGMA Government Affairs Staff, *MGMA Connexion*, November/December 2013

ABSTRACT

This past August, certain manufacturers and group purchasing organizations began collecting data in compliance with the Physician Payments Sunshine Act—part of the Affordable Care Act. CMS will receive the data, and make the information ultimately available in a searchable, public database. Medical Group Management Association (MGMA) members participating in a recent Webinar led by the organization's Government Affairs staff asked numerous questions about the new rules. Here are the staff's responses to three of them:

- *How does the Open Payments program treat lunches brought into the office?* All transfers of value from a drug or device manufacturer to a physician must be reported and will be made public. Physician meals valued at more than $10 (or $100 aggregated annually) must be reported. If the food is consumed by the entire office, the total value must be divided by the number of diners to determine the value.
- *Why should physician practices keep track of "transfers of value"? Isn't that the responsibility of the manufacturer?* Although the program is a requirement for manufacturers, physicians should want to ensure that information reported about them is accurate—and they should be prepared to answer patient questions that might arise once the data are made public. (Physicians have 60 days to review and correct information after the manufacturer reports it to the CMS.)
- *Does the rule mean we now have to pay taxes on payments from drug and device manufacturers?* The Sunshine Act doesn't change any tax laws. Whether payment received from a manufacturer is taxable or not is better answered by a financial professional.

EXPERT COMMENTARY

At last! Obamacare fixes all the problems in healthcare by catching those smarmy influence-peddlers who ply your office staff with party platters from the local Subway restaurant! Now healthcare reform finally makes sense to us!

We hope you caught the anger and sarcasm in our tone there. We believe that Congress has once again gone after the fly on the wall with a 10-pound sledgehammer. They may kill a fly, but look at the wall!

Maybe we're still angry that we're starting to have to buy our own ballpoint pens and sticky notes now that the Fed has put a stop to those ubiquitous office supply bribes. Maybe we're just generally disgusted with goofy solutions that come out of legislators and their so-called "think tanks."

Or maybe we are just tired of being handed another regulation and compliance issue that does ***nothing*** to substantially improve the American healthcare system. Nevertheless, once our rant (and yours, if you like) comes to an end, we have to comply with the law. Granted, this one is more the problem of the manufacturers, but this article gives some food for thought for us on the provider side.

It makes good sense to keep track of transfers of value for your physicians for the very reasons offered by the experts at MGMA. Set up a spreadsheet for each doctor, and enter the information throughout the year. Don't try to "catch up" months of data at a time—it won't likely be accurate, and it will make the job even more onerous.

SECTION 6
MARKETING/PUBLIC RELATIONS

1. How to Use Media Releases to Build Practice Recognition

Susan Crawford, Editor, *Medical Office Manager*, August 2013

ABSTRACT

Professional marketer Hillel L. Presser of Deerfield Beach, Florida, emphasizes the importance of using news releases to enhance your practice's name recognition in the community. But, he says, it's critical that you do it right if you want the media outlets to publicize your news.

He offers nearly a dozen strategic tips for creating and distributing effective releases:

- **Useful information:** Make sure your media release contains stuff people want to know. By all means, avoid anything that sounds or looks like advertising!
- **Tailored to the publication:** Get very well acquainted with each outlet to match its style and audience. For example, if it's a business publication, make sure your piece relates to business owners and managers.
- **Timely content:** Watch for opportunities provided by other news stories or annual seasons. For example, at the end of summer, back-to-school health stories stand a better chance for publication.
- **Appropriate writing style:** Unless the publication goes to doctors and similar professionals, avoid the scientific, clinical jargon.
- **Proper tone:** Match the tone with the content, and be mindful of the publication and its audience. If you're telling a story, really *tell a story*. If you're giving "how-to" instructions, clearly describe the steps.
- **Clear deadline:** Find out each outlet's deadline for publication—and meet or beat it.
- **Correct recipient:** Find out to whom you should submit your release. Sending it to the wrong person can be worthless.
- **Concise copy:** Write reader-friendly articles and releases. "Less is more" in most circumstances.
- **Subject lines:** Your e-mail subject line (or printed/faxed headline) can make or break your opportunity. Keep in mind that people are more likely to respond to subjects about benefits they seek—even more than threats they may face.
- **Short cover letter:** Keep your cover letter (or your press release) to one page. Use as few words as you can to get the editor's (or other decision-maker's) attention.

EXPERT COMMENTARY

Writing effective press releases is truly an art form. We in the media see so many releases, they all begin to look alike—to blur into a mass of self-serving and marginally relevant bits of toner on paper (or pixels on screens).

