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INSIDE

DECEMBER 1998

VOL. 11, NO. 12 (pages 153-168)

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Scheduling problems? There may be legal reasons to solve them

Not to mention improving patient satisfaction and practice revenue

The more managed care permeates the medical marketplace, the more regulations practices find they have to meet. These rules come not just from the payers, but also from state legislation in reaction to citizen complaints, newspaper horror stories, and anecdotes from patients dissatisfied with managed care. The bottom line: The demand for open access has led to mandates that practices see patients within a certain amount of time.

In New Jersey, for instance, a state law requires HMOs to have large enough physician panels to provide for four patient visits per year, with no physician seeing more than four patients per hour. Payers, in turn, are putting more pressure on physicians to see patients in a timely manner and not overbook their schedules, an increasing problem as capitation takes hold and practices try to increase revenue by packing in patients.

There are ways you can deal with scheduling difficulties, from changing your office hours to being stricter about late patients. *Practice Marketing and Management* interviewed physician leaders and experts to learn techniques practices can use to solve this problem.

According to New Orleans urologist **Neil Baum**, MD, managed care companies have made it clear to his practice and others that long wait times can lead to their ouster from a panel. "Waiting is the number one complaint that patients have," he says. "The payers are surveying patients about whether we see them in a timely manner, and there is a

KEY POINTS

- As more states and managed care organizations mandate easier patient access to practices, those practices must shape up their scheduling or face fines or deselection.
- Effective scheduling isn't that hard. Some simple steps, such as keeping longer hours, can help improve access to your practice.
- If you don't know whether you have a tardiness problem, try tracking appointments for a week.

real threat that if we don't, we can be deselected."

Potentially, says **John Gilliland**, JD, an attorney in Crestview Hills, KY, practices that fail to meet state mandated access requirements not only face deselection, but also fines or other penalties. "If there is a statute on the books that says you have a duty to see a patient in a certain amount of time, then if you don't, you could be liable for malpractice," he says.

At the very least, Baum adds, if you can't see your patients in a timely manner, some other practice will. In his own practice, he had a real problem at the end of each work day. Urgent and emergent cases were being squeezed into a full schedule, leaving the patients at the end of the day running up to 45 minutes late. The result was an increasing number of patients asking for their charts and leaving his practice, as well as plummeting morale among staff who were forced to hear patient complaints and stay late themselves.

There is a solution

Baum solved the problem by setting aside 20 minutes in the middle of the day that can't be booked. That time is used to see patients with sudden, urgent needs. As a result, patients have stopped switching to other physicians, and it is rare when any staff member has to work late.

To take action, though, you must be aware of the problem. Certainly, patient attrition is a big clue they're unhappy. But you can head off a patient exodus through an early warning system that tracks how late you are. **Keith Borglum**, vice president of Professional Management & Marketing in Santa Rosa, CA, has developed a form **(see sample, p. 155)** that notes how late physicians see each patient and the average wait time for the day.

There are other things you can do to make your practice more efficient and see more patients, while still reducing wait times and improving access **(for 10 quick tips, see box, at right)**.

One easy solution is to create more hours to see patients. Most practices close during lunch,

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10 Tips to Improve Scheduling

1. Reserve the first appointments. Preference should be given for established, dependable patients, especially at the start of the day.

2. Limit new patient appointments. Block time each day for new patient visits. Try to accommodate their desires for appointment time as much as possible. Don't make them wait when they come in.

3. Get paperwork done ahead of time. Mail required forms and a practice brochure to new patients in advance of their appointments to reduce no-shows and speed flow.

4. Block specific times for specific appointments. Difficult exams and procedures should be reserved for mornings. Block specific times for emergencies and for certain types of appointments. Block times for physicians to return calls rather than interrupting them during exams.

5. Schedule accurately. Use a scheduling book with 10-minute units instead of 15-minute units for greater accuracy.

6. Measure accuracy. If a physician is late more than half the time, your schedule is unrealistic **(for a sample wait time tracking form, see p. 155)**.

7. Discharge repeat no-shows from the practice. Don't try to charge for missed appointments because it may result in more cancellations from angry patients. It also is hard to collect this money and doesn't compensate the practice for lost time.

8. Limit cancellations. When patients try to cancel, sound disappointed and try to solve the problem or overcome their excuse in a courteous manner. Try to get them to honor their appointments before rescheduling. Aim for a 50% conversion to compliance.

9. Fill in cancellations. If you have a cancellation or no-show, move a patient up from later in the day or from following days to fill the gap. Say, "We've had a change in schedule," not, "We've had a cancellation." Maintain a will-call list of patients who want to be seen sooner or can respond on short notice to changes in schedule.

10. Build in buffers. Schedule 10- or 15-minute blocks of time for when a physician frequently runs late, such as late morning or afternoon.

Source: Professional Management & Marketing, Santa Rosa, CA.

COMING IN FUTURE MONTHS

- Are you being properly reimbursed?
- New Years resolutions for your practice
- How to cope when a payer abandons your region
- How to investigate a harassment complaint

WAIT TIME TRACKING

Patient Name	Arrival Time	Appointment Time	Time Seen by Doctor	Wait from Appointment Time to Time Seen
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				

Average number of early arrivals: _____ Longest wait of the day: _____

Average number of late arrivals: _____ Shortest wait of the day: _____

Source: Used with permission of Professional Management & Marketing, Santa Rosa, CA.

for example, but staying open and staggering staff during those hours can help you ease patient flow. **Sharon Humphreys**, vice president of marketing at Beaver Medical Group in Redlands, CA is looking at extending hours even further — from 8 a.m. to 7:30 p.m., with one physician working each night per week. "That way, we can have time to make more appointments." It has the added benefit of creating a convenience for patients, she adds.

Your own schedule isn't the only issue. Others' schedules can have an adverse effect on your practice as well. A while back, Baum had a surgery scheduled for 11 a.m. When he got to the hospital, he was told there was a staffing problem, and the operating room he was booked in couldn't be opened until 12:45 p.m. — the exact time he was due back at his office to see more patients.

