

AMERICAN COLLEGE OF SURGEONS

# Resources for the Practicing Surgeon: **THE PRIVATE PRACTICE SURGEON**

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100+ years

AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality:  
Highest Standards, Better Outcomes*



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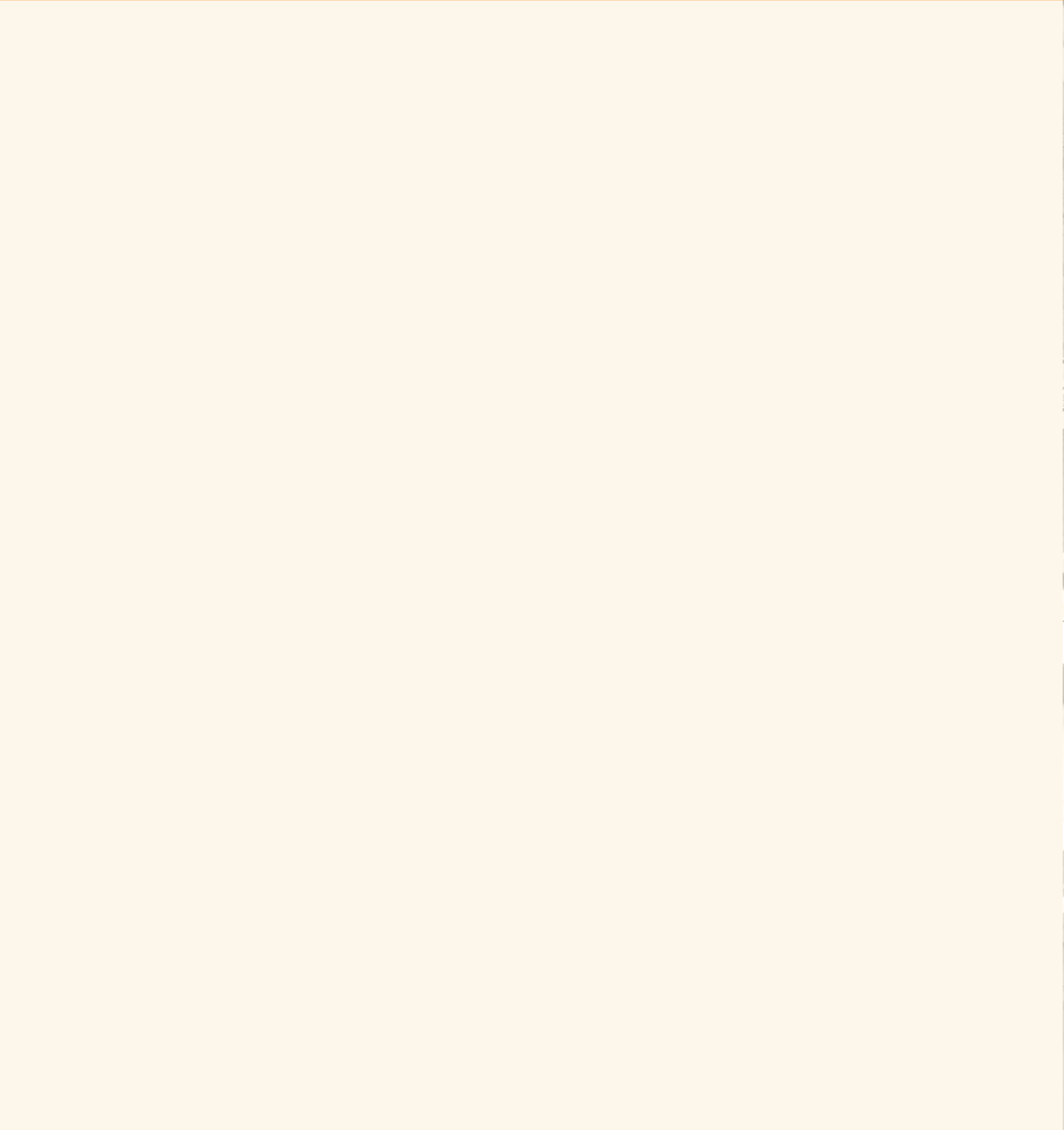
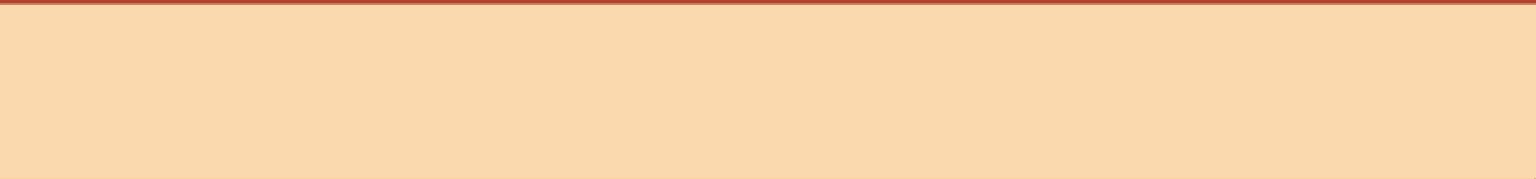
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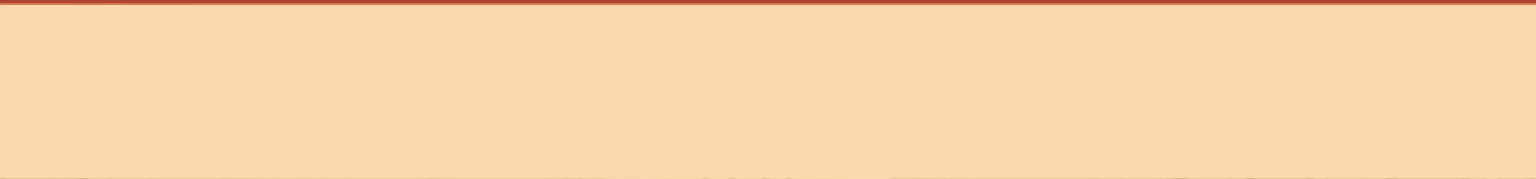


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# INTRODUCTION



## INTRODUCTION

While many markets continue to see increases in the institutional employment of physicians, there still remains a substantial number of surgeons in private practice, and many of those surgeons are operating successfully in that environment. How do they do it? What is the “secret sauce” that helps them maintain a successful private practice?

As the economy continues to put pressure on physicians and facilities to improve patient satisfaction, control quality, and increase value while reducing costs, it is important that Fellows of the American College of Surgeons (ACS) remain well-informed about the related complexities of different practice types, along with the various clinical and regulatory nuances associated with each setting. Following the positive reception of *ACS Resources for the Practicing Surgeon: The Employed Surgeon*, published by the College’s Division of Advocacy and Health Policy (DAHP) in 2018, the ACS received many requests from members to produce a similar resource for private practitioners. In response, the College’s General Surgery Coding and Reimbursement Committee collaborated with Fellows and practice management experts to capture valuable lessons, tips, and insights that can help surgeons thrive in private practice.

*ACS Resources for the Practicing Surgeon, Volume II: The Private Practice Surgeon* provides an overview of various private practice business arrangements, financial management and revenue cycle processes, relevant health care laws and rules, and mechanisms to ensure the ongoing prosperity of a practice. Understanding these issues and how they could affect your career and your patients is critical to the successful establishment and maintenance of a private surgical practice.

## Macroeconomic Trends Impacting the Practice of Surgery

There are a number of forces that impact the private practice of surgery. It is important to understand what those forces are and how they affect the private practice surgeon in order to plan for success in your practice.

### *Increasing Costs of Health Care in the U.S.*

American health care costs eclipse those in all other major industrialized countries, both on the basis of cost per dollar of gross domestic product (GDP) and on a cost-per-citizen basis (see Charts A and B, page 9).<sup>1,2</sup> In addition, these trends are projected to continue to grow and consume more of the nation’s GDP. According to the Centers for Medicare & Medicaid Services (CMS), national health spending is projected to grow at an average rate of 5.5 percent per year and a 0.8 percentage point faster than GDP annually; as a result, the “health share” of GDP is expected to rise from 17.9 percent in 2017 to 19.4 percent by 2027.<sup>3</sup>

There is continued concern that health care costs will impact the United States’ ability to compete internationally. As a result, over the past two decades there has been an exponential growth in efforts by government and private insurers, Congress, and multiple presidential administrations to contain and lower the cost of care by increasing competition and reducing utilization and payment for services.

### *Reduction in Payment for Surgical Services*

Payment via the fee-for-service process has been the main source of income for surgeons. The primary payor has been Medicare, which uses the resource-based relative value scale (RBRVS), and over time that method has been adapted in one form or another by most major private payors. Thus, the RBRVS relative value unit (RVU) and the conversion factor (CF) have become surrogates for the income earned by physicians.





# INTRODUCTION

Chart A. GDP per Capita and Health Consumption per Capita, 2017 (U.S. Dollars, PPP Adjusted)

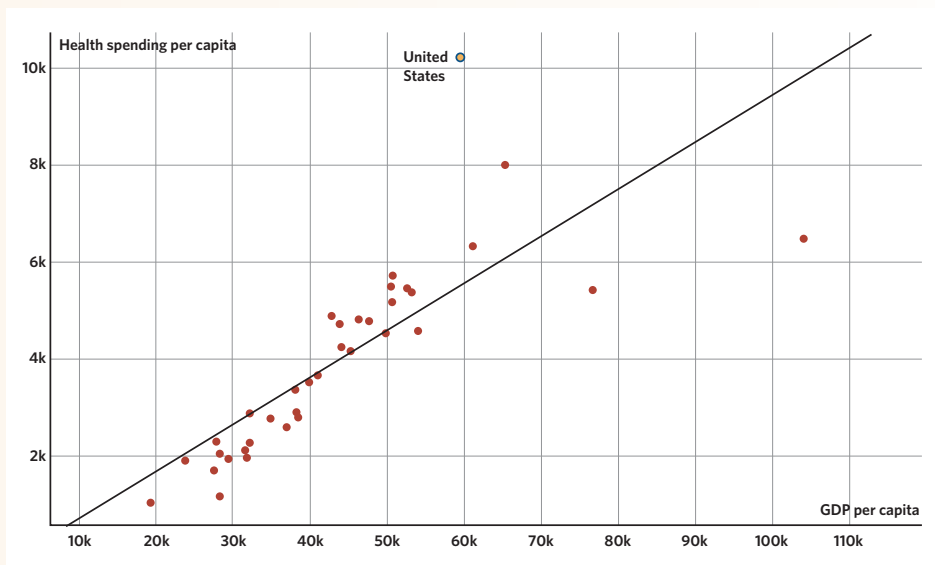
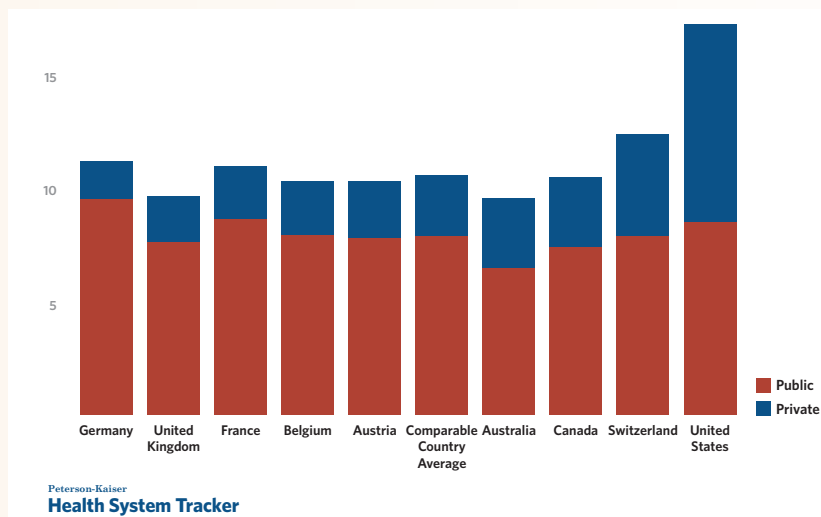


