

Notes

PRACTICE

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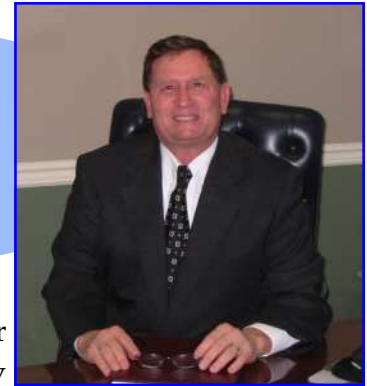
DOCTORS
MANAGEMENT

“Leave the business of medicine to us”

At DoctorsManagement, we have been helping our client practices improve the way they do business since 1956. To accomplish this, consideration of new technologies is often high on our agenda. The American Recovery and Reinvestment Act (the Stimulus Bill) that was signed into law in February of this year gives us another opportunity to assist our practices in maybe a less than familiar territory – adoption of the electronic health record (EHR).

From the
President

Paul L. King



The EHR is an interchangeable term for a more familiar term to many of our customers – the electronic medical record (EMR) - a patient’s health record that is compiled in a digital format. Benefits realized through use of the EMR/EHR systems may include, but are not limited to, improved access to medical records and improved quality of care, reduced healthcare costs, and increased billing accuracy.

For the past several years, the discussion of an in-house EMR/EHR system has been not so much a matter of “if,” but rather “when.” The stimulus bill, it would appear, has brought the “when” question closer to reality. Now we are being asked to help our clients determine “whose” is the best option for implementing an EMR/EHR system.

As with any new legislation, the details and benefits of the Stimulus Bill may not be immediately clear to the majority of those reading it. We will assist you in any we can to help you translate the incentives the bill provides regarding the additional reimbursements for Medicare and Medicaid, who qualifies for these incentives, and what EMR/EHR system might be right for your practice.

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Using Relationship Marketing To Grow Your Specialty Practice

by Valora Gurganious, MBA
Senior Management Consultant



It is essential for specialist physicians to nurture relationships with referring doctors. There are a number of steps the specialty physician can take to develop, grow and maintain steady referrals.

Have your staff participate in outreach and diplomacy.

Have your appointment setters go to the offices of the referring doctor and introduce themselves to his/her staff members. This will attach a smiling face with a name, and create an opportunity for those staffers to “bond” with one another and improve the likelihood that calls from your office will be received enthusiastically and cheerfully. Your staff may even bring a treat or small gift from your practice, which creates another opportunity for your staff member to follow up a couple of days later (i.e., “How did the staff like the brownies?”).

During that follow-up call, your staffer may casually ask if that doctor has had any patients come through with the problem that you treat. If so, the staffer can remind them that you are well-qualified and eager to take care of patients with that condition, and that you would be able to get them in to be seen quickly. Everyone should project friendliness and professionalism, demonstrating that your office would be very pleasant, respectful and accommodating to their patients.

Make an effort to personally field a call from a referring doctor.

Ask how you can help her/him and express that you will do your very best to see that patient as quickly as possible. Conclude by emphasizing that you appreciate their confidence in you, and that you will take excellent care of their patient. Have the appointment setter take over and handle the details of getting that patient “worked into” your clinic schedule.

Court your patients.

You may not realize it, but current patients are the single largest referral source to your practice and their referrals are completely free! Central to courting patients is how a physician treats a patient in clinic and surgery. Former patients are not qualified clinically to make referrals, but they base their referrals on how they FEEL about you as well as their experiences with the staff. Spend your time and money ensuring that the service you deliver to patients doesn’t just produce satisfaction, but also creates patient advocacy. True advocates not only return to you for their next healthcare need, but rave to others about you.

Work your contracts.

In group practices, be sure that your practice is contracted with the same insurance companies as the referring physicians, so

that only qualified patients are referred to you. If your practice handles workers’ compensation, a strategy to target large employers (who may self-insure) or networks of employers may generate a workers’ compensation contract for your practice. You may also develop relationships with adjusters, and consider offering to speak at the regional Workers’ Compensation Adjusters’ Association meeting to build rapport and awareness of your expertise with those professionals.