"I offered to do it at 5 p.m., but they said that would cost them a lot of overtime," he recalls. "I said I wouldn't allow their management problem to make me late for the day. They hemmed and hawed but did it. Now . . . I am back in control. If it was an emergency, that's different, but if they are having a problem getting a nurse in, that won't impact my practice."

And if patients are late, Baum also refuses to let that ruin his schedule. If patients are more than 10 minutes late, they are offered a voucher for a free cup of coffee at a nearby coffee shop and told to come back at the end of the day. "They aren't usually late again," he says.

Practices often have no influence over the things that drive patients crazy — managed care or Medicare limitations, he says. "But the No. 1 complaint people have with health care is waiting, and it is the one thing we can do something about." ■

SOURCES

Keith Borglum, Vice President, Professional Management & Marketing, Santa Rosa, CA. Telephone: (707) 546-4433.
John Gilliland, JD, Attorney, Law Offices of John Gilliland, Crestview Hills, KY. Telephone: (606) 344-8515.
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Going stark raving mad over Stark II?

Here's a guide to help you through the maze

For physicians and administrators, just surviving in an era of reduced reimbursements and increased regulation is hard enough. Trying to understand legislation like Stark II is a burden many wish hadn't been added to their plates.

But if you don't understand Stark II and its impact on your practice and violate its provisions — even unintentionally — you could face fines, lost Medicare and Medicaid income, or even removal from the program altogether.

According to **Sally Barber**, Esq., an attorney with Parker, Poe, Adams & Bernstein in Charlotte, NC, many practices are confused about the definition of Stark II. "It's a federal law that limits certain patient referrals," she explains, noting that it stemmed from a study by the Office of the Inspector General (OIG).

The OIG study concluded that when physicians had financial interests in freestanding ventures such as labs or home health agencies, they were more likely to refer patients there. "It wasn't done as a matter of convenience, either. They didn't like that."

The financial interest link

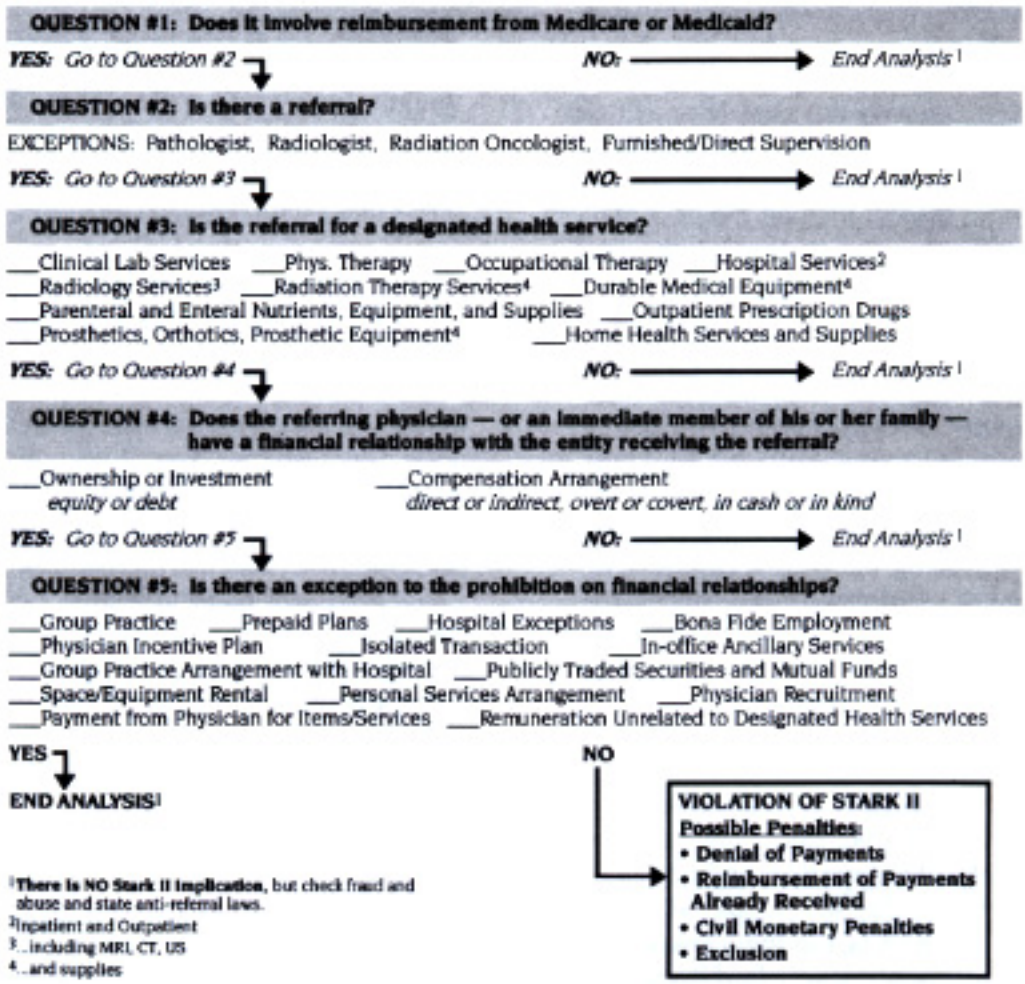
The gist of the law is this, Barber explains: Physicians — MDs, DOs, DDSs, DMDs, podiatrists, optometrists, and chiropractors — cannot refer patients to any entity in which the physicians or their immediate family members have a financial interest for a designated health service for which Medicare or Medicaid may pay. **(For a list of designated services, see chart, p. 157)**.

Immediate family members include husband or wife; parent, child, or sibling (natural or adopted); step-parent, step-child, or step-sibling; parents, children, or siblings in-law; and grandparents, grandchildren, and their spouses.

Unlike fraud and abuse laws, which require criminal intent for guilty verdicts, Stark II is a civil law.