Chart B. Total Health Expenditures as Percent of GDP by Public vs. Private Spending, 2016





## INTRODUCTION

The Medicare CF has remained essentially stagnant since the RBRVS was introduced in 1992, at which point the CF was \$31 per RVU. While surgeons briefly enjoyed an increase in the CF from 1994 to 1997, since then they have been paid between \$35 and \$36 per RVU.<sup>4</sup> During the same time period, the average inflation rate in the United States caused the cost of goods to increase by almost 78 percent.<sup>5</sup>

If the 1992 Medicare CF of \$31 paid to physicians had kept pace with national inflation, the 2019 Medicare CF would be \$57.49 per RVU. Thus, in 2019, self-employed physicians are now earning \$22 less for each RVU produced than they would have had the Medicare CF kept pace with the Consumer Price Index, which measures the average change over time in the prices paid by consumers for a market basket of goods and services.<sup>6</sup> Many private insurers have tied their reimbursement for physician services to the Medicare CF, usually as a percentage of Medicare payment for a given service. Thus, over time, surgeons have seen an erosion of the inflation-adjusted income essential to support their practices.

### **Health Care Reform and Increased Regulation**

Physicians today are inundated with a growing number of administrative requirements imposed by Congress, federal and state agencies, payors, and other entities, adding unnecessary barriers to providing essential services and increasing spending on nonclinical activities. While it is arguable whether any of these requirements have reduced the cost of health care, it is clear that they have increased the cost of *practicing* medicine. Many surgical offices have had to hire additional personnel just to handle prior authorizations, insurance verification, coding, billing, and claims management, among other processes. These overhead expenses go unreimbursed for the private practice surgeon, often resulting in a loss of revenue and a hindrance to practices' ability to maintain clinical operations.



To combat policies that impede surgeons' ability to provide timely and high-quality care, the College launched its Stop Overregulating My OR (SOMO) initiative, through which the ACS DAHP highlights specific regulatory and legislative actions that should be taken to reduce administrative burdens and enable surgeons to reinvest their time and resources in patients. Under the SOMO initiative, the DAHP has positioned the College at the forefront of the regulatory relief movement and has been invited by congressional and executive branch leaders to provide expert testimony on methods to reduce administrative burden and improve payment and quality measurement programs so that they work more effectively for patients and physicians. These efforts by the ACS have been successful in galvanizing policy changes—such as the removal of redundant or outdated clinical documentation requirements and the initiation of processes to make electronic health records (EHRs) interoperable—to ease administrative requirements and align regulations with the current practice of medicine.

### **Hospital Aggregation and Formation of Large Systems**

As pressures mounted on hospitals to cut costs, many resorted to merging with larger health systems to remain operational. These systems allowed the member hospitals to reduce duplicative administrative positions, purchase supplies and equipment at better rates, and in some cases shift whole service lines to one facility or another, further increasing efficiency and decreasing expenditures. In some areas of the United States, these systems were also able to use their broader footprint and market strength to negotiate better payment rates with private insurers.



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How does this affect surgeons? Hospital aggregation has caused smaller private practices to consolidate into larger group practices or to be acquired as employees of hospital systems. This shifting environment underscores the need for private practitioners to understand the employment landscape within their local markets to identify opportunities to ensure the sustainability of their practice.

### **Market Supply and Demand**

The supply and demand of surgical services are other important considerations for private practitioners. The surgical needs of a given patient population, along with the number of surgeons available to meet such needs, vary greatly across the United States, with some regions experiencing significant surgical workforce shortages. Location may be a key item to think about when reviewing your practice options; patient demand within the community, compounded by the maldistribution of surgeons across the country, can significantly affect a practice's prosperity.

Below are several ways to assess your environment and gauge the potential for a private practice to be successful in a particular area.

- **Degree of health maintenance organization (HMO) and preferred provider organization (PPO) penetration**—HMOs and PPOs typically don't flourish in areas without a lot of competition and therefore can serve as a rough measure of supply and demand. States with low HMO/PPO penetration may be more supportive of the private practice model (see Chart D, page 12).<sup>7</sup>
- **Percentage of states with one large insurer providing most coverage**—It may be more difficult for private practitioners to negotiate fair reimbursement rates in states where one or two large payors dominate the private insurance market, compared with states with a multitude of private payors (see Chart E, page 12).<sup>8</sup>
- **Population of surgeons in your area**—Fewer private surgical practices in a given area (adjusted for the surrounding patient population size) increases the likelihood of a private practitioner's success (see Chart F, page 13).<sup>9</sup>
- **Salaries of local surgeons**—In some instances, surgeons' salaries can reflect the amount of competition within a certain patient population. Lower salaries occur in areas of greater surgical workforce supply.

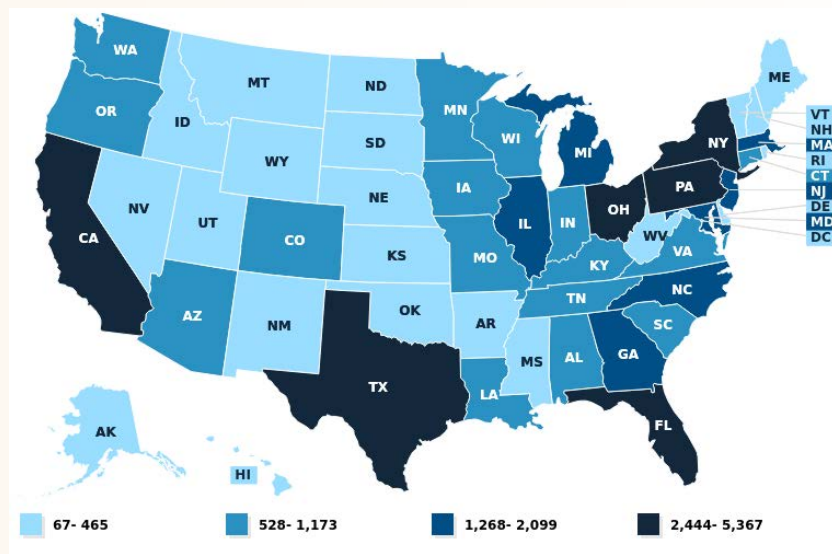






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Chart F. Professionally Active Surgeons in the U.S., 2019



## References

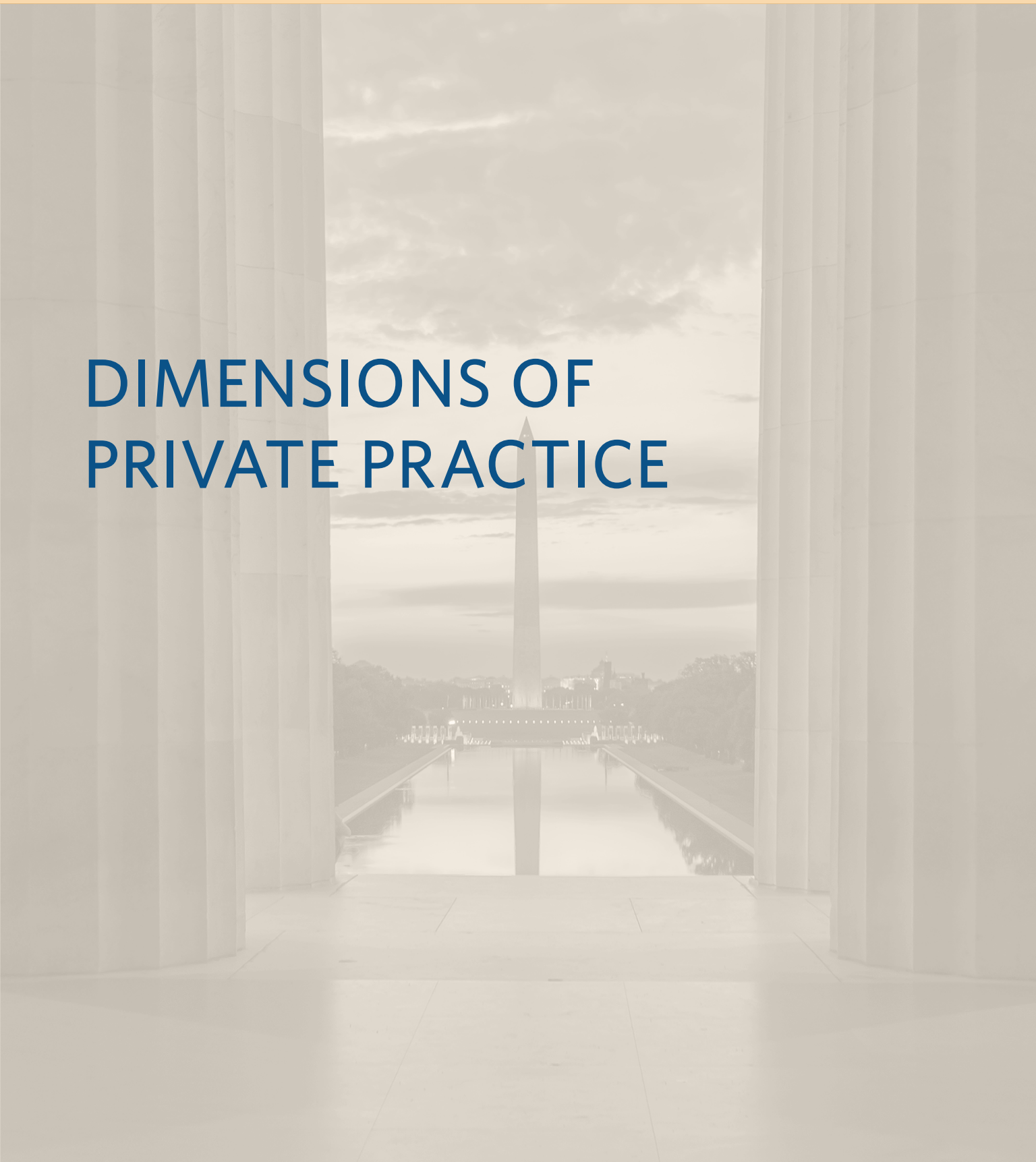
1. Sawyer B, Cox C. How does health spending in the U.S. compare to other countries? Peterson-Kaiser Health System Tracker. Available at: <http://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries>. Accessed October 9, 2019.
2. Ibid.
3. CMS Office of the Actuary National Health Expenditure Projections 2018-2027. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf>. Accessed August 19, 2019.
4. History of Medicare Conversion Factors. Available at: <https://www.ama-assn.org/sites/default/files/media-browser/public/physicians/practice-management/cf-history.pdf>. Accessed August 19, 2019.
5. Consumer Price Index, Bureau of Labor Statistics. Available at: <https://www.bls.gov/data/>. Accessed August 19, 2019.
6. Bureau of Labor Statistics Inflation Calculator. Available at: [https://www.bls.gov/data/inflation\\_calculator.htm](https://www.bls.gov/data/inflation_calculator.htm). Accessed August 19, 2019.
7. Kaiser Family Foundation. State HMO penetration rate. State Health Facts. Available at: <https://www.kff.org/state-category/health-insurance-managedcare>. Accessed October 9, 2019.
8. Kaiser Family Foundation. Market share and enrollment of largest three insurers. State Health Facts. Available at: [https://www.kff.org/private-insurance/state-indicator/market-share-and-enrollment-of-largest-three-insurers-individual-market/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Large st%20Insurer\\_\\_Insurer%20Name%22,%22sort%22:%22asc%22%7D](https://www.kff.org/private-insurance/state-indicator/market-share-and-enrollment-of-largest-three-insurers-individual-market/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Large st%20Insurer__Insurer%20Name%22,%22sort%22:%22asc%22%7D). Accessed October 9, 2019.
9. Kaiser Family Foundation. Professionally active specialist physicians by field. State Health Facts. Available at: <https://www.kff.org/other/state-indicator/physicians-by-specialty-area/?activeTab=map&currentTimeframe=0&selectedDistributions=surgery&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Accessed October 9, 2019.