Among them we see a few that grab our attention. These are the ones that clearly provide timely information that the majority of our audience will find interesting—or even vital. Your job, if you want to leverage the power of media coverage, is to figure out how to present your valuable information in different ways so that different media outlets will jump on it.

Here's a little secret for you. Editors and producers struggle almost daily with finding or creating content that will consistently sell their publications or programs in highly competitive markets. Anyone who can take even a small portion of that load off those people's shoulders will get their attention.

If you can provide story content—the more complete, the better—you will have the advantage of writing a news piece about yourself that doesn't look like marketing and doesn't look sleazy. But it does result in "branding" your physicians and your practice. When people read the article, they see the newspaper, magazine, or broadcast outlet citing ***you*** as the expert authority. Such "third-party" validation can be far more valuable than the best-crafted (and highly expensive) advertising campaign.

2. Physicians: Should You Accept Patients with Low-Paying Health Plans?

Marisa Torrieri, PhysiciansPractice.com, May 30, 2013; www.physicianspractice.com/blog/physicians-should-you-accept-patients-low-paying-health-plans

ABSTRACT

A brief article on the Physicians Practice Web site centers around a question that private practice physicians have been asking for a long time: Is it ethical to turn away patients based on their ability (or inability) to pay? Should practices focus marketing efforts and reserve physicians' best availability for patients with better-paying plans? Should doctors close their practices to patients with certain payers?

The post attracted a good number of responses from doctors and managers across the country. Their remarks reveal the anger and frustration felt by many practices fighting to survive in an increasingly difficult business environment. Responses generally followed several themes:

- Controlling payer mix is critical for business success.
- Ethics aside, physicians in failing practices will not be able to treat *anyone*.
- Primary care practices might be better off opting out of *all* insurance contracts and forfeiting assigned benefits (direct pay), forcing patients to pay first and seek reimbursement from their health plans.

EXPERT COMMENTARY

Physicians have wrestled with a fundamental ethical dilemma from time immemorial. To what degree are they obligated to provide care for people with limited means to pay? Most doctors feel a certain sense of public or humanitarian duty—indeed, most doctors we've known care more about people than about earning exorbitant incomes. It seems nearly everyone agrees that we should help folks in need.

Our current culture, however, has a difficult time drawing definitive lines and determining what "in need" really means. We wonder about Medicaid patients rolling to their doctor appointments in luxury cars. We feel conflicted about people who make a decent wage, but choose to spend their incomes on anything *but* adequate health coverage. We grow weary of the ubiquitous sense of entitlement to costly care (regardless of efficacy).

One or two lonely voices among the respondents expressed a strong obligation to treat everyone equally. They philosophically offered an opinion that businesses have good times and bad times, but physicians do what they do because they love their jobs. Others countered that they *started* their careers loving a job they anticipated, but current trends have destroyed much of their enthusiasm for the profession.

In the end, no one can settle this argument for you. It's an individual issue. We worked closely with a radiologist years ago who practiced what he called a "medical tithe." Once a month, he set aside a weekend day to treat needy patients at his private imaging center. He charged the patients a modest fee—$5.00—because he felt that it helped them maintain a degree of dignity. He helped a lot of people with this strategy, but when he suggested it to colleagues in other practices in diverse specialties, he got no takers. He couldn't understand why others couldn't make a similar sacrifice.

We've known physicians who take significant time off to serve on medical mission projects and others who regularly volunteer at public health clinics. Some physicians feel they "do their part" by participating in Medicaid programs, while others feel that not closing their practices to new Medicare patients fulfills their obligation to the community.

Who is to say? Politicians and media voices (all moral icons themselves, of course) have hammered away at physicians' images, characterizing them as greedy opportunists, for too long. We would encourage all physicians (or groups) to sort out their own values and priorities, and hold firmly to their respective sense of right and wrong. Don't judge your colleagues who seem "less humanitarian" to you. Rather find and follow your own moral compass.

SECTION 7
CODING

1. New G-Codes to Pay Doctors for Broad Array of Non-Face-to-Face Care

Cheryl Clark, HealthLeaders Media, December 5, 2013; www.healthleadersmedia.com/print/QUA-298983/New-GCodes-to-Pay-Doctors-for-Broad-Array-o

ABSTRACT

Most veterans of practice management have heard physicians complain—and often justifiably—about the time-consuming, but ***uncompensated*** extra work they and their clinical staffers put in

as they manage patients with chronic conditions. They spend a great deal of time and effort in:

- Fielding questions from patients and caregivers about diagnoses and drug dosages;
- Dealing with referral specialists' inquiries;
- Communicating with pharmacists;
- Reviewing lab and imaging test results;
- Assessing patients' functional status;
- Coordinating appointments; and
- Developing care plans.