"If you go through the hoops and don't meet one of the exceptions, then you are dead," says Barber. "That's why you need to understand it."

Stark II Analysis Flow Chart



Source: The Health Care Group, Plymouth Meeting, PA.

But most practices will find they meet the requirements through the exceptions, she says. For instance, if you are in a group practice setting that has owner physicians, they will own the radiology equipment, so you don't violate Stark II if you refer patients to your own radiology department. Office ancillary services — such as imaging or lab — are excepted. If you are an employed physician, you also have an out, Barber says. "But you have to structure it so that it meets the compensation exception."

It is in compensation systems that most practices will feel the impact of Stark II, she says. "Take a cardiology practice. If you have radiology, and you pick up EKGs, and your group lets physicians receive compensation based on the number of EKGs they do per week, that will be in question. You will have to divide that revenue in a way that doesn't take into account the volume that is done." The only exceptions to that are screening mammography and invasive radiology such as angioplasty. "Those are not designated services," she explains.

In a multispecialty situation, it grows even more complex, she says. For instance, you might have all your radiologists dividing radiology dollars and various specialities sharing lab dollars. "But we still don't know if you have to split all that revenue among all doctors or just between docs in that department. Stark II doesn't make that clear."

Under the current proposal, if there is an allocation of profit for a particular specialty or subspecialty only among those members, it is suspect, she says. "The narrower you pool, the more likely HCFA thinks you are getting paid for referrals."

Another issue yet to be decided that could affect practices is how "unified" the businesses

have to be. Stark II has introduced a concept that states you must have centralized decision making, pooling of expenses and revenues, and a distribution system that doesn't treat each office as its own entity, she says.

"If you have three offices that are all their own cost centers, then you may not qualify as a group practice. You would probably have to centralize and create a board for making decisions. If you have all three sites leased, then all the docs at all the offices should pay an equal share of the total of all the rents."

The regulations that will clarify some of these issues were supposed to be ready this year, but the comment period was extended. Barber says the optimists predict they'll be ready in 1999, while the pessimists figure it will be 2001. Until then, Stark I regulations apply.

Those regulations will include a reporting requirement for practices. "They don't have a form completed yet, but eventually, physicians will have to report all their financial arrangements," Barber says.

Get professional advice

Those who still have questions can write or call HCFA eventually, Barber says, "but they aren't answering a whole lot of questions right now." The Jan. 9, 1998, *Federal Register* published the regulations (p. 1,659), she adds, but there are nearly 100 pages to look through. The *Federal Register* can be accessed on the World Wide Web at the following address: http://www.access.gpo.gov/su_docs/aces/aces140.html/.

"The main thing to know is that if you offer any designated health service, you need to get some professional advice in terms of making sure you are doing it right," she says.

"You may be able to continue doing exactly what you are doing. But if you have any volume of Medicare/Medicaid business, you need to make sure you can meet one of the exceptions." ■

SOURCES

The Health Care Group, Plymouth Meeting, PA. Telephone: (800) 473-0032.
Sally Barber, Esq., Parker, Poe, Adams & Bernstein, Charlotte, NC. Telephone: (704) 335-9026.

Guest Column

Understanding fraud and abuse regulations

By **Reed Tinsley**, CPA
The Horne CPA Group, Houston

Fraud, abuse and compliance: Those words have become the battle cry of state and federal government agencies. Each represents potential nightmares for all health care providers, including physicians. It seems you can't read a magazine or newspaper these days without seeing at least one story on health care fraud and abuse or the government's growing investigations into allegations of false claims and overpayments.

And while the recent headlines have targeted nonphysician health care sectors such as hospitals, home health agencies, pharmacies, and reference laboratories, it is important for physicians to realize they are now the focus of more intense scrutiny by Medicare, Medicaid, and the insurance industry as a whole.

With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Acts of 1997 and 1998, the federal government has allocated more money for manpower and audits — about $500 million a year — to rid the health care system of fraudulent and abusive practices. These two laws contain more than 65 provisions to fight health care fraud and have increased investigations by 40% during the last two years alone.

Unfortunately, too few physicians are concerned about fraud and abuse. Most are confident that their practice operations are compliant with Medicare billing and documentation guidelines, and they would never intentionally defraud anyone. True or not, this laissez faire attitude and false sense of security has the potential to hurt physicians financially and professionally by preventing them from focusing on the lifeblood of their practice — documentation, coding, and billing.

Many physicians do not realize that HIPAA '96 extends the fraud and abuse regulations to all services provided to all insurance plans, not just government programs. In effect, every claim sent to an insurance plan must be "accurate and complete," or it could be reviewed as

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Practice
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The best defense for a harassment suit? A sound policy

Why every practice needs an anti-harassment policy and what it should include

Editor's Note: This is the first of two stories in Practice Personnel Bulletin *that will examine harassment in the workplace. In this issue, we look at how and why to develop a harassment policy. In the February issue, we will examine how to conduct a harassment investigation.*

Every week there are stories about sexual harassment lawsuits. Some are successful, some are not, but they are becoming more common and every single one costs money. Indeed, even a case that is thrown out of court costs a business a minimum of $20,000 to $30,000 in attorney fees, says **Chad Shultz**, JD, a partner in the Atlanta office of the national employment law firm Ford & Harrison. Add to that the costs of declining morale, high employee turnover, and recruiting and training new employees, says **Mark Strunk**, LPC, MFT, CEAP, an employee assistance representative with the Columbus, GA-based Pastoral Institute.

Strunk says one reason there are more suits now is that before 1993, litigation was heard before a judge and usually provided only back pay and a return to work for the successful plaintiff. Now, suits are brought before a jury and result in multimillion-dollar punitive and compensatory judgments. Plaintiffs are more likely to be heard and believed than in the past.

And it's not going to get any easier. Shultz says that along with sexual harassment cases, there is an increasing number of racial and age harassment cases. And in June, the Supreme Court issued two opinions making employers easier targets of suits by employees, even if the employer is not aware of the harassment *(Faragher v. the City of Boca Raton)*, and even if the employee suffers no adverse consequences *(Burlington Industries v. Ellerth)*.