# DIMENSIONS OF PRIVATE PRACTICE





## DIMENSIONS OF PRIVATE PRACTICE

“Private practice” can be a broad term with many different meanings depending on a given surgeon’s circumstances. In general, there are three dimensions of private practice that surgeons should be aware of, as each dimension has a unique set of challenges: (1) the various private practice settings, (2) the various forms of employment within a private practice, and (3) the various types of transitions to or from private practice.

Surgeons may choose to work for a solo or group practice in which the surgeon is self-employed or employed by the practice group, rather than by a hospital or health system. Such practices vary significantly in size, location, and mission. When deciding to open or join a practice, it is important to understand the different types of practice environments and the implications of each setting. Practices may differ in the amount of autonomy given to surgeons, expectations for clinical work and administrative responsibilities, and financial risks, among other factors. All across this spectrum, however, private practitioners usually have more authority over their own practice situation than institutionally employed surgeons.

### Private Practice Environments

#### *Solo Practice*

The private practice surgeon is a small business owner who must make business decisions. First and foremost, the surgeon must determine how he or she will charge for the services provided and submit a patient claim for payment; practices may work with external companies that specialize in medical claims processing, or the surgeon’s staff may themselves choose to become skilled in billing and coding. The surgeon must also negotiate annual payor contracts. Private practices are often at a disadvantage in these negotiations unless they offer some unique service, due to comparatively low patient volume relative to larger facilities. The surgeon can choose whether to participate in any insurance payment contract (including Medicare and Medicaid) or to remain out of network, and may opt out of certain federal quality reporting programs (sometimes because low patient volume excludes the surgeon, or volitionally with payment

of a penalty). The private practitioner can also generate income from outside sources, such as consulting, locum tenens work, insurance auditing, or ownership in an ambulatory surgical center (ASC), without running afoul of rules an institutional employer might impose. In order to cover emergency services and care for patients who may be underinsured or have no insurance at all, private practices often contract with hospitals for call pay, which can be remunerative if properly negotiated.

In addition, the surgeon must establish practice protocols and manage employee benefits. The independent surgeon will be able to determine his or her own work hours and vacation to a great extent and will have complete control over any staff. Although business management knowledge (finance, accounting, employment law, and so on) is not a prerequisite to opening a private practice, the surgeon will need to rapidly gain this knowledge—or perhaps hire an accountant with these skills—to be successful. Without a financial relationship with a hospital or health system, the private practice surgeon takes home all of his or her revenue, minus expenses. Solo practices can be unincorporated or can be incorporated as a limited liability company (LLC) or a professional limited liability company (PLLC), depending on state laws.<sup>1</sup>

The independent surgeon will be able to determine his or her own work hours and vacation to a great extent and will have complete control over any staff. The surgeon can choose whether to participate in any insurance payment contract (including Medicare and Medicaid) or to remain out of network. The surgeon may opt out of many federal quality programs (sometimes because low patient volume excludes the surgeon, or volitionally with payment of a penalty). The private practitioner can also generate income from outside sources, such as consulting, locum tenens work, insurance auditing, or ownership in an ambulatory surgical center (ASC), without running afoul of rules an institutional employer might impose. In order to cover emergency services and care for patients who may be underinsured or have no insurance at all, private practices often contract with hospitals for call pay, which can be remunerative if properly negotiated.



## DIMENSIONS OF PRIVATE PRACTICE

### **Small Group Practice**

Small group practices allow for improved economies of scale compared with solo practices. Different surgeons within a small group can develop themselves as experts in varied clinical areas to enhance service lines and thus increase practice revenue and patient satisfaction. In addition, small groups offer enhanced clinical support for surgeons, as members of the group can offer assist each other in the operating room (OR), provide internal consultations on tough cases, and share “on call” time. A small group setting also enables physicians and staff to spread out the administrative aspects of the practice, such as keeping up to date on coding and billing guidelines, preparing for new government regulations, and handling payroll, as well as sharing overhead costs.

### **Large Group Practice**

As a business entity grows in scope, volume, and geographic catchment, the policies and processes involved in its operation become more complex and challenging, and a large group practice is no exception. Not only do large groups require greater financial investment, but the management structure must also become more sophisticated. As large groups employ more surgeons, individual autonomy will decrease, and additional considerations must be made regarding overhead costs, distribution of revenue, and leadership succession. Groups must consider the appropriateness of increasing their staff and the potential downfalls of further expansion: How many offices can the group feasibly operate at once? What level of capital investment is the group comfortable with? Do the needs of the community warrant increasing the group’s size? If the group grows too large, conflict may emerge with other physician practices or local hospitals and health systems.

While making larger groups of physicians work effectively and efficiently together can be challenging, the level of difficulty increases exponentially when that group includes physicians of different specialties. Large, multispecialty groups may be solely surgical or may employ both surgeons and medical specialists in one practice. When successful, this arrangement can generate significant income and offset the costs of private practice

for surgical specialties with multiple revenue streams, such as orthopaedic groups, which may offer operative care, physical therapy, pain management, and imaging, all within the same office; such a setting can also increase convenience and reduce costs for patients.



### **Why Private Practice?**

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It is reasonable to ask, considering the ever-increasing regulatory burdens associated with the practice of surgery, why anyone would ever choose to be a self-employed solo surgeon. The answer is very simple: “To be your own boss.” Consider what freedoms this confers on your practice: You can tailor every detail of your office to your liking; determine your schedule, including daily office hours and vacations; select and incorporate new technologies you believe will benefit your patients; and, just as employed surgeons engage in financial negotiations with their employer, you are free to negotiate rates with commercial insurers.

This freedom, however, comes at a price. As a solo surgeon, you assume the responsibilities an employed surgeon relinquishes to his or her employer, such as compliance issues, equipment maintenance, EMR and network security, insurance audits, staff training, and more. And, of course, you are responsible for the financial success of the whole enterprise. Everyone’s paycheck—including yours!—depends on generating referrals and balancing the costs of providing the best care to your patients with the intricacies of negotiated fee schedules with third-party payors.

So, is the self-employed surgeon still a valid model? Of course it is, but it is a bit like asking a climber about the view from Mount Everest: It takes some work to get there, and some days it can be really cold, but the view is spectacular!





## DIMENSIONS OF PRIVATE PRACTICE

### From a Surgeon's Perspective: Physician Burnout in Private Practice



#### The Failure of Work-Life Balance in Medicine: Reshaping Our Minds to Embrace Work-Life Integration

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At a time when the science of surgery is advancing at an impressive rate and in such amazing directions, it is incredible how the increasing burden of actually practicing medicine weighs heavily on the minds and hearts of the physicians who so passionately deliver the care that creates the foundation for what I believe should be the most important and valued part of the art of medicine: the patient-doctor relationship. As a son of two physicians, including my father, a urologist with whom I have the greatest of pleasures to work and regularly operate, I cannot recall wanting to do anything other than to be a surgeon "like my dad." Even at a young age, I could not have imagined anything greater than to be a surgeon.

However, as I grew older and began considering a career in medicine, my parents and their physician friends would ask me why I wanted to do that and urged me "not to be a doctor." I was always dumbfounded by their response. Frankly, I never quite understood it...that is, until I finished my fellowship and actually began to practice medicine myself, as a newly trained surgeon. Many of the same sentiments seemed to echo in the halls of the hospitals and physician lounges where I spent so much of my time, day in and day out. As the years continue to pass, these echoes seem to ring louder, become a bit more contagious, and lead to commiseration with older and younger physicians alike as they share countless hours huddled around computers plugging away at their keyboards, finishing charts and electronic health record documentation. The sacrifice of time and family and the

periods of constant availability that you must provide can become unbearable, and the frustration is often palpable. If that is not enough, the politics of medicine and its influence on the economy of health care seem to be on everyone's mind and of the highest concern to everyone involved in the practice of surgery. More and more, I grow saddened to see and feel that physicians are far too often left wondering what has happened to the value ascribed to the art of medicine and the importance of the patient-doctor relationship in debates surrounding the care of our patients.

These factors, among many, seem to increase physician frustrations. As burnout becomes a much more prevalent issue from which more physicians and their families (often silently) suffer, how many doctors are simply finding a way to "just get through" the day? How many hope that they can bear the stress of hospital bureaucracy, as well as the pressure from administrators and their teams, whose focus is often not shared by the physicians walking the halls of their hospitals? How many are tired of walking on eggshells through the ever-changing landscape of health care policy and the dynamics of health care economics that most often see the physician as the casualty? All the while, these physicians are hoping that they can get home in time to see their spouses, their children, their families, their loved ones; in my case, my wife and my baby boy are heartbreakingly often the ones who have to be left behind if a call comes in, forcing me to decide between patient and family.





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In a survey of more than 15,000 physicians across 29 different specialties, the Medscape National Physician Burnout, Depression & Suicide Report of 2019 revealed that 44 percent of physicians reported feeling burned out, defined as long-term, unresolvable job stress that leads to exhaustion and feeling overwhelmed, cynical, detached from the job, and lacking a sense of personal accomplishment.<sup>2</sup>

Of the 44 percent of the physicians who reported feeling burned out, 64 percent did not seek professional help. General surgeons and urologists were least likely to get help for burnout or depression, at 17 percent and 20 percent, respectively. Interestingly, both specialties suffered high burnout rates (at 46 percent and 54 percent, respectively) and were the two specialties most likely to work long hours, with general surgery topping the list at 77 percent, followed closely by urology at 76 percent.

Additionally, and importantly, 11 percent of physicians surveyed reported colloquial depression (feeling down, blue, or sad), and 4 percent reported clinical depression.<sup>3</sup> Fourteen percent admitted, "Yes, I've had thoughts of suicide, but have not attempted suicide." One percent had attempted suicide, and 6 percent preferred not to answer. An estimated 300 to 400 doctors kill themselves each year, at a rate of 28-40 per 100,000, according to a systematic review of 10 years of literature presented at the 2018 American Psychiatry Association annual meeting. With one completed suicide every day, American physicians have the highest suicide rate of any profession. In addition, the number of physician suicides is more than twice that of the general population.<sup>4</sup> The reality of such statistics is truly alarming and devastating.

