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The Business of Medicine Newsletter

"Leave the Business of Medicine to Us"

Inside DoctorsManagement: Message from the President

The Future of Primary Care Medicine:
"Your Place In The New World"

Primary care providers are faced with a new demand: hospitals wanting to hire or acquire their private practices to bring them in-house as full-time employees to work alongside with specialists. This measure is being done because there are significant rewards that will be provided under the new law to teams of doctors who are able to provide a higher quality of care at a lower cost. Hospitals recognize the importance of primary care providers and are working diligently to bring these providers in-house.

The other big trend popping up are Accountable Care Organizations (ACO). These organizations will play a significant role under the new health reform law. Just as in the 90s, primary care physicians are going to act as the gatekeeper to control referrals and the ordering of expensive medical tests. However, the goal of an ACO is so much more!

So, what is an ACO? An ACO is a network of doctors and hospitals that share responsibility for providing care to patients. In the new law, an ACO would agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years.

An ACO would bring together the different component parts of care for the patient – primary care, specialists, hospitals, home health care, etc. – and ensure that all of the parts work well together. This eliminates the need for patients who to get their health care in parts and brings it all under one group. It is going to boil down to ACOs proving that the overall product they are creating and providing works better and costs less.

Primary care physicians who have been at this for an extended period of time will ultimately have to figure out how to change the way they have practiced medicine for decades. This isn't always an easy task. The rules are changing and to ensure your place in this industry, you have to start figuring out what you want your practice to look like in the future and if remaining in private practice is still a viable options.

While becoming a salaried employee comes with greater financial security, there are tradeoffs. One of the biggest is that you have less autonomy and individual freedom.

You often lose control over how many patients you are required to see during a given day, week or month. When you become an employee, it all becomes about the bottom line for the organization.

The time is now for you to begin the strategic planning because hospitals are moving quickly to add to their primary care staffs. If you want to know if joining a hospital is the right direction for your practice, there are those of us out here ready to help you fully understand the impact of your decision to stay in private practice, join an ACO or join a hospital staff.

In 2008, about half of physician practices were hospital-owned, according to industry reports. As of last fall (2012), new reports surfaced and found that 74 percent of hospital executives are planning to hire more doctors in the next 12 to 36 months and guess who the "Belle of The Ball" will be? Primary care doctors!

Yours in Success,

Paul King
President
DoctorsManagement, LLC

DOL Delays Its Required Notice of Insurance Coverage

On January 24, 2013, the Department of Labor (DOL) announced that it was delaying the Patient Protection & Affordable Care Act (PPACA) requirement that all employers provide their employees with information about the availability of health insurance and premium tax credits through insurance Exchanges. PPACA required that the Notice be distributed by March 1, 2013, but, as has been widely anticipated, the DOL has delayed the requirement, announcing that it anticipates implementing the requirement in late summer or fall of 2013. The DOL stated that it is "committed to a smooth implementation process including providing employers with sufficient time to comply" with the Notice provision. Additionally, the DOL noted that the Notices will be more useful to employees in the fall, as that will coincide with the open enrollment period for Exchanges. The DOL did not commit on when it will issue a new deadline, but did say that it will provide "adequate time to comply."

PPACA contemplates that each state will create a health insurance Exchange, but about half the states have opted not to create an Exchange. The federal government will create and operate Exchanges where there is no state-run Exchange, but so far it is unclear how or when the federal government will get these Exchanges up and running in time for the planned October 2013 open-enrollment period.

When the notice mandate goes into effect, current employees

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DOCTORS MANAGEMENT
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Special Features

Let Us Show You How to Get Back to Being a Doctor

Inside this issue:

2012 American Taxpayer Relief Act—Businesses

As 2012 ended, the national debate focused on the expiration of the Bush-era tax cuts and the so-called fiscal cliff. On January 1, 2013, Congress passed, and President Obama signed the next day, the American Taxpayer Relief Act. The new law includes some valuable business tax incentives. Many of these business tax incentives are temporary so taxpayers have a limited window in which to maximize their potential tax savings.

Tax rates

Depending on how a business activity is structured, it may be taxed as a corporation or its owners may pay taxes at the individual rates. The American Taxpayer Relief Act permanently extends the Bush-era income tax cuts except for single individuals with taxable income above $400,000; married couples filing joint returns with taxable income above $450,000; and heads of household with taxable income above $425,000. Income above these thresholds will be taxed at a 39.6 percent rate, effective January 1, 2013. The $400,000/$450,000/$425,000 thresholds, which will be adjusted for inflation after 2013, are also used to determine the point at which the maximum tax rate on capital gains and dividends for an individual rises from 15 percent to 20 percent.