But there are things you can do to alleviate the situation. Indeed, Shultz says the two judgments that may increase the number of suits provide a good plan of action to defend against them. The

What is sexual harassment?

There are two kinds of sexual harassment situations, says **Mark Strunk**, LPC, MFT, CEAP, an employee assistance representative at the Pastoral Institute of Columbus, GA. First, there is a *quid pro quo* demand for sexual favors for job benefits, he said. "Those are really hard to defend because there is an established contract," he says. "If you have a physician or anyone involved in that kind of scenario, you are setting yourself up for a fall."

More confusing and harder to deal with is a situation where there is a compliant or consensual relationship where the employee partner leaves and later files suit. "It may have been willing but unwelcome compliance," says Strunk. "When you have any kind of relationship between a supervisor and a subordinate, it has the potential of becoming a sexual harassment claim."

A hostile work environment due to harassment is another common issue, and Strunk says you have to go by the rule that perception is reality: if the person believes the situation constitutes harassment, then you had better do something to change it. "There is a rule about a 'reasonable person's standard,' which can give you some protection, but it's better to deal with the perceived hostility than wait to see if a court believes the plaintiff or you." ■

court held that an employer is responsible for discrimination caused by a supervisor, *unless it can prove it took reasonable care to prevent and promptly correct any sexually harassing behavior and demonstrate that the employee failed to take advantage of the employer's well-publicized complaint procedure.* The lesson, says Shultz, is to have a sound anti-harassment policy in place.

Most people who sue don't report harassment incidents, Shultz says. And usually, they cite one or two of these reasons:

- "I didn't know the company had a policy."
- "I didn't know who to go to when I had a problem."
- "I didn't think the company wanted to know."
- "I thought I'd get fired if I made a report."

Because of the recent Supreme Court rulings, employers now have to prove it was unreasonable for the employee to not come forward, Shultz continues. Employers must answer each of those four "excuses," he says, which they can do by showing the court they have a zero tolerance policy and proving they communicate the procedure for reporting violations, encourage such reporting, and will not punish anyone making a report about harassment.

While having a policy in place and making sure staff know about it isn't an absolute defense that will result in the dismissal of a lawsuit, Shultz says it can reduce liability. "You can have gross misconduct, where an employee grabbed someone's breast, and even if it occurred, if you took action, you have a defense."

Making the policy understood

A harassment policy should contain four basic elements, says Strunk:

1. It should spell out that harassment of any kind is not tolerated.

2. It should describe harassing situations using examples, such as the *quid pro quo* where sexual favors result in work perks, raises, or promotions.

3. It should describe how to file a complaint and to whom those complaints should be directed.

4. It should describe the process of investigation that a complaint will generate.

The policy should end with a statement that there will be no retribution against an individual for filing a complaint, but that anyone found to be making false accusations will be treated with severity.

Shultz says the nonretaliation aspect of harassment policies can lead to their own problems. "A lot of small employers will try to separate the two people involved or somehow make it so they don't communicate with each other or work together," he says. "But that is retaliatory. The person making the report can say, 'I didn't want a transfer,' or 'I didn't want a lack of communication on work issues with that person, just no harassment.' That can sneak up on employers."

Go the extra step

The policy should be presented employees, and they should have to sign a statement that they have read and understood the policy. Shultz goes a step further and recommends that employees be given a video on the harassment policy. A supervisor should be in the room during viewing to answer questions. The employee signs a statement that he or she saw and understood the video and had the opportunity to ask questions afterward. In addition, the supervisor signs a statement that the employee saw the video and was given the chance to ask questions.

In the event of litigation, you not only have the signed statements, but you can introduce the video into evidence, says Shultz, whose firm has such a video presentation.

Shultz says once you have a policy, be sure to train supervisors and managers on it. "We often expect them to know what's appropriate, but we don't train them on it," he says. Your lawyer should be able to help you draw up a list of what your staff should know about harassment issues.

If your investigation concludes there was harassment, the best course of action you can take is to terminate the employee. If you have no proof — if there is a he said / she said situation — Shultz says you should make sure you report the results to the person who made the allegation. Tell him or her you can't find any proof, but you won't tolerate the action and you want to know if any further incidents occur, then thank him or her for reporting the incident.

"A lot of times, people sue because they feel they aren't believed or taken seriously," he says. "Take it all seriously. Document everything that the plaintiff says, and the person they are accusing. Write it all down."

If you are a small practice, don't think that exempts you from litigation, says Shultz. While federal discrimination claims are limited to companies with 15 employees for sex discrimination

and 20 for age discrimination, there are often state laws that make no bones about the size of your business. "Or you could be in Alabama and bring a claim of sex discrimination under a theory of severe intentional infliction of emotional distress," he says. "Then the number of employees doesn't matter."

But there are some special problems that small professional firms with owner partners such as medical practices face, says Shultz. For instance, it's hard to fire an owner. But you still can do all in your power to correct the situation, he says. If you let the ownership position prevent action, you may be sorry.

Strunk remembers such a case where a woman was working in a medical practice with husband and wife physicians as owners. The husband physician, while alone with the employee, grabbed her breast. "She couldn't believe it, and her jaw dropped. He grabbed it again. She didn't want to lose her job, didn't want to tell her husband, and couldn't tell the wife. So she quit, got an attorney, and sued."

If you have a small office, Strunk says, finding an advocate outside the practice as an alternative with whom to discuss an incident is a good idea. "The policy in a small practice should be to talk to anyone in it, or if you are uncomfortable talking to someone in the practice, then contact our legal counsel. You should make them understand that you want them to be comfortable with the person they are reporting to, and give them the name and number of that person in the policy."

Jury trials, liability, and big damage awards can be prevented, Shultz says, even if, in the Supreme Court's words, the occasional suit is an unavoidable "cost of doing business." Proactive human resource practices are the key to reducing those costs of doing business.