A 2010 survey by ACS found that 6.3 percent of participants reported suicidal ideation during the prior 12 months, only 26 percent of whom sought psychiatric care. The remainder suggested being afraid to seek help because they were concerned about its impact on their career and medical license.<sup>5</sup>

The current rates of burnout suicide among physicians in the United States should force us all to take pause. Looking at the reasons why physicians are so frustrated with the current state of medicine is a start and an important part of the process of understanding how to make meaningful changes to create a less stressful work environment.

When looking at work-life integration in my own practice, I find that many sources of frustration are centered on time. With the amount of time I spend at work, I am always trying to find ways to have more free time to spend with my family. At work, I try to find extra time to do nonclinical activities that I truly enjoy to prevent burnout and keep me engaged in the day-to-day practice of medicine. My practice has initiated changes as part of a work-life integration effort aimed to make work more efficient and to address sources of frustration that we could manage in a way that would decrease stress. Not surprisingly, the first changes that we looked to make were associated with those factors that most physicians find to be the major sources of burnout:

- Too many bureaucratic or administrative tasks (such as charting and paperwork)
- Spending too many hours at work
- Increasing computerization of practice
- Insufficient compensation/reimbursement
- Lack of respect from administrators
- Lack of control/autonomy
- Government regulations<sup>6</sup>

Looking at these factors individually and together, we considered ways to make our practice more fluid and allow us to work both hard and smart.

First, we employed a scribe service to handle all computer-based EHR patient documentation. For me, the time saved and stress relieved by this one change was



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priceless and invaluable. Our charting is timelier and more accurate from a billing standpoint, and all clinic notes are generally completed by the end of our clinic day. Our EHR system is integrated with our practice management system to allow for more fluid and efficient billing, and the fact that I do not have to stop in between patients to write notes allows me to see more patients. Lastly, our scribe system allows me to speak to my patients without having to worry about charting during our time together.

Using a scribe helps decrease some of the burden physicians feel from too many bureaucratic and administrative tasks (such as charting and paperwork), as well as decrease time spent dealing with EHR and other concerns regarding the increasing computerization of the practice of medicine. Our scribe program does not eliminate long hours at work, but it does significantly decrease the hours and the amount of time spent charting and in front of the computer and the EHR. Most importantly for me, it decreases the stress of having an incomplete chart hanging over my head so that when I am home, I can actually be home.

The next thing I looked at was time management, and not necessarily in the way you may think. For me, starting my clinic day at 9:30 am instead of 9:00 am allowed me an extra 30–45 minutes each morning to share with my infant son and to help my wife, who also works, as we both got our day started. We looked at patient placement in our early and later appointments, as well as the timing and spacing of our patients to allow for minimal change in patient flow and patient volume, which we accomplished by paying attention to our clinic team dynamics. We looked at doing the same thing with certain operative days and found that with some efficient scheduling and smart planning, I could start my operative day at 9:00 am for certain types of cases and allow for the benefits of a later start without later nights in the operating room or a decrease in case volume. Similarly, using efficient templates with hospital EHR order sets, operative notes, and charting has improved efficiency and led to just a little less time in front of the computer at work.

Next, I began having very proactive conversations regarding things happening at work and at home so that my schedules corresponded more seamlessly and enabled me to spend more time with my wife and new baby. If not obvious by now, most of these changes were inspired by the birth of my son, which made the importance of creating a more time-efficient practice even clearer. My father ran a solo private practice for most of my childhood and entire adulthood until I joined him following my fellowship. In my opinion, he is the hardest-working urologist and the best surgeon with whom I have ever had the pleasure of operating. He never missed a soccer practice or game. He and my mom, chair of an academic department of pathology, took us to and picked us up from school each day. We never heard of “all the problems with medicine” when we were growing up. I want to be a great physician, a great surgeon, a great urologist, and a very hard worker, but I also want to be a great and present father, a great husband, a good son to my parents, and a good sibling to my brother.

The last part of our work–life integration efforts has actually been the hardest for me: learning to say “no.” A mentor of mine once told me that “when you say yes to something that you do not want to do, you are saying no to something that you want to do.” Being selective about the things to which you devote your time is of the utmost importance for multiple reasons. One is simply making the time to do it. Next, will you be able to do it effectively and to the best of your ability? Is participation for the sake of participation good enough? Be mindful of that question. Agreeing to do something and then not being able to do it or doing it badly may be a lot worse than not agreeing to do it in the first place. I often bring up this point in discussions with my colleagues regarding participation in organized medicine, for example. Organized medicine has always been plagued by the conundrum of how to increase membership and how to retain members. The challenge is perceived value of membership. Is the time away from family and other activities, as well as the associated cost of participation, worth the perceived value of being a member of that organization?



## DIMENSIONS OF PRIVATE PRACTICE

I have tried to be mindful of the reality of my limitations and time demands at work. I have made a concerted effort to consider the return on investment of the organizations and efforts with which I was and am involved. In doing so, I was able to take an honest look at the value I provided to these organizations and vice versa. Was I able to make a meaningful impact by remaining involved, and, importantly, did I have the time to do so? Although a work in progress, I believe some of the changes described above not only allowed me to have more free time after work and on weekends but also allowed me to be more present and focused on the organizations in which I do participate. Learning to say “no” still remains one of the most difficult parts of my attempts to keep my time a bit more free. However, I know what I am passionate about and how I can help lead and facilitate impactful and meaningful change. I also know what I really enjoy. Over time, I have come to the realization that by spending time I do not have on activities I am not passionate about and do not enjoy cannot be meaningfully helpful.

An important part of any work-life integration process is self-awareness; knowing yourself is an integral part of any attempt at balance, whether at work or at home. When I looked at the parts of the practice of medicine that I found frustrating, I realized that I could not change the health care issues of the United States in a timeframe that would get me home any faster. So, I took a step back and looked at what I could actually and realistically change in my day-to-day practice. We took a hard look at our practice patterns and made changes that were successful and effective at moving toward our goals without negatively impacting us or our patients. I still work hard and long hours, but I get home earlier, am traveling less, and have more time to spend with my family. Most importantly, when I am home, I am home.

This last part is such an important aspect of the self-awareness component of this journey: knowing what is important to you. Time, for example—what you do with that time is up to you. How you spend it to achieve balance in your life is up to you. It is up to you whether you strive for healthy work-life balance measures such

as daily exercise, sleeping the recommended seven to eight hours a night, or spending time with loved ones. For me, the fact that I have a little bit more time to make that choice is a cherished victory on its own. Although not intended, getting home just a little earlier has allowed for better sleep and more regular exercise patterns that have naturally emerged from a more regular work day—another positive consequence of our work-life integration efforts.

Earlier, I mentioned my parents’ physician friends giving me all the reasons in the world not to go into medicine throughout my early years of dreaming to be doctor. What I carry with me from those memories is what my mom used to tell me and, in fact, still reminds me of almost every time I start complaining about work-life balance. My mom, who is a world-renowned breast pathologist and who has made a career of being an innovative physician-scientist, a passionate teacher, the epitome of a patient advocate, and an amazing physician role model for my brother, an orthopaedic surgeon, and me, always said, “If you can imagine doing anything else with your life, do that. If you cannot, then you will not be happy doing anything else...become a doctor.” She was right. I love being a physician, and I love being a surgeon. I am blessed to be able to practice with my father and cherish the fact that I have had the unique opportunity to be able to operate with and learn from my dad. Even at the worst of times, we have the opportunity to practice the greatest of professions and help people in the most amazing of ways. Surgery is still amazing to me, and I am beyond grateful for the ability to be in the operating room every day. The science of medicine is taking us to places our predecessors could not have imagined, and the art of medicine deserves the respect and admiration they taught us never to forget. We have to be our own strongest advocates. It is only then that we can serve and advocate for our patients’ best interests. We cannot do either if we do not take care of ourselves. Self-awareness—and awareness of the reality of burnout, depression, and suicide within the physician community—have to remain an important part in the conversation about health care; physicians cannot continue to be casualties of the health care system.



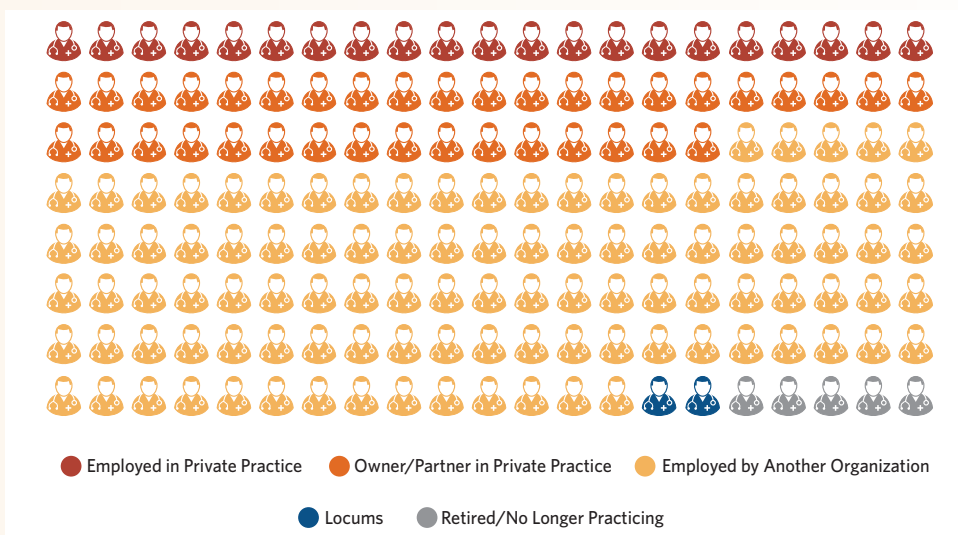
## DIMENSIONS OF PRIVATE PRACTICE

### Private Practice Ownership and Employment

What do we know about the status of private practice ownership and employment in the United States today? The ACS recently conducted a large and comprehensive survey of the membership and types of practices for surgeons, the results of which are shown in Chart G on this page.<sup>7</sup> More than two-thirds (69 percent) of respondents are employed by either a private practice or another organization. One-fourth (25 percent) are an owner/partner in a private practice. The three most common work settings are university/academic medical center, not-for-profit hospital/health system, and surgical group practice (see Chart H, page 23). More than one-third (36 percent) of those who have shifted their mode of practice moved from private practice to employment by an organization (see Chart I, page 23).

In private practices that operate as an LLC or other type of corporation, surgeons typically are “employed” by that corporation. Most would consider those surgeons to be “self-employed” and strictly in private practice. However, in some private practices, surgeons are hired on a temporary basis or as part of a trial to see if both parties are compatible before integrating into the group as a partner down the road. Other private practices have two classes of surgeons: those employed by the group and those not. Who are these surgeons “employed” by private practice groups? Are they truly employed by the practice or not? This distinction has been the source of confusion in recent surveys and even in articles about private practice employment. Because “employed” surgeons don’t have ownership or control of the corporation that employs them, and to avoid confusion, those surgeons will be considered practice employees for the purposes of this publication.