Bonus depreciation

Bonus depreciation is one of the most important tax benefits available to businesses, large or small. In recent years, bonus depreciation has reached 100 percent, which gave taxpayers the opportunity to write off 100 percent of qualifying asset purchases immediately. For 2012, bonus depreciation remained available but was reduced to 50 percent. The American Taxpayer Relief Act extends 50 percent bonus depreciation through 2013. The American Taxpayer Relief Act also provides that a taxpayer otherwise eligible for additional first-year depreciation may elect to claim additional research or minimum tax credits in lieu of claiming depreciation for qualified property.

While not quite as attractive as 100 percent bonus depreciation, 50 percent bonus depreciation is valuable. For example, a $100,000 piece of equipment with a five-year MACRS life would qualify for a $60,000 write-off: $50,000 in bonus depreciation plus 20 percent of the remaining $50,000 in basis as "regular" accelerated depreciation, taking into account a half-year convention.

Bonus depreciation also relates to the vehicle depreciation dollar limits under Code Sec. 280F. This provision imposes dollar limitations on the depreciation deduction for the year in which a taxpayer places a passenger automobile/truck in service within a business, and for each succeeding year. Because of the new law, the first-year depreciation cap for a passenger automobile/truck placed in service in 2013 is increased by $8,000.

Bonus depreciation, unlike Code Sec. 179 expensing (discussed below), is not capped at a dollar threshold. However, only new property qualifies for bonus depreciation. Code Sec. 179 expensing, in contrast, can be claimed for both new and used property and qualifying property may be expensed at 100 percent.

Expensing

The American Taxpayer Relief Act enhances or extends several expensing provisions. These include Code Sec. 179 small business expensing, 15-year recovery period for qualified leasehold and retail improvements and restaurant property, special expensing rules for film and television productions, and a seven-year recovery for motorsports complexes.

Code Sec. 179 expensing

In recent years, Congress has repeatedly increased dollar and investment limits under Code Sec. 179 to encourage spending by businesses. For tax years beginning in 2010 and 2011, the Code Sec. 179 dollar and investment limits were $500,000 and $2 million, respectively. The American Taxpayer Relief Act boosts the dollar and investment limits for 2012 and 2013 to their 2011 amounts ($500,000 and $2 million) and adjusts those amounts for inflation. Keep in mind that the increase is temporary. The Code Sec. 179 dollar and investment limits are scheduled, unless changed by Congress, to decrease to $25,000 and $200,000, respectively, after 2013. The new law also provides that off-the-shelf computer software qualifies as eligible property for Code Sec. 179 expensing. The software must be placed in service in a tax year beginning before 2014. Additionally, the American Taxpayer Relief Act allows taxpayers to treat up to $250,000 of qualified leasehold and retail improvement property as well as qualified restaurant property, as eligible for Code Sec. 179 expensing.

Leasehold, retail and restaurant property

The American Taxpayer Relief Act extends for 2012 and 2013 the special treatment of qualified leasehold and retail improvement property and qualified restaurant property as eligible for a 15-year recovery period. Otherwise, this property generally is depreciated over a 39-year recovery period. To take advantage of this enhanced expensing, the qualified property must be placed in service before January 1, 2014.

Work Opportunity Tax Credit

The WOTC expired after 2011 with an exception for employers that hire qualified veterans. The American Taxpayer Relief Act extends the WOTC (including the special rules for veterans) through 2013. Each new employee hired from a targeted group generally entitles an employer to a credit equal to 40 percent of first-year wages, up to $6,000.

Planning opportunities

Unlike many of the individual incentives in the American Taxpayer Relief Act, many of the business tax benefits are not made permanent. As a result, planning to maximize tax savings under these extended incentives takes on a new urgency.

T. Blake King , CPA, MAcc, CVA
Partner, DoctorsManagement, LLC

DM University has launched new courses. For more information log on to www.dmuniversity.net

Affecting Change in the Medical Practice— Are you an effective leader?

With everyone focusing on revenues and denials management, many of the fundamentals of running a medical practice get overlooked. Many of these issues, if left unattended for any duration, can lead to significant issues down the road.

Practices are facing skeleton crews, larger workloads and the inability to increase wages for your staff. Anxieties are running high and practice managers find themselves more often than not having to walk a fine line so as not to chase off any of their employees. The days of having high rates of turnover in a medical practice have slowed due in part to practice managers and physician owners finally understanding the cost of losing an employee. The costs were not just tied to the amount of money they had invested into the individual but were really tied to revenues and productivity.