For a complimentary preview copy of Chad Shultz's harassment orientation video or his harassment training video in English or Spanish, or for an investigation tips outline, contact him at (800) 554-7751, ext. 3874, or cshultz@fordharrison.com. ■

SOURCES

- **Chad Shultz**, Attorney, Ford & Harrison, Atlanta. Telephone: (404) 888-3874 or (800) 554-7751, ext. 3874.
- **Mark Strunk**, LPC, MFT, CEAP, Employee Assistance Representative, The Pastoral Institute, Columbus, GA. Telephone: (706) 649-6500.

Checklist for harassment policies

1. Put the harassment policy in writing and make it easy to understand.
2. State in the policy that the employer prohibits all forms of illegal discrimination and harassment.
3. Identify three managers — at least one female — to whom all complaints and concerns should be directed.
4. Specifically train those persons on how to properly react to complaints of inappropriate conduct.
5. Inform all employees, especially supervisors, of their duty to report inappropriate conduct to the people above.
6. State in the policy that the employer will investigate all claims and not retaliate against anyone.
7. Make sure every employee sees and understands the policy.
8. Have them read it and sign it.
9. Place a signed copy in their personnel files.
10. Have all employees view a video that further explains the company's policy and sign an acknowledgment that they watched it, had an opportunity to ask questions, and know where to report inappropriate conduct without repercussions. That way, if a case gets to trial, a judge and jury can see the video and the company can prove exactly what the employee was told.
11. Laminate and post notices highlighting the policy by the time clock, in common areas, and in the restrooms.
12. Most importantly, train supervisors. Without proper training, supervisors cannot be expected to know what the law requires of them. Training will assist your company in preventing lawsuits and in defending suits that are unavoidable. Training also shows your company's commitment to prohibiting discrimination.

Source: Chad Shultz, Ford & Harrison, Atlanta.

Memo to self: Improve communication with staff

Does your practice need an 'internal organ?'

Your practice wins a new managed care contract. Management and physicians hear the news and celebrate. But there's no need to tell the rest of the practice, right? They'll eventually hear about it, and why would they care, anyway? Such attitudes can be detrimental to your practice, experts say. Formal communication — through e-mail, memos, internal newsletters, and meetings — is vital to the success of practices.

"Everyone from the cast technician to the coders need to know about the complexities of our business," says **Cam McClellan**, director of marketing and business development at the Hughston Clinic in Columbus, GA. "Otherwise, they can't help us maintain an environment free of chaos that puts patient welfare first."

Neil Baum, MD, a urologist in practice in New Orleans and a national speaker on practice management and marketing issues, says every member of your practice needs to know everything. "If you don't keep everyone informed, you run the risk of creating conflict because one party doesn't have all the information necessary," he says.

But different kinds of information need different types of communication. Some things favor a quick e-mail message or memo. Other items need to be talked through in a meeting.

Baum's practice has six people in the office. He holds brief daily meetings on vital information for the coming day — such as which patients are coming in, who has lab work, and who is difficult or likely to be late. "That keeps people informed about what has to be done that day."

The practice of limiting daily meetings to necessary information but having longer ones for discussion purposes is endorsed by experts. **Keith Borglum**, vice president of the Santa Rosa, CA, consulting firm Professional Management & Marketing, tells his clients that daily "huddles" help the schedule flow smoothly. Hourlong weekly meetings then can be used to discuss accomplishments and prioritize the upcoming week. They also can be used for inservice education.

While daily meetings cover what you expect to happen, situations often change during the day. Baum's practice uses e-mail for urgent issues or tasks that must be completed quickly.

Jennifer Krasnoff, MD, a dermatologist in a two-physician practice in Petaluma, CA, agrees that task-specific information is best delivered in a written format, like a memo or e-mail. "Remember that verbal requests are forgotten and can't be tracked," she says. "That makes them ineffective methods of communication for important tasks."

There is a danger in communicating everything to your staff, warns Baum. You can provide too much information, and meetings can start to cut into time that would be better spent on other tasks or patient care. "You have to make all staff aware of the most important things, especially those relating to patient care," Baum says. "But poor collections one month may not be vital for everyone — just to those in charge of collections."

Krasnoff also limits information the five full-time practitioners and staff get, making sure personnel issues and financial specifics aren't discussed at meetings. "But general information on scheduling, patient flow, charting, efficiency, marketing, and patient problems can all be discussed in daily meetings." She often uses the meetings as a way to generate and talk through ideas.

Aside from creating a smoother environment, there are more concrete benefits to a good internal communications program. Recently, at Krasnoff's practice, patients started asking staff about glycolic acid products as they left the office. "They purchased the products at the front desk, but the staff was not familiar with them and did not have the time to spend with the patient," she says.

Krasnoff and her partner staged an inservice led by the manufacturer to familiarize staff with the product line. Not only did they learn about the products, but some staff started using the products themselves. The physicians then could prime patients to direct their questions to staff who knew about the products from both the manufacturer and their own personal use. ■

SOURCES

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problematic enough to result in civil penalties of $5,000 to $10,000 per claim, plus treble damages under the False Claims Act. Further, the number of *qui tam* or whistle-blower cases — those initiated by current or ex-employees, competitors, patients, or anyone else with an ax to grind — now account for more than 58% of all false-claim cases presented to the government.

The sad reality is that even the simplest billing mistakes now can become fodder for hungry auditors from agencies such as the Health Care Financing Administration, the Office of the Inspector General, the Federal Bureau of Investigations, and the Department of Justice, all of whom are hellbent on recovering funds improperly received by health care providers.

And to add fuel to the paranoia fire, a 1997 General Accounting Office report on the Medicare Payment System found that nearly 22% of the $28 billion improperly paid to providers by the Medicare contractors were received by physicians. To say the government is out for physicians' blood (money) is an understatement.

Taking control of your destiny

So what should physicians to do to protect their practices? The answer, of course, is to pursue a compliance "checkup." Physicians must take steps to review and improve operations, enhance documentation and coding data quality, and then, based on the findings, develop, implement, and maintain a vigilant compliance program to keep their practices out of the government's cross hairs.