It is also important to periodically review your managed care and government insurance contracts to be sure that they are still profitable for your practice. Some plans may prove to be unprofitable for the practice and should be eliminated.

Be available.

There are four major areas of a specialty practice that are amenable to marketing: Ability, Availability, Affability and Price. The hardest aspect to market is price, because other providers (especially physician extenders) can charge less than you do. You can, however, control the other three aspects.

You may have a sub-specialty or niche which appeals to certain patients (i.e., pediatric spine surgery) that distinguishes your ability from other physicians. The affability demonstrated by you and your staff can also nurture new patients or drive them away. The easiest aspect to market to referring doctors is availability, which may include offering after-hours urgent care or Saturday morning hours.

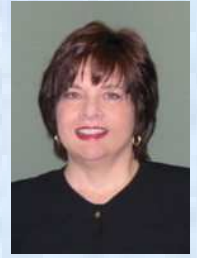
Be sensitive to the biases of other physicians.

A marketing plan to develop and grow referrals from other physicians should also take into account the special interests of different groups of physicians. Hospital-employed surgeons, for example, may sense resentment from independent private practitioners who view them as already having a “sweet deal” with guaranteed income. These independent physicians often prefer to support fellow independent providers. It is difficult to change that bias, so perhaps this is a segment to which you should dedicate minimal marketing resources, opting instead to appeal directly to the patient population with your marketing dollars.

Relationships will always drive physician referral patterns, whether those relationships are financial, contractual, or interpersonal. The interpersonal relationships are relatively inexpensive to develop and are much more enduring. Take the time to build rapport, have your staff reach out to other practices and to your patients, remain committed to delivering excellence, and your referrals should grow steadily over time!

Red Flag Rules

by Ann Bachman, Partner
Compliance Department



The Federal Trade Commission (FTC), the National Credit Union Administration (NCUA) and various banking agencies issued the Fair and Accurate Credit Transactions Act (FACTA, a.k.a. Red Flag Rules), requiring financial institutions and creditors to establish and enforce written identity protection programs. The original compliance date was November 1, 2008, and extended to May 1, 2009. The current compliance date is now August 1, 2009. The main reason for delaying enforcement is that many of the institutions subject to these regulations were completely unaware of the rules or were unaware that they were required to comply.

Although doctors' offices are not financial institutions, they may indeed meet the official definition of "creditor" because they do often allow patients to make payments over time rather than full payment at the time of service. A "creditor," according to FACTA, is "any entity that regularly extends, renews, or continues credit; any entity that regularly arranges for the extension, renewal, or continuation of credit..." According to at least one interpretation, accepting credit card payments does not in itself make an entity subject to the FACTA rules.

The American Medical Association appealed to the FTC for an exemption. Unfortunately, the FTC upheld the original interpretation, maintaining that most private practices meet the definition of "creditor" under the "Red Flag Rules."

Entities subject to the regulation must establish a written program that is managed by the board of directors or senior employees of the entity and includes staff training. The program should be designed to fit the size and complexity of the entity. No guidelines on training are provided. Therefore, we have concluded that reading the information and signing an acknowledgement statement should meet the training requirement.

As the wise and venerable Benjamin Franklin once said, "An ounce of prevention is worth a pound of cure." That oft-repeated statement applies in many, many situations, including current interpretations of the FACTA rules.

Therefore, we developed a basic FACTA compliance policy that will be incorporated into a future revision of DoctorsManagement's HIPAA Implementation Plan Notebook. It is available on the DoctorsManagement web site, www.drsmgmt.com.