While my primary focus for the last decade has been on compliance (i.e. chart auditing and audit/appeal representation) for physician and hospital groups, I really found myself on a lot of engagements getting involved with the Revenue Cycle Management of the practice. I found myself playing more of the role of a coach, teaching managers to be effective leaders and helping them to maximize the skills of their employees rather than focusing on the negatives. One of the things I quickly realized is that managers, in many cases, function more as firefighters, which detracts from their ability to really lead their staffs towards success. Oftentimes we are more focused on the type of frosting on Susie's birthday cake than with how many months out we are with our A/R. This cannot be if we are to drive a successful business.

What is lacking in most practices these days is effective leadership. "*Leadership is the skill of attaining predetermined objectives with and through the voluntary cooperation and efforts of other people." There are three key words in this definition:*

- **Skill**: Leadership is a skill because one may learn management techniques and, through practice, perfect them
- **Attaining**: Leadership requires achievement. Leadership is not the skill of working hard; it is a matter of giving a best effort and accomplishing the goal. Good leaders always must focus on the results.
- **Voluntary**: An effective leader is able to enlist and motivate employees to accomplish desired aims voluntarily.

You can learn to be a leader if you know who you are, how people respond to you, what needs to be done, and you take the necessary steps to get it done using your resources. To be an effective leader one must understand you have to do the following: Enable others to act, Inspire a shared vision, Model the way, Encourage others to succeed, Teach, Coach, Manipulate and Consult.

Study after study has shown that strong leadership is not only one of the best recipes for survival and success in the business world, it is a key part of effectively navigating the world of small business as well! Researchers at a leading institute indicate 30-35% of leadership is genetic. Additionally, researchers indicate that "Much more leadership ability is clearly attributable to things like education, life events, and trigger moments!" So how do we best define leadership? Well, you could say, "Leadership is the interaction between leaders and followers and how one achieves direction, alignment, and commitment in the other." Or you could say that "Leadership is where you are creating an environment where your people go beyond the norm and do more than even they would have expected." Or even still, you could say that "Leaders make others feel like they are more and so they then want to do more." Any way you cut it, effective leadership has to come from the top and there needs to be a level of consistency with your message, otherwise you will leave your staff guessing at what you are really trying to convey.

This leads me to the next part of the discussion, leadership vs. managing… What is the difference between managing and leading? The answer according to the U.S. military is this: People are led, things are managed. It is critical to understand that managing is looking retrospectively, or backward; basically, being reactive. Leadership is forward-looking, seeing what is next. Stanley C. Allen said, "Leadership involves remembering past mistakes, an analysis of today's achievements and a well grounded imagination in visualizing the problem of the future."

When I lecture on effective leadership, I often talk about core competencies. In my mind there are four core competencies that all managers must possess in order to be successful. All of these are learned except for one, which plays a critical role in whether one is capable of leading and ties directly back into the point I was making earlier about genetics and its role in one's effective leadership:

- Clinical (learned)
- Financial (learned)
- Marketing (learned)
- Psychological (innate)

The takeaway point is this, it's more than just genetics that makes an individual an effective leader and even if you're not born with it, you can still learn to be an effective leader.

There are four main types of leaders.(*There are a few other types of leaders as well that I am not addressing in this article and they include: the absolute dictator, the benevolent leader, the unpredictable leader, the one who avoids responsibility, and the democratic leader*) Each of these four types of leaders its pros and cons, but how do you know what type of leader you are? Take a look at each of these and see where you fall. Maybe you are a combination of one or two or all of them. There is no one right answer as to what makes an effective leader, but it is important to understand the type of leader you are so you know how your staff views you and, more importantly how you view yourself.

The first of these is the Drill Sergeant. The Drill Sergeant's positive attributes are that they act decisively, they are results-oriented, they value consistency and past experience, and they show determination. The Drill Sergeant's attributes that can be viewed as negative include that they value action above wisdom, they show impatience, they can be abrupt or even rude, they can be stubborn or unwilling to adapt, and they don't listen to subordinates.

The second is the Coach. The Coach's positive attributes are that they tend to act logi-

Affecting Change in the Medical Practice, Cont.

cally and methodically, they are team-oriented, they value teaching and delegating tasks, and they display long-term commitment. The attributes that the Coach displays that can be viewed as negative include that they tend to employ a hierarchical and controlling attitude, that individual performance can go unrecognized, they dump too much responsibility too early, and they can set unrealistic, overly ambitious goals.