These and many more tasks have not been compensated by Medicare (and payers who follow Medicare's lead) because they have been treated as part of the regular E & M visits already coded and billed. This year, however, CMS introduced **G codes**, an attempt to incentivize physicians to do a more thorough job managing patients with chronic conditions.

Beginning January 2015, physicians will be able to bill for 20 minutes of non-face-time activities like these ***in addition to regular E & M codes***. It will only pay about $30, but as many physicians say, "At least it's *something*."

Other physicians and administrators point out that it's not all good news. While CMS hopes this small incentive will encourage physicians to provide more structured, comprehensive care for patients with chronic conditions, the limits are significant:

- Only patients with two or more chronic conditions expected to last 12 months (or until death) are eligible for G-code services.
- The physician must document at least 20 minutes of non-face-time care to support billing for G-code services.
- Providers can only bill for 20-minutes' worth of care per patient per month, regardless of how much more time they spend actually providing these services.

Since this kind of non-face-time care becomes billable, the G-codes will be treated just like other charges, subject to patient copayments and requiring them to consent to treatment. Skeptical doctors ask, "What if the patient refuses to consent?" Most conscientious physicians already provide these services without additional compensation—and most will continue to do so even without payment. And that seems to render the whole concept somewhat moot.

EXPERT COMMENTARY

It will be interesting to watch this one develop. That first "At last!" sort of fades away when you consider the hassle of gaining the patient's consent and deciding what to do if you fail. There are a few other caveats to consider as well:

- While a nonphysician can provide these services, the supervising "qualified professional" must be available regardless of the time of day—in other words, 24/7.
- The original rule that didn't make it to the Final Rule included two other requirements for eligibility: the provider had to use a Meaningful Use-certified EHR, and the practice had to be certified as a medical home. Although it dropped those requirements, CMS said it would revisit them in the future.

It sounds like not many bucks for a lot of "banging" on the part of Medicare providers. In the end, is it going to be worth all this hassle to garner an additional $30 per month per qualified patient? That's hard to tell—and a lot can happen between now and next year.

2. Wound Care Billing Update

Paul Kesselman, DPM, *Podiatry Management*, September 2013

ABSTRACT

Dr. Paul Kesselman focuses much of his practice on wound care and has become an expert on the ins and outs of coding and billing for those services. This article lists a lot of details about those processes that may not interest our broad audience. Several "pearls," however, could prove useful in your practice. For example:

- **Coding isn't the same as reimbursement.** Wound care, like durable medical equipment, finds providers sometimes interchanging the terms. Just because something has a code

doesn't mean the health plans will actually pay for it. Further, just because the product or procedure "qualifies" for reimbursement, you can't necessarily count on payment. Effective coding requires constant communication and research to stay up to date.

- **Global periods often affect wound care.** Based on medical necessity, a provider may bill an appropriate E & M code and find that some payers restrict the number of debridements per wound and follow-up periods. Let the coder/provider beware.
- **Documentation must be thorough.** Particularly in human skin equivalency (HSE) coding and billing, it's critical to document the rationale for the services and products you use, including digital photography of the wound site. Specify size and site and all the details to justify the codes used.
- **Facility- or office-based procedures call for different strategies.** Podiatrists who can get the facilities in which they work to pay for and bill the products used can relieve the doctor of those hassles. But doing HSE wound care only in rehab facilities surrenders important controls and can require the doctor to spend an inordinate amount of time outside the office, hurting his or her overall productivity.

EXPERT COMMENTARY

We've oversimplified the issues in our abstract for the purpose of illustrating several important principles for physicians trying to provide good service and make a buck these days. Kesselman's advice serves to remind providers of all professions how important it is to understand the coding and billing process.

We once worked for a surgeon who had a more-or-less "hands-off" approach to his billing office. He liked to say, "You guys are the experts. To me, it's like I do a surgery and dictate the op-notes. Then it goes into a little black box, and money comes out the other end." On the one hand, it was nice to have his confidence and be able to do our jobs without him hovering. On the other hand, it was extremely difficult to help him understand what we needed from him to optimize his collections.

There has to be a balance that includes the provider understanding more than the very rudiments of how he or she gets paid for services. Lackadaisical coding, ignorance of global-period rules, and half-hearted documentation all have a bad effect that the best certified procedural coders can't fix.

Create a healthy dialogue among billers, coders, and providers in your practice. When everyone understands what others in the work stream need, you'll have a better flow of work, information, and cash.