Chart G. Practice Characteristics of ACS Respondents







## DIMENSIONS OF PRIVATE PRACTICE

Chart H. **Work Settings of ACS Respondents**

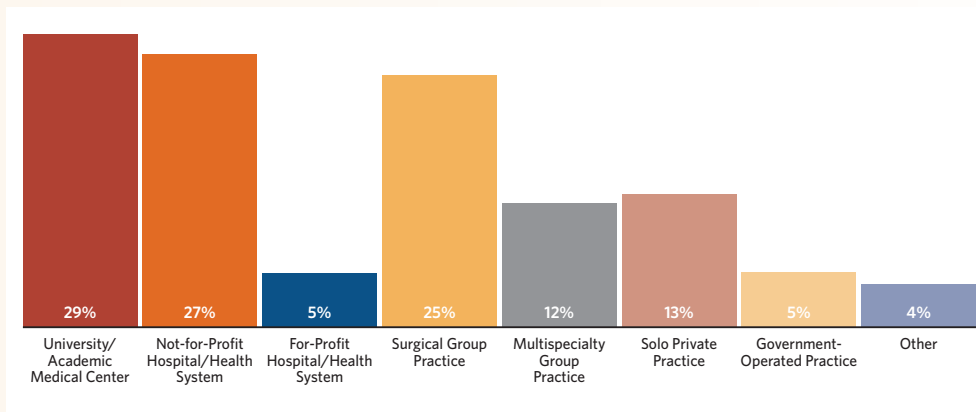
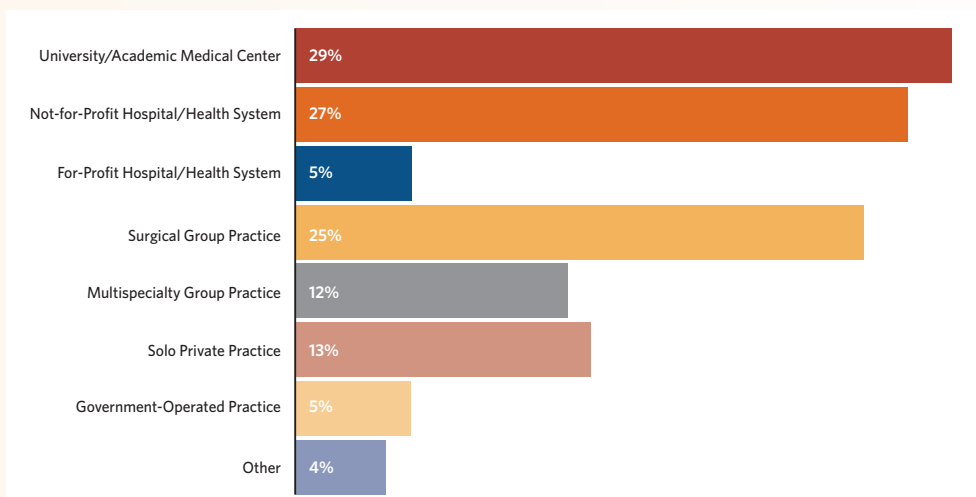


Chart I. **Shift in Work Settings of ACS Respondents**





## DIMENSIONS OF PRIVATE PRACTICE

### **Surgeon as Contractors**

As hospitals increasingly seek to align themselves with various physician specialists, but also want to avoid the financial investments required to purchase such specialists' practices, they may choose to hire surgeons as independent contractors rather than as full-time employees. As an independent contractor, a surgeon renders services, exercises independent judgment, and is under the control of the facility for which the services are performed with respect to the result of the work, but not as to how it is accomplished. The advantage of this arrangement is that the surgeon typically retains the ability to be self-employed, still controls his or her professional corporation, and, under some instances, can practice outside of the independent contractor agreement (for example, emergency room call).

An independent contractor arrangement has important legal and financial ramifications to consider. Agreements on fees and charges for services paid to a surgeon by the hospital can pose significant fraud, abuse, and antitrust risks if such a relationship is not based upon market benchmarks. In addition, independent contractors are responsible for their own income tax, do not typically qualify for workers' compensation benefits, and are excluded from participating in employer-sponsored benefit plans, including paid sick leave, vacations, or holidays. In the situation where a surgeon works as a part-time contractor for two or more hospitals, it is essential that the surgeon also understands Medicare billing regulations. Medicare assignment rules typically prohibit a provider from billing Medicare for services performed at a location other than their own practice. As a result, most independent contractors will have separate provider numbers—one set for their original private practice (which they may keep active and use) and an additional number(s) for use by the employing hospital(s), under which the hospital bills for services on behalf of the surgeon.

### **Hospital Support or Stipend While Remaining in Private Practice**

In many regions, hospitals are facing increasingly scarce physician coverage for critical services. As a result, hospitals have created support or stipend arrangements with private practices to ensure patient access to care. Such an arrangement may be very similar to the situation of a surgeon joining a private practice group that receives support from a specific hospital; the hospital support or stipend arrangement may also look similar to a capitation model and may be created around a specific service line. The hospital may pay the private practice surgeon(s) a set amount for each enrolled patient assigned to them, per period of time, regardless of whether that patient seeks care, or may pay an on-call stipend for emergency room coverage. Other variations on this theme might include additional payment for call coverage, administrative duties, and so on.

In this model, a surgeon's practice assets are not bought by the hospital, and the surgeon does not have to relinquish control of the day-to-day operations of his or her practice. This arrangement also has unique barriers that should be examined in relation to the federal Stark Law, anti-kickback statute, and state physician self-referral laws; these arrangements must not be seen as enhancing referrals for the private "stipended" surgeon. Caution is key in these types of arrangements, and sound legal advice is strongly encouraged.

### **Transitional Situations for Private Practitioners**

For surgeons who remain in private practice, there will inevitably come a time to "transition" their practice, whether that be changing to an institutional employment model, joining a larger group, merging or selling practices, or retiring.



## DIMENSIONS OF PRIVATE PRACTICE



### Six Tips for Solo Practitioners

**Charles Dunn, MD, FACS**

President, Crighton Olive Dunn Surgical Group, Inc.  
Springfield, MO

- 1. Always be available.** When called for a consult, ask minimal information about the patient and gladly accept the consultation. Always call the referring physician after you see the patient. **CALL, DON'T TEXT.**
- 2. Think outside the box.** If you have chosen to go to an independent private practice, you have an entrepreneurial spirit. Use it to your advantage. Hire a marketing consultant to brand your practice. Offer free screenings to the public for various general surgery conditions. Open your office on Saturdays. The beauty of an independent private practice is that you can do with it whatever you want without some overbearing administrator telling you no.
- 3. Choose someone in your group to pay attention to the financial side of your practice.** Physicians are not trained in reading a financial statement, understanding accounts receivable, insurance reimbursement, and the like. This is important for the survival of any group.
- 4. Build your practice with staff and make them feel as if they are part of a family.** Your staff is the face of your practice. Take time to choose the right people to be in your practice, as they are essentially your second family. Engage them in some decisions regarding the practice.
- 5. Set goals for your practice. See all new consults for a week.** Have semi-annual events for your staff. (We took our staff to see Def Leppard and Journey in concert, and they loved it.) Set a marketing budget and use a consultant to help with things like branding and SEO.
- 6. Be realistic concerning malpractice claims.** If you practice general surgery until you are 60 years old, you have a more than 90 percent chance of being sued. Be sure you have an excellent lawyer (not necessarily the one provided by your malpractice insurance company). Your employed colleagues have an advantage, as they are often not reported to the National Practitioner Data Bank—their employer is reported instead. If you settle or lose in court as an independent physician, you are more likely to be reported. Do not let this trouble you. Most of your older colleagues are in the Bank with you.



## DIMENSIONS OF PRIVATE PRACTICE

### **Practice Consolidation**

Corporatization of medicine is increasingly common, with large single-specialty or multispecialty groups entering the local marketplace and acquiring smaller practices. As reimbursement rates continue to go down for both hospitals and physicians, decisions will have to be made by private practice surgeons as to whether it is economically feasible to remain an independent practitioner. If it ceases to be financially viable to remain in private practice (for example, you're not able to fully fund your retirement plan or you're experiencing significant declines in your monthly income), then merging with another physician group or joining a hospital or health system may become necessary.

The corporate structure of the two entities will impact how the consolidation occurs, and individual physicians should closely review the legal assurances made by the acquiring entity. Surgeons in the practice to be acquired will need to investigate thoroughly the financial health of the larger group and have a plan to dissolve the acquisition/merger if there are disagreements. This process is essentially business and has nothing to do with surgery; business decisions will be made at the group level based on a number of different factors, such as the length of time individuals plan to practice, financial incentives associated with consolidation, and changes to call time and time off. Still, it will be important to notify your patients and staff of the upcoming changes; it is

also vital to ensure that the acquiring organization will take over certifications, insurance contracts, and billing without financial or professional risk to you.

How to assess the value of a private practice has changed considerably over the past several decades. There is essentially no value to traditional "goodwill" based on patients' habits and loyalty; conversely, there can be considerable value attributed to "branding" and social media reviews, as well as to the transfer of patient records. In addition, practices need to assess their value in the local health care marketplace rather than simply from the perspective of another surgical specialist. For example, a surgical oncology practice may have value not just to another surgical oncologist wishing to start a practice but could have even more financial value to a large oncology group that sees referrals from the surgeon.





## DIMENSIONS OF PRIVATE PRACTICE

### Establishing and Closing a Practice: Practical Aspects

#### Establishing a Practice

##### Tips for Opening a Successful Surgical Practice

Launching a private surgical practice is an exciting, but often challenging, undertaking. There are many questions to answer, processes to think out, and tasks to complete as you work to build your own practice, and this journey requires diligence and making cost-effective decision-making from the beginning.

A business plan is a road map to your practice success—this plan should describe the strategic goals of the organization and outline the activities and resources needed to obtain funding and direct operations. Operational issues associated with new practice development range from the defining the legal and financial structures, finding a location for your office and hiring staff. Once the decision to establish a practice has been made, the professionals below can be invaluable resources to provide guidance on the business and administrative components of medicine:

- Health care attorneys with experience representing physicians and medical practices
- Accountants and other financial advisors with expertise in small business issues
- Consultants with knowledge about insurance coverage requirements for medical practices, such as professional liability, corporate, health and disability, and life insurance, among other forms of coverage types
- Medical specialty societies, such as the ACS, with practice management and other educational tools for surgeons.<sup>8,9</sup>

##### Important Documents & Certifications

Following is a series of essential numbers, certificates, and other documents you need to obtain and be aware of to begin your surgical practice. You may find that some have already been completed if you are joining an existing group, but solo practitioners will need to obtain each of these on their own.

- **State medical license**—Physicians should plan for at least a 60-day period between the time they submit a completed license application to a state medical board and the actual date licensure is granted. You can use the Federation of State Medical Boards' online Federation Credentials Verification Service to store your credentials—including medical education, postgraduate training, examination history, history of medical board actions, and board certification—and submit multiple state medical board applications.
- **National Provider Identifier (NPI)**—An NPI is a 10-digit numeric identifier used in the electronic exchange of health care data. It does not carry information about you (such as the state where you practice, your provider type, or your specialization) and will not change, even if your name, address, provider taxonomy, or other information changes. Surgeons can obtain an NPI through the National Plan and Provider Enumeration System.
- **Taxpayer Identification Number (TIN)**—A TIN is a unique identification number assigned to a business entity to facilitate easy identification by the Internal Revenue Service (IRS). You will need to have this number if you are starting a new practice or hiring new employees. Surgeons can obtain a TIN on the IRS website.