The third is the Negotiator. The Negotiators positive attributes are that they tend to acts cautiously, they avoid unnecessary risks, they are people oriented, they embrace change and creative input, and they demonstrate an openness and willingness to listen. The Negotiator's attributes that can be viewed as negative include they can miss opportunities by waiting too long, they want to be liked more than they want to lead, and they lack structure and organizational skills, and they suffer from "paralysis by analysis."

The fourth and final type of leader is the Innovator. The Innovator's positive attributes are that they act intuitively, they are vision oriented, they value enthusiasm and big ideas, they display charisma, and they are very personable. The Innovator's attributes that can be viewed as negative include that they can be impetuous, they take unnecessary risks, they lack follow-though and are easily distracted, they can overlook key details and be too optimistic, and finally, they rely solely on charm as a way to motivate.

Were you able to identify the type of leader you are from the above? If so, do you now have a better understanding as to how you may be perceived by your staff? Do you have what it takes to affect change in your organization?

I want to share with you a story by an unknown author that I believe is totally appropriate for this article. It allows me to finish by making you chuckle but also by making you very aware that this may be the story of your practice; so, here goes… This is a story about four people named Everybody, Somebody, Anybody and Nobody. There was an important job to be done and Everybody was sure that Somebody would do it. Anybody could have done it, but Nobody did it. Somebody got angry about it, because it was Everybody's job. Everybody thought Anybody could do it, but Nobody realized that Everybody wouldn't do it. It ended up that Everybody blamed Somebody when Nobody did what Anybody could have… What does this story tell us? If you are not an effective leader providing a clear vision for your staff then you can wind up nowhere!

Sean M. Weiss
Vice President/Chief Compliance Officer
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NAMAS is proud to announce that they have joined with BC Advantage to offer our NAMAS members free subscriptions to BC Advantage. Special thanks to Storm Kulhan, the CEO of BC Advantage! DoctorsManagement's own Sean Weiss was on the cover of BC Advantage in February as he was fortunate enough to have a personal interview with Newt Gingrich.

Think Before You Speak

With an endless number of words in the English language, we have many options for communicating information to patients and our colleagues. Often, we are in such a hurry to move on to the next patient or task, we do not realize how our words can affect others.

In healthcare, we deliver good and bad news. The delivery and choice of words of the information can influence the reactions going forward.

Studies have shown that people respond positively to active words rather than negative words like "cannot" and "necessary." Just simply replacing "I do not know" with "Let me check on it" can change the perception of the patient from annoyed to trusting. Let's look at the common phrase "Let me see what I can do." When a patient hears this phrase, the expectation is set very low. When you simply change the statement to "I'd be delighted to help you," you have now changed the expectation from low to confidence that you are actually interested in helping.

Below are examples of positive phrase options.

Phrases to Avoid	Replacement Phrases
I do not know	Let me check on it
Unfortunately,	As it turns out,
We cannot….	We are able…
That is not my job.	Let me connect you with that department.
You are required…	Can you please…
I can…	I will...

Saying the positive phrases will only get you so far; it is also important to look at the delivery of the words. Delivering the words in an upbeat and cheerful manner will suggest your desire to help and can influence the reaction. Of course, depending on the circumstances, you should act in a natural manner and not disingenuous.

Next time you are speaking with a patient or even your supervisor, try to stop and think before you say something that could simply be replaced with a positive phrase. You might be surprised about the difference in the reaction.

Lauren King,
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DoctorsManagement, LLC

Record Keeping

E-mails concerning OSHA's recordkeeping requirements are filling our inboxes. We are constantly being reminded to post that 300A form. Please be assured that medical and dental offices and laboratories have been granted a "partial" exemption from those requirements. Here is that assurance straight from OSHA's website. The numbers on the left (below) are the Standard Industrial Classification (SIC) Codes.

"Establishments classified in the below SICs are exempt from most of the recordkeeping requirements, regardless of size. Establishments exempt from preparing and maintaining records are still required to report fatalities and catastrophes to OSHA …….

801 Offices and Clinics of Medical Doctors
802 Offices and Clinics of Dentists
803 Offices of Osteopathic Physicians
804 Offices of Other Health Practitioners
807 Medical and Dental Laboratories
809 Health and Allied Services, Not Elsewhere Classified"

The "partial" exemption reserves OSHA's authority to require employers on the exempt list to keep those records upon request from OSHA. This happens when OSHA needs to gather statistics as part of their quality improvement program, evaluating where they should focus their resources.