The following is the basis for a comprehensive physician reimbursement, management, and compliance analysis.

1. Complete a practice analysis to provide *baseline* statistics and develop a snapshot of the practice's current operations relative to reimbursement, compliance, and operations. This involves a detailed review of all CPT/HCPCS codes and productivity reports for coding compatibility, unrepresented services, and baseline statistics. It also involves a detailed comparison of each physician's E/M service utilization to specialty-specific Medicare E/M data to identify under- or overutilization of level of service codes.

Medicare utilization data can be obtained by filing a Freedom of Information Act request with the Health Care Financing Administration. Look specifically for E/M services that appear to be upcoded. The initial results of the analysis then are linked to diagnostic coding and documentation compliance to enhance revenues while reducing post-payment demands from Medicare, Medicaid, and other payers.

You also should perform a detailed review of your explanation of benefits statements. Look specifically for charge denials and why these denials occurred. Do the denials and how the charges were billed indicate a potential compliance problem or problems?

2. Because the medical record is the ultimate billing document, it is imperative that you have a thorough review of practice documentation. If necessary, the review should be conducted by a qualified reimbursement consultant. This step involves a review of coded billing documents such as superbills, encounter forms, and ancillary lab result reports for accurate code assignment. This step also includes an audit of five to 15 medical records per physician to review:

- ❑ E/M level of service justification;
- ❑ medical record compliance with the E/M documentation guidelines;
- ❑ CPT and ICD-9-CM coding compatibility;
- ❑ appropriate use of coding modifiers;
- ❑ full charge capture or improperly billed services;
- ❑ appropriate billing under the incident to provision;
- ❑ compliance with teaching physician supervision and IL-372 billing;
- ❑ compliance with medical necessity guidelines;
- ❑ compliance with Medicare's correct coding initiatives.

Further, you should review the practice's top ICD-9-CM diagnostic codes and develop a diagnostic-related level of service coding, cross-reference table. The type of table standardizes E/M coding by diagnosis, the objective of which is to enhance the physician's understanding of documentation and coding by diagnostic conditions.

3. Finally, have a customized Practice Compliance Program (PCP), based on continuous quality improvement developed and implemented. The customized PCP is a necessary evil in today's heavily watched fraud and abuse environment. By having an *effective* and operational PCP, your practice may reduce any future criminal penalties by up to 95%. Further, PCPs contribute to profitability through the liability reduction, operational enhancements, and revenue enhancements by receiving and keeping appropriate service reimbursements.

With the passage of HIPAA and the expansion of health care fraud definitions and penalties to all health insurance plans, physicians are finding themselves under increased government scrutiny. Medical groups (and their physicians, officers, and board members) now may be held criminally liable for questionable billing practices, simple or "innocent" billing errors, or outright violations.

To minimize these risks, providers need to review current operations, identify exposures, and then design and implement a customized practice billing compliance program. Legal counsel should be consulted during this process. Unfortunately, most practices today think all they have to do is put in place a boilerplate compliance document and they will be in compliance. Don't make the same mistake — it could be costly.

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Marketing

Getting your rookies on the marketing bandwagon

Charting progress brought success to one group

When **Randall Doerman**, MD, a physician with Internal Medicine Associates in Fairfax, VA, tried to get physicians just joining the group interested in business development, he met with limited success. But he knew that in the Washington, DC, area, competition was tough, and if his practice was to grow, everyone would have to play a role in developing the market.

"We have hired most physicians straight out of good universities," says Doerman. "But they tend to rely on the institution's name and don't realize that when they are out, they have to create worth on their own."

He developed a way to show new physicians the importance of their contributions and help them keep track of their progress. Through meetings, seminars, and the use of visual aids, he has assisted the physicians who have joined the practice in the last two years in making a real contribution. His program also has helped weed out physicians who are not willing or able to take on some of the marketing burden. Since the inception of the program, the practice has grown from five physicians to 12.

It all started in 1996, after two physicians hired the previous year failed to bring in the business needed to cover their overheads.

First, Doerman started to hold monthly meetings on the business and financial aspects of a practice. In the meetings, the group covers how to generate patients and money, how to keep patients happy, and how to market to patients. "They have to understand that the word of a patient is the best marketing tool we have."

The meetings last about an hour and are supplemented by another monthly meeting devoted purely to marketing issues.

A picture's worth a thousand words

But that wasn't enough. Doerman decided to use a computer spreadsheet program that compared the overhead for each physician with the revenue the physician brings in. He made up a chart to use as an example and provided each of the new physicians with a chart showing his or her actual progress.

Part of the problem is that physicians don't receive any kind of business training, he explains. "They think if they bring in enough money to cover their salary, they are making an impact. But there is more to overhead than their salary." A chart including things such as their portion of rent, supplies, and support staff salary gave them a real idea of what they needed to do.

If you don't know all the things that make up your overhead and how to break them out into shares per physician, Doerman says, your accountant should be able to help you.

"We tried explaining it to [physicians]," he says. "But people just do better with pictures. They need to see more than just charges and receipts once a month. We needed to put it together with expenses."

Seeing the numbers had a galvanizing effect. One physician was spurred to increase his marketing efforts. His patient load increased, and he started to contribute to the practice's profitability. The other new hire decided marketing wasn't her cup of tea, and she left the practice.

The overall effect has been "gratifying," Doerman says. "It really had an impact." The

biggest benefit, he adds, has been an increased understanding of the need for marketing among his physicians.

"We do minimal advertising. We put something in the local paper every couple of months or in church bulletins. But this has helped us to grow, add new people, and become much more widely known in the community."

He says other practices bringing in new physicians should discuss marketing expectations during recruitment so it doesn't come as a surprise.

Discuss marketing expectations during recruitment so physicians aren't surprised later.

Once physicians are on board, be sure to restate those expectations.