## DIMENSIONS OF PRIVATE PRACTICE

- **Medicare Identification Number**—Physicians must enroll in the Medicare program to get paid for covered services they furnish to Medicare beneficiaries. Surgeons can submit an electronic Medicare enrollment application through the Provider Enrollment, Chain, and Ownership System.
- **Drug Enforcement Agency (DEA) Number**—Physicians must obtain a DEA number before they can write prescriptions for controlled substances. You may already have a DEA number; you also may need to change the registered address when starting your practice.
- **Occupational Safety and Health Administration (OSHA) Requirements**—All medical offices, no matter how small, must be in compliance with OSHA regulations, which are intended to safeguard your employees' safety and health. To meet OSHA standards, you must have your *own* safety rules and an individualized Exposure Control Plan for blood-borne pathogens. You must keep a record of your employees' training and of your cleaning schedule, including periodic checks of exit signs, eye-wash stations, fire extinguishers, and so on. You must also have available all Material Safety Data Sheets for all chemicals in the office, from "white-out" to rubbing alcohol.

The risk management office of your malpractice insurance company can help you comply with OSHA requirements. At your request, the local Bureau of Workers' Compensation can send someone for a walk-through OSHA inspection of your practice. In order for these inspections to be worthwhile, you must first have tried to achieve a minimum level of compliance.

- **Clinical Laboratory Improvement Amendment (CLIA)**—In most states, practices must obtain a CLIA certificate regardless of how many laboratory tests you perform, even if you do not charge the patient or bill Medicare or other insurances.

However, you may not need a CLIA certificate if your laboratory is located in the states of New York or Washington, as those States operate their own laboratory regulatory programs. Contact the appropriate CLIA state agency to determine if you need certification.

- **Environmental Protection Agency (EPA)**—EPA regulations may address issues of hazardous waste disposal in your area. For information, contact the district office nearest you.
- **National Practitioner Data Bank (NPDB)**—The NPDB is an online repository of reports containing information on medical malpractice payments and certain adverse actions related to physicians and practices. You may wish to review a copy of your NPDB record, which you can obtain once per year, free of charge.

### Displaying Documents

The federal government requires employers to display the following posters where employees can readily see them:

- Equal Employment Opportunity Is the Law ([https://www.eeoc.gov/employers/upload/eeoc\\_self\\_print\\_poster.pdf](https://www.eeoc.gov/employers/upload/eeoc_self_print_poster.pdf))
- Employee Polygraph Protection Act (<https://www.dol.gov/whd/regs/compliance/posters/eppac.pdf>)
- Fair Labor Standards Act Minimum Wage (<https://www.dol.gov/whd/regs/compliance/posters/minwage.pdf>)
- Job Safety and Health—It's the Law! (<https://www.osha.gov/Publications/osh3165-8514.pdf>)
- Employee Rights Under the Family and Medical Leave Act (<https://www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf>)



## DIMENSIONS OF PRIVATE PRACTICE



### Tips for Closing a Private Practice

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There are multiple practical considerations important in closing a practice. Some, such as notifying the utility or phone company, seem so simple that one wonders how a surgeon might overlook them, but the emotional issues associated with retirement and severing ties with patients makes these steps easy to forget. Fortunately, the basic principle guiding closure of a practice is no different from what surgeons do every day to build a successful practice—simply doing their best to care for their patients.

- **Staff**—Notify staff of your plans for closure of the practice in time for them to search for new job opportunities. They may benefit from meeting with an insurance or financial counselor to discuss optimal management of health and retirement benefits for the current practice.
- **Patients**—Notify patients once you have made a decision and selected a date for closure. Requirements for how this must be done are state specific and include sending a letter to active patients but may also include an announcement in a local paper. Patients must be informed of how their medical record will be transferred or stored and should be given the option of obtaining a copy of their record before the practice has closed.
- **Referring providers**—Notifying referring providers and clinics is not only a courtesy but will also help facilitate the transition of their patients to other surgical practices.
- **Professional liability carrier**—You will need to arrange for “tail” coverage if appropriate for your policy. Your carrier may also have additional recommendations for closing the practice.
- **Other professional entities**—Hospitals, surgery centers, the DEA, state medical board, pharmacy board, contracted payors, and other professional organizations should all be updated with your anticipated date of closure.
- **Office support services**—Internet service provider, phone and answering services, U.S. Postal Service, utility companies, housekeeping and laundry services, medical supply companies, local couriers, and any other outside organizations should be notified of the closure date and your plans to discontinue service.



## DIMENSIONS OF PRIVATE PRACTICE

The documents below should also be clearly placed in your office for all employees to see:

- OSHA Hazard Communication Standard Labels
- Workers' Compensation Risk ID (refer to your state's workers' compensation board for specific display requirements)
- CLIA certificate(s)
- Emergency exit plan for your office(s); one must be posted in a clearly visible location in each room

### **Closing a Practice**

Once the decision has been made to close a practice, one of the most important considerations will be to provide for patients' access to their medical records. Specific requirements vary by state, but most require that practices make patient records accessible for six to seven years (and longer, for pediatric patients). This step is commonly part of a merger/acquisition agreement, but for practices that are simply closing, options include the transfer of custodianship to another practice in the community or use of a commercial record storage and retrieval service. The process is potentially more complex than in the days of paper charts, as the acquiring entity may need to ensure the maintenance of the closing practice's existing EHR if the data cannot be transferred to another system.

It is also important to give patients sufficient notice to allow them time for the transition of care. Even surgeons retiring from a group may feel the stress of transferring care of patients with complex problems to their partners, and this anxiety may be magnified for smaller groups or solo surgeons. Requirements for patient notification are state specific and vary from general recommendations to very strict, specific legal requirements. For example, the Arizona Medical Board "recommends" that active

patients be notified three months prior to closure but does not have a specific requirement for this and does not define who is an "active" patient.<sup>10</sup> In contrast, Texas law requires that the physician post a written notice in the office two months prior to closure, publish notification in a local paper, and notify all patients seen within the last two years.<sup>11</sup>

### **References**

1. NOLO press: Professional LLCs. Available at: <https://www.nolo.com/legal-encyclopedia/forming-professional-llc>. Accessed August 19, 2019.
2. Kane L. Medscape National Physician Burnout, Depression & Suicide Report 2019. Available at: <https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression>. Accessed January 16, 2019.
3. American Psychiatric Association (APA) 2018. Abstract 1-227. Presented May 5, 2018.
4. Anderson P. Physicians Experience Highest Suicide Rate of Any Profession. Available at: [https://www.medscape.com/viewarticle/896257#vp\\_1](https://www.medscape.com/viewarticle/896257#vp_1). Accessed May 7, 2018.
5. Shanafelt TD, Balch CM, Dyrbye L, et al. Special report: Suicidal ideation among American surgeons. *Arch Surg.* 2011;146(1):54-62.
6. Simmons S. Striving for Work-Life Balance. *Nursing* 2019. January 2012; Volume 42, Number 1 Supplement:2012; 25-26.
7. American College of Surgeons Quantitative Survey Report March 2019. Conducted by Association Laboratory, Inc. of the membership for the ACS.
8. Medical Group Management Association. Checklist for New Practice Start-Up. Available at: <http://www.thepracticeresource.com/tools/new-practice.pdf>. Accessed September 4, 2019.
9. Wasserman D. Opening a Medical Practice: Your How-To Guide. Available at: <http://www.massmed.org/openmedpractice/>. Accessed September 4, 2019.
10. Arizona Medical Board. Change of Name/Address/Email. Available at: <https://www.azmd.gov/PhysicianCenter/PhysicianCenter/change-of-address#>. Accessed August 19, 2019.
11. Texas Medical Association. Notifying Your Patients When You Leave a Practice. Available at: <https://www.texmed.org/template.aspx?id=6676>. Accessed August 19, 2019.





# REVENUE CYCLE MANAGEMENT





# REVENUE CYCLE MANAGEMENT

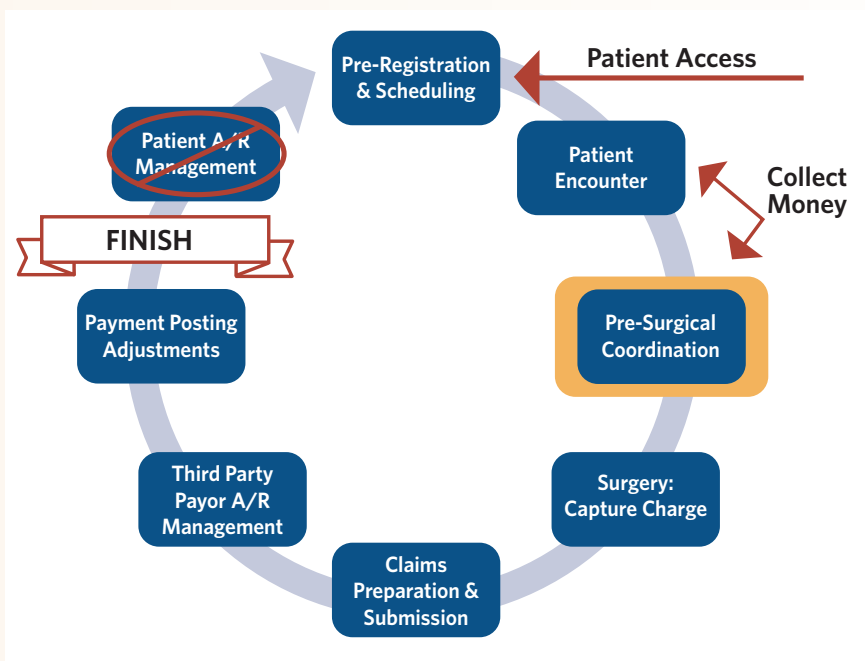
## What Is the Revenue Cycle?

Simply put, the *revenue cycle* is a process that includes all the steps required to get you paid—from preregistration through charge capture, claims submission, and payment posting. In many practices the revenue cycle also includes collection efforts, either internally or by using an outside collection agency.

For many years, the revenue cycle for physician practices has been reactive. The standard line staff used with patients in the office was, “You don’t owe anything today.

We’ll bill you after insurance pays.” Only after a claim was filed and insurance paid would the patient receive a statement. Often that was four to six weeks or more after the date of service.

Today, that’s all changed. With so many patients having high-deductible health plans (HDHPs), it’s important that practices be proactive, or they risk a high amount of unpaid and often uncollectible accounts. Many modern practices collect patient financial responsibilities on the front end of the revenue cycle process, as shown in the revenue cycle graphic below.





