

# Notes

PRACTICE

Fall 2007

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**DOCTORS**  
MANAGEMENT

## “Leave the business of medicine to us”

As DoctorsManagement celebrates 50 years of service, our goals for each practice remain the same: to increase patient satisfaction, improve practice profits, enhance employee morale, and to reduce everyone’s stress level. With these goals in mind, we continually strive to improve our current departments and services and add new levels of services as needed.

Our Power Buying Program (PBP) was added in 2005 to provide practices with a real and practical way to obtain cost reduction. By offering a purchasing partnership component to our customers, the practice can maximize the use of resources and minimize waste and inefficiency. The PBP team has extensive knowledge in many areas of practice purchasing and the ability to assist the key personnel in your practice in understanding the

program and utilizing it to the fullest.

Our most recent program addition is course training for accreditation as a Certified Medical Auditing Specialists (CMAS) offered through our Coding department. After hundreds of practice coding audits, we have found that because more healthcare practices are using Electronic Medical Record systems (EMR), they need Coders with auditing education and experience. The EMR system scores the physician note and chooses the level of service for the documentation. One way to remain in compliance is to prospectively audit encounters. This helps the practice obtain better treatment outcomes, proper reimbursements and reduced denials.

From the

**President**

Paul L. King



The CMAS courses are now under way, with a number of locations and dates offered.

You can find information about all of DM’s departments on our new web site. It is still [www.drsmgmt.com](http://www.drsmgmt.com), with a new look designed to be more informative and easier for you to use. Just as a coach must continue to study and work on new plays for his team, DoctorsManagement strives to better ourselves and in turn, your practice.

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## EMPLOYEE REWARDS & RECOGNITION: POLICY REFERENCE GUIDE

by Philip Dickey, MPH, PHR  
HR Services Director/COO



### THE CHALLENGE:

It is a fact of life that everyone wants to be appreciated. This is true of physicians, practice managers, and employees alike. We never outgrow this need and even if it looks like we are independent, self-sufficient, and on top of the world, the fact is we need to feel valued. Although this might sound like common sense, often the simplest forms of appreciation are not shown in medical practices. Physicians and practice managers are often too busy to remember or don't take the time. Studies have shown that recognition, rewards and positive reinforcement all do work and that recognition for a job well done is a top motivator of employee performance. When a physician or practice manager learns of this fundamental principle, their typical reaction is that employees only appreciate rewards and forms of recognition that directly translate to their pocketbook—usually in the form of raises or promotions. While both are important to employees, what tends to motivate employees to perform is the thoughtful, personal kind of recognition that comes from true appreciation for a job well done—a good ole pat on the back!

### WHAT TO DO:

A physician or practice manager must think in terms of formal and informal rewards and recognition. A formal approach typically means anything related to an established program; an informal approach would be more spontaneous. There is also a difference between rewards and recognition. Basically, the first recognizes behavior (to reinforce it), and the latter rewards results. Reward and recognition programs do not have to be complicated. In fact, informal recognition is the simplest and can serve to effectively achieve behavior that can lead to the more formal rewards.

**Follow these few easy guidelines to get started:** First, always match the reward to the person. We are all different when it comes to what motivates each of us.

Start with an employee's personal preferences and reward him/her with what is truly meaningful to him/her. Such rewards may be personal or official, public or private, and may be gifts, activities, or actions. Have each employee complete a list of things he/she likes signifying what motivates him/her. Since we have determined that people differ as to what motivates them, compiling such a survey is a good way to know what actions are effective.

**“It's a fact of life that everyone wants to be appreciated”** Second, match the reward to the achievement. Effective reinforcement should be

customized to take into account the significance of the achievement. An employee who does something big should be rewarded in a more substantial way than one who does something on a much smaller scale.

Be timely and specific. To be effective, rewards need to be given as soon as possible after the desired behavior or achievement. It has been shown that rewards that come too long after the action serve little in the way of getting the employee to repeat the behavior.

The most effective rewards ultimately link to formal programs. A thank-you letter or public praise can be an important means of acknowledging an employee's efforts, but if that is the only form of recognition a physician or practice manager uses, such rewards will soon lose their effectiveness. A good rule of thumb is for every three informal rewards (e.g., a thank-you, pat on the back, etc.), there should be a more formal acknowledgment (e.g., a day off from work), and for every three of those, there should be a still more formal reward (e.g., a plaque, public praise at a staff meeting). These kinds of rewards and recognition ultimately lead to bigger formal rewards such as raises and promotions.