When OSHA determines that a certain type of employer, maybe in a particular industry or in a certain geographical area, should participate in this program, they inform the employer in advance, providing all the instructions and forms needed. This is usually done in December or January, requiring the employer to submit the completed forms in January or February of the following calendar year.

If you should get this directive, please do as requested. Failure to return the data could trigger an onsite inspection.

What are the records referenced here? The OSHA 300 and 300A forms. OSHA 300 is the log used to document occupational injuries and illnesses as they occur. The 300A is a summary, listing numbers only.

Employers not on the exempt list, which includes hospitals, nursing homes, and ambulatory surgery centers, must keep these records every year. They do not have to send them to OSHA unless OSHA asks them to do so. OSHA is currently focusing on nursing homes and not private practices; however, no employer is exempt from an exception if there is an employee complaint!

So what to do about all those e-mails? Delete them!!!

OSHA Must-have Records

Here are the documents that every employer must have should OSHA decide to visit:

- Hazard Assessment and Personal Protective Equipment Assessment, certified by the employer
- Written exposure control plan to cover the hazards found in the assessment
- Annual review of the Bloodborne Pathogen exposure control plan
- Documentation of training as required by the various standards
- List of all hazardous chemicals, updated yearly, and detailed documentation of exposure incidents
- OSHA poster displayed where all employees can access it, not covered by other items, and emergency exit routes posted in main hall
- Employee medical records that include the employee's name, Social Security numbers, job title, documentation of Hepatitis B vaccination (including ability for employee to receive the vaccine and post-vaccination titer), and exposure records
- Annual sharps evaluation, which includes a list of all sharps used and sharps injury log (summary) if required by a State law or if the employer is subject to the 300/300A record keeping.
- OSHA 301 (see page 4) - used to document work-related, recordable injuries and illnesses. This form, or an equivalent, must be completed within 7 days of the incident. Your workers' compensation or other insurance form may be used if it has all the information that is on the 301.

Reporting to OSHA

When and what must employers report to OSHA?

1. Workplace incident that results in one or more employee fatality. This includes a fatal employee heart attack triggered by a job-related incident.
2. Workplace incident that results in in-patient hospitalization of three or more employees.

These situations must be reported orally to OSHA within 8 hours of the occurrence or the employer's knowledge of the situation. Use OSHA's toll free number to immediately report these incidents or any situation that poses immediate danger to employees: 1-800-321-OSHA (6742) or TTY 1-877-889-5627

Ann Bachman, CPC (AMT), MT (ASCP)
Director of OSHA/CLIA/HIPAA Dept.
Partner, DoctorsManagement, LLC

DOL Delays, cont.

must receive the notice in writing. New hires must receive the notice at the time of hire. The notice may be distributed electronically or via hard copy. The regulations require employers covered by the Fair Labor Standards Act (FLSA) to provide the notice.

The notice is required to have the following information:

- Services provided by the Exchanges and contact information for the Exchanges.
- Possibility of losing employer contributions to any employer-sponsored health plans if insurance is purchased through an Exchange.
- Employee's eligibility for premium tax credits or cost-sharing reductions in situations where the employer's share of the employer-sponsored health plan is less than 60% of the total costs and the employee purchases a qualified health plan through an Exchange.
- Possibility that a portion or all of an employer's contributions to employer-sponsored health plans may be excluded from income for tax purposes.

The Department of Health and Human Services (HHS) has indicated that model notices will be available; however, as of January 2013, a release date has not been announced. The Department of Labor (DOL) has not yet indicated whether a model notice will be provided.

In the same vein, and for purposes of early communication, the Secretary of Health and Human Services recently announced its relaunching of HealthCare.gov to include new information about the Healthcare Insurance Exchanges. Families and small businesses will be able to easily compare and purchase high-quality health insurance plans starting October 1, 2013, with coverage beginning January 1, 2014. Individuals will be able to buy insurance from qualified private health plans and check if they are eligible for a new kind of tax credit to help pay their premium costs. The site encourages people to sign up for emails or text message updates so they don't miss a thing when it comes time to enroll. If a state is running its own marketplace (Exchange), Healthcare.gov will redirect people to the right place.

So, for now no action is required by you as it pertains to the insurance coverage notice. However, be on the lookout for future updates on this and other significant health care reforms that are due to be implemented in less than twelve months..

Philip Dickey, MPH, PHR
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What's in your wallet?