Many physicians out of residency are uncomfortable dealing with business issues such as marketing, he adds. "But we have them meet other physicians, and if they have strengths, we use them." For instance, if a physician is a "performer," he or she is encouraged to give health talks in the community.

Give regular feedback

Whatever they do, Doerman says, you should give physicians constant feedback through regular meetings. The graphs needn't be done every week or every month. He uses them quarterly with his physicians.

With appropriate instruction, support, and training, he says, good physicians can cover their overhead within a year. Most will do so within 18 months, and two years is the upper limit.

The important thing is to get them started. "The longer they go sitting around idly, the more the rest of the practice has to pay for it," he says. "But if you create a sense of wanting to be an owner — and we are a little different because in three years they can become a partner — then if they put forth the effort, they know they will share in the profits. That really helps." ■

SOURCE

Randall Doerman, MD, Internal Medicine Associates, Fairfax, VA. Telephone: (703) 385-1900.

Physician Perspective

Changes demand hard decisions for physicians

By **Jean Edwards Holt**, MD, FACS
San Antonio

From personal experience and years of anecdotal conversations, I have observed that the decision to become a doctor and begin the journey toward medical school admission is a tough one. As overwhelming as this decision may seem, it rapidly becomes evident it is just the beginning.

Each subsequent decision in a physician's career path looms much larger and more significant than the previous one. What area of medicine — primary care vs. specialty? What specialty — academic vs. research vs. private practice? What type of lifestyle or location? How do you find time for family and yourself? What about income potential? Do you join a group practice, set up a solo practice, or obtain a salaried position?

A general rule in making decisions is that it is often helpful to list "wants" and "don't wants" concerning the choices. Many times, there will be overlaps in these columns, so absolutes or non-negotiables must be identified.

For many students in medical schools, most clinical rotations are enjoyable, and the choice of residency seems impossible. "Wants" may include a desire to be the patient's "real doctor" (a primary care physician, in today's jargon) and yet have a special fund of knowledge (a specialist).

The ideal of giving ourselves completely to the profession and the patient must be balanced with a desire of having a family and nonprofessional fulfillment. In these cases, "non-negotiable wants" must be decided. A helpful non-negotiable in this decision path is a desire to perform or not to perform surgery. If this is an absolute non-negotiable, then enjoyable areas such as primary care, anesthesiology, and pathology are eliminated. If not, then forget making a decision based on specialty. This is a clear line in the sand to delineate a proper path. Many of the "wants" will not be compatible with this and will have to be discarded.

Once a specialty is chosen and achieved, how to use the skills learned can vary widely. Traditionally, clinical practice, academic medicine, or military service have been the primary choices.

At this decision stage, alternatives in location, lifestyle, money, and autonomy usually determine our final path. Due to externalities affecting our noble profession, changes are present, and more are on the horizon, forcing us to another fork in the road.

Simply put, it just isn't as much fun as it used to be. Although there still is tremendous satisfaction in restoring vision to an elderly patient with cataracts or even providing a first pair of glasses to a young myope, there also are stresses of a demanding and litigious society, external demands of enforced rules (the hassle factor), marked decrease in reimbursement, and loss of autonomy. For many of us in the great healing profession, we sense frustration with our present situation and are asking, "What's next?"

The nonmedical factor

In the past, the full-time practice of clinical medicine has involved "running a business" in only a modest sense. Receptionists, billing clerks, and technical or nursing personnel were in place primarily to assist the physician and move patients through the continuum of care.

With the introduction of "managed care," the nonmedical aspects of running a medical office now consume more than 50% working hours. Those tasks include obtaining referrals, checking on precertification, verification of benefits, contract negotiation, and resubmitting denied claims. (My office has dealings with more than 996 separate third-party payers, each with varying copays, deductibles, rules, regulations, and submission criteria.)

Medicine has shifted from its role as solely a clinical science to that of a business. Instead of serving as the "captain of the ship," the physician is considered a "worker bee" and often as a "cost center." To be successful in this new environment, a physician must possess not only expert clinical skills, professionalism, and compassionate patient relations, but also business acumen. Unfortunately, business is an area for which we were not trained, and many of us may not desire to start that training now. Ignoring the transition, however, will lead to complete loss of autonomy, decrease in patient base, and less-than-acceptable satisfaction with the profession we have chosen.

Large single-specialty or multispecialty groups are joining to look more like businesses, hiring administrators, and allowing physicians to go about the business of practicing medicine. However, bringing groups of physicians together oftentimes creates the "tragedy of the commons" unless strong leadership can be supplied from the ranks and not just from the administrators.

This concept of "just doing what I do best" and leaving the management to others has been attractive to "true clinicians" and opened the door to the concept of physician practice management companies (PPMCs). The premise of the PPMC is to acquire medical practices, manage them on a day-to-day basis, (hiring, firing, billing, etc.), plus do the contracting, marketing, and strategic planning. Physicians are left to "see the patients." I'll talk more about PPMCs in a future column, but for now, let me just state my prejudice that they represent the ultimate loss of autonomy we have been fighting.

An alternative to succeeding in this new business of medicine is not to relinquish control to others but to take control ourselves. True, we may not have the training, and we didn't go to medical school to run a business. However, without our permission (managed care is a social experiment without the consent of the participants), the rules have changed, and our profession is no longer purely a clinical one.

It is no longer enough to be a professional scientific community. Increasingly, medical success depends on financial skills and business sense. These management skills may not be inherent to the physician, but with the level of intelligence required to be successful clinicians, they can be learned. Acquiring these new skills can place the physician in a leadership role to manage the new health care delivery continuum, just as the acquisition of clinical skills allowed successful management of the patient.

Most present-day physicians will need to seek out this business and management training in a similar manner to clinical training as a part of medical school. A few progressive medical school curricula are offering a new dual-degree program (remember the traditional MD-PhD combination?): the MD-MBA. The University of California at Davis and the University of Pennsylvania in combination with the Wharton School of Business, for example, offer combined six-year clinical and business programs.