After putting in the time and effort to develop a recognition program, keep it fresh by reviewing it and staying on top of what works and what does not. Your efforts will be rewarded many times over!

# Top Ten Reasons to Say No to a Managed Care Contract

by Psyche Wimberly  
Director, Managed Care



I am always amazed at the number of physicians who sign managed care contracts without reading them. We've heard the excuses and some of them may be valid. Short-sighted, but valid. Here are my top ten reasons to "Just Say No," or at least take a very close look at the contract.

*Disclaimer: The following information is not intended as an all-inclusive list of managed care contracting issues. The views expressed are based on experience reviewing and negotiating managed care contracts and are presented for informational purposes only, not intended as legal advice. As with any legal contract, it is recommended that you seek appropriate legal counsel before signing a managed care agreement.*

## 10. Contracts That Are Extended To Affiliates, Indirect Participants, Or Blind/Silent PPO Activity

National payors and network PPOs may include a statement that says that the agreement is entered into by ABC Health Plan and its *affiliates*. If your payor has affiliates, make sure that your contract includes an addendum that lists all affiliates that are included as parties to your contract to prevent the network from being "leased" or subject to blind or silent PPO activity. This language is usually found in the opening paragraph of the contract.

## 9. Contracts That Allow For Unilateral Changes

This means that the payor can change any terms or conditions of the contract without agreement by the physician. These changes are usually associated with fee schedules or reimbursement but can include credentialing requirements and even continued participation in a network. Do not sign any agreement that requires that any changes to policy or procedure must be accepted by the physician, even if the payor reassures you that they will notify you within 30 days of the change. Instead, require that all changes be reported to the physician with 30 days advance written notification by certified mail with return receipt requested, or by a commercial method (e.g., FedEx with tracking capabilities). Also

include a statement that the physician has the right to terminate the contract without cause in the event that the changes are not acceptable. This language can be found anywhere within a contract but frequently is buried in the MCO or Provider Obligations sections.

## 8. Contracts That Contain Vague Language

Examples of vague language include "as may be established by the XYZ Payor" or "as may be deemed necessary," especially if it occurs "from time to time." This may obligate you to policies and procedures that **haven't even been established, but may be in the future!** It's a less obvious way to require you to accept Unilateral Changes. "As may be deemed necessary" and/or "from time to time" means whatever and whenever the payor chooses. This caution also applies to any attachments or addendums that may be "modified or added at the discretion of Health Plan." Do not agree to these terms. Treat these statements the same way as those that give the payor the authority to make unilateral changes. If you see these clauses in a contract, do not sign until the contract has been reviewed by appropriate legal counsel.

On a related note, you should always ask for policy and procedure manuals before you sign and make sure you review them and are able to comply. Specific policies and procedures may cost you money or add additional administrative burden to your staff, but usually are not spelled out in the contract. Examples include referrals and pre-certification requirements or whether or not you can bill for lab or x-ray or other ancillary services performed in your office.

## 7. 30-Day Filing Limitations

Some managed care payors have filing limitations as short as **30 days** from the date of service or EOB from the primary payor. If your payor will not negotiate the filing limit, ask for a clause that addresses "special" circumstances such as loss of key staff or significant equipment failure. If your contract does not identify a

## Top Ten Reasons to Say No to a Managed Care Contract (continued)

filing limitation, ask if there is one. It might fall under an unwritten policy and procedure. Filing Limitations are usually addressed in the Payment and Reimbursement section of your contract. (See also **Vague Language** and **Unilateral Contract Changes**.)

### 6. 30-Day Appeal Limitations

What is troublesome about appeal limitations, regardless of length, is that the responsibility falls on the physician to identify claim processing errors. Unless you report the error within the filing limitation, your payor will probably refuse to reprocess claims over 30 days old. Filing Limitations are also usually found under the Payment and Reimbursement section of your contract.

### 5. Contracts That Have A Limited Disclosure Of Fee Schedules

It is common practice for payors to offer fee schedules represented by 25 arbitrary codes chosen by the payor or described as paying “X percentage of Medicare.” For a fee schedule evaluation to be accurate for your practice, you need to identify the frequency of all procedures you perform and compare the fee schedule amounts to your high volume procedures. Consider the ramifications of a fee schedule that pays 90% of your charge for CPT code 99203 but 45% for a surgical procedure that accounts for 50% of your revenue.