## REVENUE CYCLE MANAGEMENT

**A focus on the front end of the revenue cycle process is critical to successful revenue cycle management. Following are 11 best practices to implement in your workflow:**

- 1. Preregister patients.** This means that staff have collected and entered all of a patient's personal and insurance information into the computer system prior to the patient's arrival. This step can be done by phone, but modern practices ask patients to preregister in the patient portal, where they can also complete their clinical history.
- 2. Verify eligibility and benefits.** If you've preregistered patients, you have the data needed to verify eligibility and ensure that patients have coverage prior to the visit. This step helps staff know what they should collect. Use automated tools such as batch eligibility and clearinghouse features to execute this task.
- 3. Verify patient identity, information, and insurance at check-in.** The front desk plays a critical role in the revenue cycle by verifying this information for both new and established patients. Set your front-desk team up for success by minimizing multitasking and allowing them to focus on verification tasks.
- 4. Collect patient financial responsibility amounts at the time of service.** Collect the patient's full responsibility, not just encounter co-pays. This step is made easier if staff know what amount to collect. Research and organize the contracted rates for your most common Current Procedural Terminology (CPT) codes for evaluation and management (E/M) and also for procedural services, and create cheat sheets for the most common CPT codes for your top 10 payors.
- 5. Collect deposits before a surgical procedure is scheduled.** Have your staff prepare a cost estimate and educate the patients about the amount their plan will pay and what they will owe. Depending on your practice policy, your staff then collect a certain percentage or a flat amount in order to schedule a surgery date. The balance is paid prior to surgery, or staff arrange for patient financing or an automated recurring payment to the practice from the patient's credit card to pay off the balance.
- 6. Post charge/submit claim within 48 hours.** Do so electronically, of course. This is especially important with motor vehicle accidents, as the first insurance company that will pay will be car insurance, which usually has a limit. Getting your bill in first will help you get paid.
- 7. Implement electronic remittance advice (ERA) for all payors who offer it.** Manual payment posting is an outdated practice. Automate as much of it as possible.
- 8. File explanation of benefits (EOBs) forms in a batch, by posting date.** If you've scanned all paper documents, this will be easy, and it makes finding and retrieving data for follow-up or collection purposes faster than searching through a paper filing system. Scan the EOBs in a batch, name them by posting date, and store them in a public folder on the server. If you use software such as Adobe Pro/Document Cloud, staff can even search PDFs and other documents by keyword.
- 9. Use automated work queues in the practice management system (PMS).** Set up work queues for each staff member to guide their account follow-up. This means no more wondering what you last did or leafing through paper accounts receivable (A/R) reports that are highlighted in yellow or pink. The system does the work and queues up the accounts that require action.
- 10. Check the status of unpaid claims online.** Modern practices manage most of their claims follow-up this way. Denials are corrected and resubmitted (not just resubmitted as duplicate claims) using online appeal tools at payor websites.
- 11. Use the PMS collections module to manage patient A/R follow-up.** Arrange for training and implement this time-saver, which helps staff prioritize follow-up.





# REVENUE CYCLE MANAGEMENT

## Financial Management

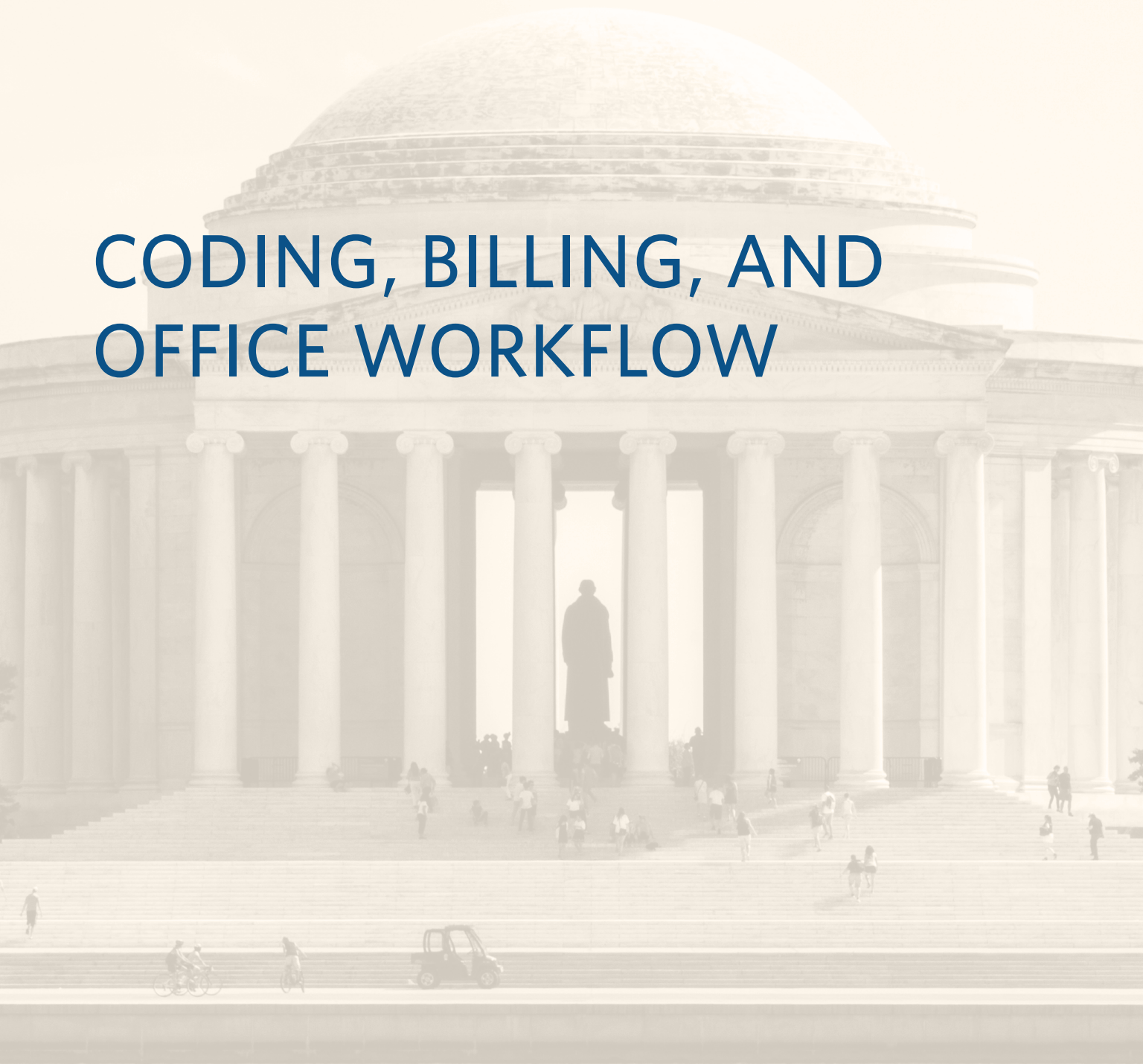
**Monitoring collections, cash flow, and overhead is an important aspect of maintaining financial health for the practice. So is the establishment of good cash controls that protect against theft. Physicians don't need to analyze every detail on every report, but it is important to monitor select reports and your metrics dashboard monthly. Here are seven financial reports to review each month:**

- 1. Charges, payments, and adjustments**—This report comes directly from the PMS and should be reviewed by provider, payor, location (if you have multiple sites), and CPT category. Use this data to monitor and discuss high-level trends.”
- 2. Profit and loss (P&L)**—The P&L provides a high-level view of total revenues and expenses and indicates how efficiently the practice is being financially managed. The report is generated from an accounting software system, such as QuickBooks. Well-run offices include current and last year's period-to-date and year-to-date data, as well as budget data, in the P&L statement. Such offices keep a keen eye on the overhead percentage, which is the proportion of total revenue that is being spent on operating expenses.
- 3. Aged A/R, by date of service**—This report shows you the total receivables due. Generate this report aged by date of service (not the date of posting), and be sure to separate insurance balances from patient balances. With patient receivables on the rise due to HDHPs, it's essential that the physicians see the amounts patients owe in each aging category. A large dollar amount of patient collections can indicate the need for implementing or improving collection at the time of service and presurgical deposits.
- 4. Credit balances**—Credit balances are a financial liability. Monitor the amount you owe payors and patients on a monthly basis, and process timely refunds. In addition to the liability risk, credit balances negatively offset the total A/R, resulting in an inaccurate total on that report. Ideally, the practice's total credit balances should be as close to zero as possible.
- 5. Noncontractual adjustments**—This report provides granular detail of the charges that were adjusted due to reasons other than contractual adjustments. Monitoring it enables you to question amounts written off to categories such as bad debt, small balances, timely filing, or lack of authorization. Asking questions about noncontractual adjustments can identify inefficiencies and other issues relative to front-end workflows and collection processes.
- 6. Unapplied payments**—To keep your accounting clean, it's important that every dollar collected be posted to a specific category in the PMS. In some cases, staff collect money up front—for instance, in the case of presurgical deposits—and allocate it to a specific account and category after the payor reimburses for the service. Sometimes this step gets overlooked. Monitoring the unapplied payments report can identify large sums that may be still sitting in “unapplied” and that must be moved to the correct category and account.
- 7. Rejection report**—This report summarizes the claims that were rejected by payors. Review it to monitor rejection reasons and identify trends such as “timely filing” or “patient ineligible on date of service.” Rejection patterns such as these indicate that front-end workflow and other processes are not optimal. Address them to reduce claim denials and improve reimbursement and collections.





# CODING, BILLING, AND OFFICE WORKFLOW





## CODING, BILLING, AND OFFICE WORKFLOW

### Organizing Your Practice for Optimal Efficiency and Production

To be successful, your practice has to run at its best efficiency to get the most output from your labor and the labor of your staff. While many of the procedures that surgeons perform occur elsewhere, the office is the engine that keeps things running. Thus, “operational efficiency” includes the larger concept of efficiency of your practice overall, no matter where you see and care for patients.

#### Patient and Information Flow

##### Patient Flow

How patients flow through your office is an important cycle to know and optimize. A smooth and organized flow is critical for patient satisfaction and for reducing costs and delays. Even before patients come into your office, good surgical practices begin educating them. Education includes not just your office hours and phone number but also important issues such as how much payment is expected up front for new and established patients. What about co-pays and deductibles for minor or major elective procedures? Do you want the patient to pay some or all of these fees before the surgery or after surgery when all the other hospital and provider bills hit? If there is a problem with a bill, who do you want them to call to discuss it? Setting out clear expectations will go a long way toward a satisfied, prepared, and happy patient.

It helps to think of the journey that the patient makes through your office. There is the front end, the mid-office (where you and other clinicians are), the back office and hospital. Front-end engagement starts with office communications, which can be transmitted electronically, via a patient portal, or with old-fashioned paper and mailings. Your reception area also forms part of the front-end engagement with the patient. How does it look? Is the check-in and information gathering process orderly and efficient? Is there a long wait until the patient gets recognized and signed in? All of these items make a big difference in patient satisfaction.

The back office deals with the mechanics of insurance processing and collections. This is where submitting a “clean claim” starts and ends. A *clean claim* is one that has (1) correct patient and insurance company information, (2) correct diagnosis and procedure coding, (3) correct location and patient status (hospital inpatient admission or observation, emergency department, outpatient, office, and so on), and (4) correct provider information and practice information (such as where to send the check). This is followed by the collections process, during which money is collected on the front end (such as deductibles and co-pays), and the status of insurance claims submitted is reviewed to determine if any claims need to be resubmitted, have been denied, or need to be appealed. It is important to regularly review your clean claim denial rate by carrier (this should be a low number) and your net collection percentage.

Lastly, there are some patients who present to the hospital without ever coming into your office on the front end. It is important to ensure that—by whatever method—you take credit for work done there and transmit that to your office. You have done the work; now it is important that you be reimbursed for that work.

##### Information Flow

As patients come into your practice, either in the office or in the hospital, they come with health issues and surgical issues, which you treat. But they also come with names, phone numbers, insurance cards, old medical records, laboratory or X-ray imaging data, and other information that your practice must absorb. How well your practice takes these critical data and uses them for medical records, charge capture, billing, and collections form the foundation for a successful practice. Poor handling of this information suggests that the foundation of your practice is weak and may crumble over time. A strong foundation, however, will enable you to refine these data to help improve billing, reimbursement, and other essential functions of a practice.