Basic medical school curricula eventually may evolve in this direction (an absolute necessity!), but at the present time, supplemental instruction must be considered. Intelligent physicians can learn the needed business, marketing, negotiation, financial, economic, and legal skills. ■

Extenders' value rewarded through salary increase

MGMA survey shows boost for PAs

With reimbursement down and physicians stretched, there has been an increasing push for practices to make more use of midlevel providers to take on some of the patient burden in a busy practice. With the increasing value put on midlevels, their salaries are on the rise, according to the latest Physician Compensation and Production Survey by the Medical Group Management Association (MGMA) in Denver.

The survey looked at compensation during 1997. *Practice Marketing and Management* compared salaries with those reported in last year's survey, which reflected 1996 compensation.

Mid-level Provider Compensation

Specialty	1996	1997	% change
Audiologist	$40,425	$43,888	8.6
CRNA*	$79,002	$82,942	5.0
Dietitian/Nutritionist	$39,829	$33,830	-15.1
Midwife	$62,177	$62,769	0.9
Nurse Practitioner	$50,910	$52,788	-3.7
OT**	$44,240	$43,550	-1.6
Optometrist	$77,450	$71,025	-8.3
Pharmacist	$48,891	$50,398	-7.4
PT	$48,175	$47,893	-0.6
PA*** (nonsurgical, non-primary-care)	$54,419	$60,325	10.9
PA (primary care)	$56,249	$57,200	1.7
PA (surgical)	$63,589	$67,953	6.9
Psychologist	$62,379	$66,993	7.4
Social Worker	$43,532	$46,405	6.6
Surgeon Assistant	$56,827	$61,762	8.7

*Certified Registered Nurse Anesthetist **Occupational Therapist ***Physician Assistant

Source: MGMA Physician Compensation and Production Survey, Denver.

Physician assistants were the big winners, with non-primary care PAs and surgical PAs seeing strong increases in their compensation **(see table, above)**. Other midlevels with positive showings included midwives, psychologists, social workers, and surgical assistants.

There were some extenders who saw declining fortunes, however. Nurse practitioners' compensation dropped 3.7% from 1996 to 1997, and dietitians and nutritionists registered a 15% decline. Optometrists and pharmacists also had a drop in their compensation.

Copies of the survey are available by calling the Medical Group Management Association at (303) 799-1111. ▼

MGMA elects officers; ACMPE new president

Robert Wright Jr., FACMPE, president of University Health Associates at West Virginia University in Morgantown, has been named new chairman of the Medical Group Management Association (MGMA). He assumed the position at the association's October conference.

Wright, who has spent the last 2½ years in his current position, replaces Michael Wilson, who resigned earlier this year.

Other new officers include Robert Goldstein, FACMPE, chief administrative officer of the McHardy Clinic in Metairie, LA, as vice chairman of the board; Larrie Dawkins, CMPE, associate director of Wake Forest University Physicians in Winston-Salem, NC, as finance/audit committee chair; and Lynda Venters, FACMPE, executive vice president of Anesthesia Associates in Albuquerque, as member-at-large. Thirteen others were elected as board members-at-large.

Also at the conference, the MGMA-affiliated American College of Medical Practice Executives named Sherry Gentry, MBA, FACMPE, as president. Gentry is executive director of operations for Presbyterian Medical Services in Albuquerque. She succeeds Patty Brewster, FACMPE, regional director of the Hughston Clinic in Atlanta.

The ACMPE also elected other new officers. President-elect is Robert Nelson, FACMPE, senior vice president of medical groups development at the Canon Group in Santa Barbara, CA. Karen Buck, FACMPE, was elected secretary/treasurer. Buck is executive director of the

Center For Health Care Medical Associates in San Diego. New board members include Norma Plante, FACMPE, administrator of Orthopaedic Sports Medicine & Rehabilitation Center in Red Bank, NJ, and Thomas Stearns, FACMPE, vice president of medical practice services at the State Volunteer Mutual Insurance Company in Brentwood, TN. ▼

Philadelphia physicians form union

A move by Pennsylvania-based Independence Blue Cross Blue Shield to lower reimbursement rates has spurred a group of Philadelphia area surgeons to join a union hoping to gain better bargaining leverage when it comes to plan payment rates.

Since this summer, some 300 Philadelphia-area orthopedic surgeons, urologists, and ear, nose, and throat doctors have joined the Federation of Physicians and Dentists (FPD) union. Physicians in Independence Blue Cross Blue Shield's network keep an average of only 40% of each dollar they make, says FPD spokesman **Michael Connair**. On top of this, last July, the plan instituted a 2.5% across-the-board fee cut to dampen a recent rise in health care costs averaging 5% to 8% annually.

Hardest hit by these cuts were surgical specialists who had a 16 % decrease in their reimbursements, says **John Zamzow**, vice president for contracting at Independence.

Because they are considered independent contractors, the surgeons are restricted from collective bargaining by the Sherman Antitrust Act. However, they have agreed to pay the Florida-based FPD annual dues in exchange for its consulting services on reimbursement and bargaining issues. One such service is a review and consultation on insurance company contracts along with assistance drafting counter-proposals. FPD also will gather information on customary charges for key medical procedures and reimbursement rates of other insurers in the Philadelphia area.

"We're now being paid about one-third of what we got paid five years ago for the same procedure," says **Michael Okin**, MD, an orthopedic surgeon in Philadelphia. Affiliating with a union like FPD to help give physicians more leverage in contract negotiations is "the only venue we have left to save our profession," says Okin. ■

Practice Marketing and Management (ISSN 1042-2625), including **Practice Personnel Bulletin**fi (ISSN 1042-2625), is published monthly by American Health Consultantsfi, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Practice Marketing and Management**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (custserv@ahcpub.com). Hours: 8:30-6 M-Th, 8:30-4:30 F, EST.

Subscription rates: U.S.A., one year (12 issues), $299, $369 for institutions per year. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $150 per year; 10 or more additional copies, $90 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $26 each. (GST registration number R128870672.)

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