### 4. HMO Contracts That Include Withholds

No matter how the payor presents it, a withhold is an additional discount taken from your reimbursement to cover the HMO's losses. Payors may insist that they *always* return withhold funds, but the reconciliation may be complicated and rarely results in the physician receiving 100% of the funds withheld. Be aware that the withhold clause may also require the physician to *cover the deficit* in the event that the HMO operates at a loss. Before you sign any HMO contract with a withhold provision, have the contract reviewed by someone with proven expertise in risk contracting. Withhold language is usually found under Payment and Reimbursement or may be included as a separate addendum or attachment.

### 3. Capitated Contracts That Don't Include A Covered Services List

Most physicians know that under a capitation contract they will be paid a fixed amount per member per month regardless of the number of times the patient presents to the office. But many physicians are not aware that the capitation payment may include hospital services, lab, x-ray, or any other ancillary services provided. Also, some payors “carve-out” or have an exclusions list for the capitation services. This means that there is additional (discounted) reimbursement for certain services, for example pediatric immunizations. Make sure you are aware of what's included in your capitation payment and of any services that can be billed “over and above” the capitation payment.

### 2. Contracts That Allow For Unlimited Overpayment Recovery Or “Take-backs”

Periodically, physicians receive letters from payors or independent vendors requesting refunds for claims that were paid as long as three years ago! You should never sign a contract that allows for unlimited overpayment recovery, especially those identified by independent vendors (affectionately referred to as “bounty hunters”). You should also be aware of contracts that allow for processing errors to be corrected by withholding payment against any future payment made to your practice. This “takeback” may also be referred to as an “offset” and may be found in the Payment and Reimbursement section of your contract.

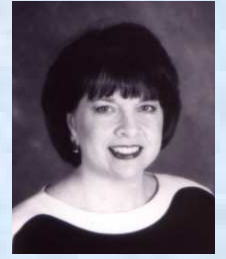
**And the Number One Reason to walk, no, run away from a Managed Care Contract:**

### 1. Contracts That Include Application Or Processing Fees

It is *never* appropriate to pay a fee to participate in a managed care organization. *Never*.

# HIPAA ENFORCEMENT ACTIVITIES

by Ann Bachman  
Director, HIPAA, OSHA, CLIA, AAPOL



Since April 14, 2003, Health and Human Services Office of Civil Rights (HHS / OCR) has received over 27,070 HIPAA Privacy complaints. They have investigated and resolved over 4,577 cases by requiring changes in privacy practices and other corrective actions by the covered entities. Corrective actions obtained by HHS from these entities have resulted in change that is systemic and affects all the individuals they serve. HHS has successfully enforced the Privacy Rule by applying corrective measures in all cases where an investigation indicates noncompliance by the covered entity including:

- National pharmacy chains;
- Major medical centers;
- Health plans;
- Hospital chains; and
- Small provider offices.

In the remainder of completed cases (16,500), the investigations found no violation had occurred or that the complaint did not present an eligible case for enforcement of the Privacy Rule. The unenforceable cases include alleged violations prior to the compliance date or complaints against an entity not covered by the Privacy Rule; the complaint was untimely or was withdrawn or not pursued by the complainant; or the activity described does not violate the Rule – such as when the covered entity has disclosed protected health information in circumstances permitted by the Rule.

The compliance issues investigated most frequently are, in order of frequency:

1. Impermissible uses and disclosures of protected health information;
2. Lack of safeguards of protected health information;
3. Lack of patient access to their protected health information;
4. Uses or disclosures of more than the Minimum Necessary protected health information; and
5. Lack of or invalid authorizations for uses and disclosures of protected health information.

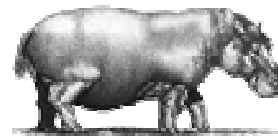
The most common types of covered entities that have been required to take corrective action to achieve voluntary compliance are, in order of frequency:

1. Private Practices;
2. General Hospitals;
3. Outpatient Facilities;
4. Health Plans (group health plans and health insurance issuers); and,
5. Pharmacies.

The OCR refers to the Department of Justice (DOJ) for criminal investigation cases involving the *knowing* disclosure or obtaining of protected health information in violation of the Rule. As of the date of this summary, OCR made over 393 such referrals to DOJ.

## SECURITY VIOLATIONS

The OCR refers cases that may be violations of the HIPAA Security Rule to the Centers for Medicare and Medicaid Services (CMS). As of April 30, 2007, the OCR has made over 153 such referrals. In the referred cases that describe potential violations of both the HIPAA Privacy and Security Rules, OCR and CMS coordinate the investigations.