Managing Supply Costs

The economy has taken its toll on virtually every segment of the economy. Healthcare is no exception. As businesses close, laid-off workers lose access to health insurance and, subsequently, delay or stop seeing their doctor. The ripple effects of this scenario can devastate small town practitioners. One thing that a practice can do to combat a decrease in patient visits and the related loss in revenue is to manage supply costs. Actually, it (managing cost) is good business practice regardless of business health. Sadly, most practices approve vendor payments without reviewing or even knowing that price "creep" has occurred. Strained resources, little time for such activities, or reliance on the vendor is often at the heart of the issue. Most practices have some form of manual control system in place to monitor overall costs but evidence of runaway cost only becomes apparent after the money has been spent.

There is some emerging good news in today's electronic world about some great tools appearing on the scene that simplify the ordering process while automating the process of price monitoring across multiple vendors. Sure, there are costs associated with these tools, but imagine what it could mean spending less time with the day-to-day supply costs and order issues and having more time for more pressing matters such as a school play or relaxing at home. If you want to know more about automating and managing the supply chain to reduce cost and gain valuable time, contact our Power Buying Department for more information. They will be happy to talk with you.

Managed Care Contracts - What Do They Cost?

By: Juliana Stanley
Managed Care Specialist



In medical practice today, managed care contracts are a necessity. You contract with insurance carriers and networks in order to make your practices available to the patients you serve, but are they sometimes too expensive?

To determine which managed care companies or networks to contract with, begin by evaluating the population of your service area. Learn what insurance carriers the major employers use, the number of members in your service area, and the median age of the population. Obtain the fee schedules of the payors and compare them to your practice's fee schedule and government plans. Be careful not to become over-contracted, and be aware of "silent PPOs." The main point of contracting is to increase the volume of patients who have access to your services.

Evaluate your own fee schedule before you begin looking at insurance contracts. A cost-based fee schedule that is easily comparable to the RBRVS will be the most meaningful in both your projected charges and your projected revenues. Overinflated charges will result in excessive write-offs and misleading revenue expectations. Conversely, fees lower than standard represent immediate loss of potential revenue.

Managed care contracts have many administrative requirements, such as prior authorizations, referrals, and formularies. You may have to dedicate staff members just to managing these items in order to ensure payment for services rendered. In most cases, if you fail to adhere to these terms, the patient cannot be held responsible for the charges and the amount must be written off.

When obtaining a new contract, be aware that it takes up to six months to become credentialed and finalize the agreement. A new provider should be credentialed prior to seeing patients. If the provider sees patients before becoming contracted, there will be issues with claims processing. The claims may be processed out of network at a lower rate and higher patient responsibility, paid to the patient, or denied altogether.

Once you have entered into the managed care contracts, reports from your practice management system help to determine which should be the first to be renegotiated. First, run reports of outstanding claims by insurance. Note the total number of claims, the percentage of total

claims, and revenue. The number of patients by insurance determines your payor mix.

Denials and accounts receivable give you another piece of the puzzle. List the reasons claims are denied. Claims should be processed in accordance with current coding guidelines. If a carrier is not using the same guidelines your coders are, you may see unusual denials and/or more frequent denials than expected. Your provider representative will be able to assist you in obtaining the guidelines set forth by the contract. Renegotiating a contract can alleviate many of these issues.

Look at the timeliness of claims payments. A long turnaround time for payment directly costs the practice money because the staff has to repeat work already performed. Often, even if claims are processed and paid quickly, they are not paid in accordance with your agreement. The explanation of benefits should match the amount negotiated in the insurance contract. Perform a payment audit quarterly. Compare your insurance allowed amount, according to your contract, to the actual allowed amount on the explanation of benefits. Do this for each insurance quarterly; you may find significant underpayments. Perform a coding audit when conducting a payment audit. An auditor will review documentation, charges, payments, and denials. Certain carriers may deny services even though the coding is compliant with CPT guidelines. You may be able to negotiate with the carriers to allow these codes to be paid. In addition, an audit may reveal that certain services are not even billed anymore because the coders knew they wouldn't be paid. This is lost revenue that could have been negotiated for payment.