If the answer is not enough money, then read on. Establishing a charge for your services has long perplexed most practice administrators especially those administrators, in pediatric practices and at ASCs that are out-of-network providers. Typically, most fee schedules are set by using some multiple of Medicare. Sometimes I've been told that the doctor and his office manager just guess at a rate. While guessing is definitely not the preferred way to establish a charge for your services, using a multiple of Medicare does not always answer the two most important questions:

- Is the charge for my service set high enough to capture my highest paying payer's reimbursement?
- Is the charge set high enough to cover the cost of the service?

As a seasoned managed care contract negotiator who has reviewed thousands of fee schedules, 99.9% of the time we find at least one charge that is set too low to capture all the available reimbursement, and 95% of the time it is multiple charges and thousands of dollars left on the table because the charge is too low. Managed care companies will not pay you the negotiated rate if your charge is lower. The reimbursement is always the lesser of (a) your billed charge or (b) the negotiated rate, so if your billed charge is less than the negotiated rate, you are paid the lesser amount. As part of our managed care services, we discover this when we compare your billed charge to the payers allowable reimbursement. It can also be discovered by reviewing your EOBs. If something pays at 100% of the billed charge, there is probably a problem.

The cost of service is also very important. What you charge for your services should reflect the value of the services, including the costs involved in delivery of the services. It is very important that patients, payers, regulators, and other reviewers have a clear picture of how your charges are determined, and cost is a very important component of the charge. A fee schedule that is based not only on a multiple of Medicare but on a cost of service formula sends a strong signal that your charges are fiscally responsible and determined by a sound methodology.

Because CMS has provided doctors with a methodology for costing their services (RBRVS), what better way to establish a charge then to have it based on the RBRVS data elements? It's hard for any payer or regulator to argue with a costing methodology that the Federal Government has established. As part of our managed care review, we compile the necessary information to complete a cost analysis, using RBRVS, for each of your CPT codes.

In RBRVS, services are ranked according to both the physician effort (Work RVU) and the practice expense (PE RVU), and the malpractice insurance expense (MP RVU). The RBRVS values are converted into dollars by multiplying the RVU for each CPT code by a dollar conversion factor that is unique to your practice.

The details of how all these calculations are made and the methodology for establishing the values and conversion factors are complex and beyond the scope of this article. None-the-less, the RBRVS methodology is the best method for establishing a fee schedule for both a physician office and an ASC. Policy adopted by the AMA House of Delegates states that a RBRVS that is annually updated and rigorously validated could be a basis for a non-Medicare based fee schedule.

The chart below details the analysis involved in establishing a cost for each CPT code.

CPT	DESC	UB	PE RVU	MP RVU	WRK RVU	PE &MP RVU	PE	PE/MP Cost per CPT	Wrk EXP	WRK EXP per CPT	Est. Cost per CPT
20550	Inj Tendon Sheath /lig	6	0.86	0.08	0.75	0.94	5.64	$41.04	4.50	$19.61	$60.65
20551	Inj sinus Tract x-ray	3	0.92	0.08	0.75	1.00	3.00	$43.66	2.25	$19.61	$63.27
20552	Inj Trigger pt 1/2 muscl	16	0.88	0.07	0.66	0.95	15.2	$41.47	10.56	$17.26	$58.73

RBRVS is applicable for all physician specialties, especially pediatrics where few Medicare fees exist and at ASC's that are out-of-network providers. As the government looks for ways to control healthcare costs, a sharp focus will be placed on the fees charged by out-of-network providers.

In addition to providing the basis for a physician fee schedule, the cost per unit methodology can be used to evaluate a payer fee schedule and help you determine if a contract pays enough to cover your costs. This same methodology can be used for Grouper reimbursement at ASCs.

For more information on establishing your physician or ASC fee schedule or using RBRVS to analyze contract reimbursement rates, contact Bob Rotar, Director of Managed Care at DoctorsManagement.

Bob Rotar
Director of Managed Care
DoctorsManagement, LLC

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Dermatology practice—Humboldt, TN
Oral Surgery practice—Knoxville, TN
Gastroenterology practice—Memphis, TN
Family Medicine practice—Pigeon Forge, TN
Capital Investment group—Fairfax, VA
Infectious Disease practice—Charlotte, NC
Urgent Care practice—La Grange, KY
Podiatry practice—San Antonio, TX
Oral Surgery practice—Fisherville, VA
Dermatology practice—Danville, VA
Cosmetic Surgery practice—Milwaukee, WI