**HIPAA** regulations can be confusing and frustrating. DoctorsManagement HIPAA Specialists can show you how to avoid HIPAA complaints, investigations, and inspections.



# DOCTORS MANAGEMENT

Leave the business of medicine to us

10401 Kingston Pike  
Knoxville, TN 37922  
(800) 635-4040  
(865) 531-0176  
(865) 531-0722 Fax

2631-A NW 41st Street  
Gainesville, FL 32606  
(800) 388-9140  
(352) 373-9140  
(352) 371-6216 Fax

205 Executive Park  
Asheville, NC 28801  
(800) 635-4040  
(828) 255-8825  
(828) 255-9774 Fax

PO Box 111450  
Nashville, TN 37222  
(800) 635-4040  
(615) 833-5864  
(615) 833-8958 Fax

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We welcome questions, comments, and suggestions.

## MANAGEMENT CONSULTANTS

Paul King, President, Partner  
Bob Fraim, Founder  
Dale Rothenberg, CHBC, Partner  
Bill Bristow, Partner  
Bill King, CPA, CFP, CHBC, Partner  
David Keller, CHBC, CFP (Asheville, NC), Partner  
Doug Driver (Nashville, TN), Partner  
Phil Evans, CFP, CHBC (Gainesville, FL), Partner  
Sam Thomas, Partner  
Ray King  
John Temple  
George Lane  
David Shropshire (Lexington, KY)  
Alan Sharp (Celina, TN)

## HUMAN RESOURCE MANAGEMENT

Philip Dickey, MPH, PHR, COO

## POWER BUYING PROGRAM

Wayne Walters  
Michael Lawson  
Craig King  
Walter Cook  
Robert Keeton  
Kim Gehrke  
Mike Masters\*  
Tommy Bryant\*

## BUSINESS DEVELOPMENT

Debbe Childress

## DM MEDICAL PRACTICE MANAGERS

Sherry Jernigan (Waycross, GA)

## ACCOUNTING SERVICES

Ruth O'Connell, CPA, CHBC (Gainesville, FL)  
Heath Hammett, CPA  
Blake King, CPA  
Christopher Bryant  
Melissa Rutherford  
Laura Twilley  
Heather Dolbeare  
Jacquie Fagan  
Laura Johnson\*  
Felicia Cash (Blackshear, GA)\*  
Cassie Pittman (Asheville, NC)  
Kevin Kendall (Asheville, NC)  
Micheal Farlow, CHBC, EA (Asheville, NC)  
Nancy Choba (Gainesville, FL)  
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Nancy Ruth (Gainesville, FL)  
Michele Thomas (Gainesville, FL)  
Sophie Edwards (Gainesville, FL)  
Sherry O'Steen (Gainesville, FL)  
Georgette Ayers (Gainesville, FL)  
Chris McVety (Gainesville, FL)\*  
Gene Good (Gainesville, FL)\*

## IMAGING SERVICES

Bill Hall

## MANAGED CARE

Psyche Wimberly (Asheville, NC)  
Shirley Howell

## ENROLLMENT

Abigail Rockwell (Asheville, NC)

## HIPAA/OSHA/CLIA/AAPOL

Ann Bachman, CLC (AMT), MT (ASCP)  
Debra Lutrell  
Mary Blount, MT (ASCP)  
Virginia Brown  
Chery Kendrick\*  
Joyce Kantner (Granger, IN)\*  
Michelle Hill (Memphis, TN)  
Carol Fowler (Cookeville, TN)\*

## CODING/BILLING/COLLECTIONS

Shannon Smith, CRTT, CPC, CMSCS  
Donna Hurley  
Barbara Pross, CPC\*  
Kelly Redwine\*  
Theresa Powers, LPN, CPC\*  
Denise Butler, CPC (Louisville, TN)\*

## ADMINISTRATIVE

Jo White, Partner  
Anita Sharp  
Dawne Tunkel  
Gloria Salmans  
Barbara Crouse  
Jane Cumpston  
Linda Lesh  
Tammi Revis (Asheville, NC)  
Jenny Haas, (Gainesville, FL)  
Steve Faison, (Gainesville, FL)  
Wanda Martin, (Gainesville, FL)

## CLINICAL TRIALS MANAGEMENT

Shirley Trainor-Thomas\*

\* Independent Contractor

Employees located in our corporate office in Knoxville, TN, unless otherwise noted.