If you determine that a contract is no longer practical for your practice, you may renegotiate the contract, close your practice to new patients with that particular insurance, or even terminate the agreement. In any case, you will need to notify the carrier well in advance of any action and be sure to fulfill the obligations under the agreement.

You can still contract with managed care companies and accomplish the goal of making your practice accessible to the patients you are here to serve. Remember, be diligent about evaluating new contracts, negotiating good terms and auditing contracts periodically. Your contracts will be assets to your practice.

Stimulus Package Changes COBRA Procedures



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



UNITED STATES DEPARTMENT OF LABOR

The enactment into law on February 17 of HR 1, The American Recovery and Reinvestment Act of 2009 (ARRA), provides for significant temporary COBRA premium reductions for eligible employees and imposes new notice requirements on employers. The Act became effective March 1, 2009.

HR 1 establishes a 65% government subsidy for eligible workers towards their COBRA coverage for up to nine (9) months. The Treasury Department will administer the subsidy, providing employers or health plans with a credit against payroll taxes for the cost of the subsidy. Employees who were involuntarily terminated between September 1, 2008, and December 31, 2009, with annual income less than \$125,000 (single) or \$250,000 (couples) are eligible. Additionally, the employee, not the employer, will be responsible for abiding by the salary cap that determines eligibility. Should an employee accept COBRA coverage when they are ineligible, they will have to remit the subsidy to the federal government through their tax returns.

Hence, under the new law, eligible former employees, enrolled in their employer's health plan at the time they lost their jobs, are required to pay only 35 percent of the cost of COBRA coverage. Employers must treat the 35 percent payment by eligible former employees as full payment, but the employers are entitled to a credit for the other 65 percent of the COBRA cost on their payroll tax return.

Qualified individuals who initially declined COBRA coverage have an additional 60 days after they receive notice of the special election period to receive the subsidy. Should an employee subsequently elect coverage, the effective date of coverage would begin March 31, 2009.

Employers must amend their COBRA Election Forms to include information on the premium reduction for future qualifying COBRA events. In addition, supplemental notices must be given no later than April 17, 2009, to all former employees (and their qualified beneficiaries) who have been involuntarily terminated since September 1, 2008, informing them of the opportunity for a premium reduction.

Employers must maintain supporting documentation for the credit claimed. This includes documentation of receipt of the employee's 35 percent share of the premium. In the case of insured plans, this includes a copy of an invoice or other supporting statement from the insurance carrier and proof of timely payment of the full premium to the insurance carrier, as well as a declaration of the former employee's involuntary termination.

The Employer's Quarterly Federal Tax Return (Form 941) has been modified to allow employers to claim the new COBRA premium assistance payments credit, beginning with the first quarter of 2009.

The new COBRA subsidy provisions also apply to insurers required to offer continuation coverage under state law similar to the federal COBRA. This is generally an employer with less than the 20 employees, as required of COBRA.



Thank You!

"We appreciate our clients referring our services to their colleagues. We continue to be honored with this manner of obtaining new business and are grateful to each of you."

Paul King, President

New Business

Women's Care	Tennessee	Urgent Care Center	Florida
OB/GYN	Florida	Sports Medicine Clinic	Florida
Women's Health Center	Louisiana	Podiatry	Louisiana
Neurology	Tennessee	Family Medicine	Georgia
Eye Care	Tennessee	Primary Care	Florida
Orthopedic	Tennessee	Dental	Tennessee
Children's Clinic	Louisiana	Community Health Care	Virginia
Cardiology	Tennessee	Family Practice	Kentucky
Internal Medicine	Tennessee	Internal Medicine	Florida
Dermatology	North Carolina	Sports Medicine	Georgia
Weight Loss Clinic	Florida	Sports Medicine	New Mexico
Family Medicine	South Carolina	Rheumatology	Georgia
Primary Care	South Carolina	Dermatology	Tennessee
Pediatric Group	Tennessee	Gastroenterology	Tennessee



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