SECTION 8
INFORMATION TECHNOLOGY

1. As the BYOD Movement Gathers Speed, Privacy Concerns Assume a Whole New Dimension

Michael G. Mathews, PhD, and Mac McMillan, FHIMSS, *Executive View*, Fall 2013

ABSTRACT

Some surgeons used to rely heavily on old-fashioned, film-based photography to help them document procedures or aid them in teaching others. They never had to worry much about where those photos were. Today, however, a doctor might snap a great eight-megapixel photo in the operating room with his or her iPhone 5 and upload it to "the cloud." It's immediately available to anyone subscribed to the user's *Photo Stream* **anywhere in the world!**

The same holds true for videos, audio files, documents, and almost any other information-sharing media. Smart phones, tablets, and laptops have become accessories at least as common as wallets and handbags for most people. And healthcare is being deeply impacted by this BYOD—or *bring your own device*—movement.

Users don't want to lug around a business device ***and*** a personal device! Using a personal device for business purposes is irresistible. Further, cost-conscious employers don't

especially want to invest in a closet-full of portable devices for their staff members. So the personal and business uses have become intermingled in a way that raises privacy and security risks to new levels. At the heart of the issues lies this question: *How do you control practice data residing on personal devices?*

BYOD risk goes well beyond the devices owned and controlled by your staff, however. What about patients who bring their own devices to the practice? Have you considered vendors who access data related to the pharmaceuticals and medical devices they sell and maintain? Do you use an outsourced transcription service? How do you control data transmitted to a typist in India?

Practices can help control external data traffic by maintaining a fully segregated "guest" network in their offices. Protected health information can be kept on the securely closed network.

Of course, any data in a medical practice's system must be securely encrypted. Most common apps and programs on personal devices do not encrypt data (with notable exceptions like Apple's iMessage and Face Time). Some practices have deployed software on select personal devices that maintain encryption. EHR programs often have tablet and smart phone apps that allow physicians to document remote encounters or access charts from remote locations.

Data management remains the responsibility of the data network's owner (this means *you* in a medical practice setting). The liability for protecting that information rests with you and your organization.

EXPERT COMMENTARY

No doubt about it, wireless personal devices have revolutionized information access for healthcare professionals. "Connected" doctors can access their patients' full medical records from their smart phones during a middle-of-the-night emergency. What a tremendous leap forward!

But (as Mr. T would say) "pity the fool" who rushes into mobile information-sharing deployment without thoroughly considering risks for data breaches! We're not even sure that the industry has identified all the ways you can leak what HIPAA regulations call "personally identifiable, protected health information." From device theft to careless sharing of unencrypted data, there appear to be countless ways to lose control of data.

If you experience a data breach and can't demonstrate that you have taken reasonable precautions to encrypt data, ensure that uses and disclosures are appropriate, and secure proper authorizations and tracking for disclosures, you're risking some potentially expensive penalties and a lot of bad publicity.

2. Smart Technology Budgeting

Janet Colwell, *Physicians Practice*, June 2013

ABSTRACT

High-tech is quickly becoming the "norm" for medical practices—especially in the area of EHRs. But a number of stragglers continue to wonder how they can ever afford to take the plunge. Some standard strategies and creative advice can help make technology more affordable:

- Attest to Meaningful Use as soon as possible in order to capture all potential incentives available to doctors who deploy EHRs.
- Consider strategies like buying refurbished hardware for use in places (like exam rooms) where you don't need a lot of computing power.
- Consider cloud-based data storage to minimize in-house storage costs.
- Figure out where you get the most bang for your technology buck when it comes to adding enhancements to your technology

Most smaller practices (and quite a few big ones) have limited resources to invest. So consider the following enhancements for your "short list" of less expensive add-ons that can actually save your practice money in the long run:

1. **Upgraded billing system:** Upgrading your billing system when you purchase an EHR system makes a lot of sense. It probably costs less

than doing it separately later, and hopefully it will improve your collections.

2. **Automated phone system:** New systems with capabilities for integration in your practice management system can save hours of labor for staffers managing calls.
3. **Patient portal:** A robust portal not only helps in later stages of Meaningful Use, it can also save staff time (and money) as patients learn to "help themselves" with appointments, questions, and payments.

EXPERT COMMENTARY

Taking firm control of your technology strategy can be time consuming and exhausting at times. It requires you to stay on top of developments and offerings so that you understand what choices actually benefit the practice. Many "essentials" forwarded by vendors do more good for *their* bottom lines than for yours.

You don't have to buy everything on the "latest-and-greatest" list, but you don't have to be a complete techno-skeptic. There are a lot of good, affordable tools that can benefit your practice and more than pay for themselves in the long run. It's up to you to learn as much as you can and develop relationships with experts you can trust for sound advice to make decisions that only benefit your practice.