## CODING, BILLING, AND OFFICE WORKFLOW

### How Do These Two Flow Cycles Intersect?

The data that come along with patients are not only important to capture—it's important to capture the data *correctly* to avoid duplicate work or time spent correcting errors introduced on the front end. Then, as charges are generated, they must be accounted for, submitted, and collected. At each stage of this process, new information is created by your practice. Thoroughly reviewing this information can be immensely helpful to you and your practice in improving collections.

For instance, information from claims rejections and denials can alert the practice that incorrect data is being entered at some stage in the process. Tracking down the source of these errors can then help the practice put in place new processes, education, monitoring, and other steps to reduce and prevent future errors from being entered and clogging up the system. Another example of the benefits of data capture is review of information from collections, such as the gross and net collections percentages of your practice, by payor. This is the kind of knowledge that separates strong private practices from failing private practices when it comes to deciding on insurance contracts, payment policies for patients, and financial quality of patient referrals.

Some practices outsource these back-office functions, in part or in whole. Others manage these processes in-house. In either case, there is no reason why you should not be getting reports on these processes on a regular basis. This is essential information for you to use to gauge the health of your practice.

### **Scheduling Surgeries: Checking All the Boxes before You Cut**

Many surgeons have become familiar with the ritual of the “surgical time-out” in their ORs. However, some practices miss revenue and incur unreimbursed costs by rushing to put a patient on the OR schedule before all of the prerequisite approvals and insurance checks have been accomplished.

In some larger institutions, obtaining prior authorization is mandatory (and completed by hospital staff) before scheduling procedures, but in many practices, surgeons and office staff are responsible for ensuring that they meet a given payor's prior authorization requirements before a service is rendered. In others, it is a task left up to the surgeon and his or her office to complete. Once a surgery has been completed, there is little, if any, incentive for the insurance company to rush reimburse you for your work.

Below is a short list of items for you to remember and for your staff to check off before you head into the OR for elective cases:

**Insurance and patient information confirmation**—While this may seem simple, it is critical to ensure that the patient's insurance policy is still in effect and that all of the patient's information is up to date and correct at the time the procedure is scheduled.

**Procedure that is scheduled to be performed is approved by the insurance company**—Not all procedures that you can do are allowed for payment by an insurance company policy. These coverage issues will vary from company to company and also will vary for particular policies that are written within a company. Similarly, for workers' compensation, ensure that all requirements for the surgery to be covered by that particular company's policy have been met.

**Need an assistant surgeon?** Better double-check with the insurance company for that particular procedure. The ACS, in conjunction with other surgical organizations, regularly publishes a listing of procedures that typically do and don't need a first assistant. This list is very helpful to have in hand if there is an argument about coverage for a surgical assistant who is felt to be needed.





## CODING, BILLING, AND OFFICE WORKFLOW

**Are you a credentialed provider ("in network") for the patient's insurance company?** What about your assistant surgeon? This is an area of increasing controversy and is something that always should be double-checked prior to an elective procedure. If one or both surgeons are "out of network," then the patient needs to be informed before the surgery so that you can have a conversation with that patient and your staff about potential out-of-network charges.

### Coding Basics

To code accurately, for services performed, physicians must understand the following terms:

**CPT code**—CPT stands for Current Procedural Terminology. CPT is a code set used to bill for physician services and procedures and is owned by the American Medical Association.

**E/M code**—E/M stands for evaluation and management, and E/M codes are a type of CPT code. These codes are used to report cognitive services, such as office and hospital visits and consultations, for new and established patients.

**HCPCS**—HCPCS stands for Healthcare Common Procedure Coding System, which is an umbrella system for three levels of code sets—one of which is CPT.

**ICD-10-CM codes**—ICD-10-CM stands for International Classification of Diseases, Tenth Revision, Clinical Modification. ICD-10 codes describe a patient's diagnosis and support the reason why a physician recommends a particular treatment or surgical plan.

**Global surgical package**—A single payment that includes all care associated with a surgical procedure, including pre- and postoperative care and the procedure itself. Different surgical procedures have different lengths of follow-up care periods.

**Modifier**—A two-digit code indicating that the service or procedure that was performed has been altered in a specific way but not changed in its definition. For example, modifier 50 is used to report bilateral procedures that are performed during the same operative session by the same physician in either separate operative areas (e.g., hands, feet, legs, arms, ears), or the same operative area (e.g., nose, eyes, breasts).

### Unbundling

Reporting multiple CPT codes when a single, comprehensive code exists to describe the procedure as a whole is referred to as *unbundling*. Unbundling is considered inappropriate reporting and does not comply with coding and reimbursement rules.

For example, the ventriculoperitoneal shunt placement code (CPT code 62223) includes placement of the ventricular catheter and valve and the peritoneal catheter. Therefore, when the general surgeon places the peritoneal catheter of the shunt for the neurosurgeon, that service is included in 62223 and would not be separately reported with a laparoscopy code (for example, CPT code 49320). In this example, both surgeons would report 62223 with modifier 62 (two surgeons) to show that neither surgeon performed all aspects of the single CPT code.

Another example is the use of the exploratory laparotomy code (CPT code 49000). An exploratory laparotomy is included in all other laparotomy codes; therefore, 49000 would not be separately reported. To do so is considered unbundling, because the more comprehensive code includes the exploratory laparotomy.

If a CMS or commercial insurer audit uncovers instances of unbundling, it could trigger payment reversals, penalties, or other actions.





## CODING, BILLING, AND OFFICE WORKFLOW

### Coding versus Reimbursement

An important distinction to make when it comes to the basics of coding is that *coding rules* are not the same as *reimbursement rules*. *Coding* is a system of reporting services physicians perform. *Reimbursement* is a result of payment system rules, and these rules vary by payor.

Medicare may have one rule, but a commercial payor may have a different one—even for the same code. Check payor websites for specific policies and billing guidelines.

The table below gives an overview of important resources physicians should utilize to comply with coding and reimbursement rules.

Coding Rules Reporting Mechanism (How You Report Services)	Reimbursement Rules Payment System (How You Get Paid)
Resources to Know	Resources to Know
<b>CPT Manual</b> —Provides CPT codes for most procedures/services performed. Indicates when codes should or should not be used with other codes.	<b>CMS Internet-Only Manuals</b> —Provide Medicare and Medicaid coverage information (what’s paid and under what circumstances).
<b>CPT Assistant</b> —Monthly newsletter that provides coding direction. Archives available. (Use to support appeals!)	<b>National Coverage Determination (NCD)</b> —Describes coverage of specific procedures. Must be followed by all Medicare carriers.
<b>CPT Changes</b> —Annual book that provides clinical vignettes for new CPT codes. CPT changes archives also available.	<b>Local Coverage Determination (LCD)</b> —Describes coverage policies written by local carriers (Medicare Administrative Contractors, or MACs). Unique to each Medicare carrier.
<b>Coding Software</b> —CPT codes, Medicare payment policies, ICD-10 codes, and links to CPT Assistant archives.	<b>CMS Transmittals and MedLearn</b> —Describe new and revised coverage policies.
	<b>Medicare Physician Fee Schedule</b> —Gives RVU values, fees, and payment policies for CPT codes.
	<b>National Correct Coding Initiative (NCCI) Edits</b> —Lists code combinations that are “bundled” by Medicare and includes narrative policy guidelines.

**Source:** American College of Surgeons *Successful Surgical Coding 2019* course, developed and taught by KarenZupko & Associates, Inc.



## CODING, BILLING, AND OFFICE WORKFLOW

### Medical Necessity and Payor Coverage Policies

A patient presents complaining of symptoms of venous insufficiency, which are confirmed by imaging. Is it time to escort the patient to the surgery scheduler? Not yet. Most payors have coverage policies dictating medical necessity criteria for various procedures.

Although you have confirmed the patient's condition, to ensure payment you need supporting documentation corroborating that now is the right time for this patient to proceed with this surgery. Without that documentation, it's unlikely the payor will preauthorize the surgery. And even if the surgeon performs the surgery and receives reimbursement, a retrospective audit by a payor could result in a payment take-back if the payor's definition of medical necessity was not met.

Preparation is vital to properly demonstrate medical necessity and get paid. Follow these steps to get organized.

#### 1. Collect medical policies from your top 10 payors for your most common procedures.

Payors define their medical policies (also known as *coverage policies*) in documents often provided on their websites.

If a payor's medical policy development group determines a procedure should *not* be paid for, it's labeled "experimental and investigational," which means that if the patient proceeds with surgery, he or she is responsible for payment. If you want to get paid for such services, you must collect from the patient.

If the medical policy development group determines a procedure is a "covered benefit," the resulting policy is quite clear about the steps required to justify medical necessity. It will include details such as the appropriate ICD-10-CM and CPT codes to use for payment, as well as specifics about conservative treatments that must be tried prior to proceeding with a procedure.

#### 2. Create "cheat sheets" that lay out payor policy details for each procedure.

Assign this project to the billing team:

- Create a binder or online document for each of your commonly performed procedures.
- For each procedure, include the medical necessity and other billing guidelines for your top 10 payors. **Example:** For a cholecystectomy payable under Anthem, Inc., list the correct CPT codes and supporting ICD-10-CM codes the documentation required for the patient's history of conservative treatment, and so on.
- List all of each payor's covered diagnosis codes mapped to the covered CPT codes. Although you are paid on CPT codes, denials are typically driven by ICD-10-CM codes. Sharpen your diagnosis coding, and you will likely see denials drop.

When complete, these cheat sheets give you a fast and easy way to check off whether you have all the right criteria for precertification or preauthorization and ultimately for coverage.



## CODING, BILLING, AND OFFICE WORKFLOW

### 3. Use words from the medical policy when documenting or dictating.

Think of the medical or coverage policy as a recipe for payment. Follow the recipe when assembling documentation for preauthorization or precertification and for the claim. Include the exact terminology the payor uses to describe the problem, the treatments tried, and the CPT and ICD-10 codes specified in the policy.

Following are a few dictation tips:

**HISTORY:** State the problem, its duration, the treatment options tried, and the results.

**PLAN:** Summarize why the patient has failed conservative therapy, your discussion of other available options, and your recommendation about why you feel this procedure is now appropriate for the patient.

Even when there is not a prior authorization or precertification requirement, make sure you've met payors' medical necessity requirements. Regardless of how you personally feel about the payor's coverage policy or restrictions, billing for a procedure that doesn't meet the requirements and hoping you get paid is ill advised.

### 4. Collect from patients prior to surgery when procedures are not covered.

Transparency is essential. Explain that although you feel the prescribed procedure is the correct course of action, their insurance company won't pay for it. Calculate the amount patients owe, and collect it prior to the date of surgery. Ask commercially insured patients to sign a waiver of understanding, and ask Medicare patients to sign an Advance Beneficiary Notice. Many modern surgical practices employ a financial counselor to have these conversations and execute these tasks.

## Documentation

Following are five of the most common documentation dos and don'ts.

### 1. DON'T choose E/M codes based on the amount of documentation the EHR produces.

You must choose an E/M code based on what is medically necessary for the current encounter. That varies depending on the history, examination, and medical decision-making associated with a given patient—not the number of pages that print from the EHR.

### 2. DON'T use the EHR to auto-populate information from the patient's last visit unless it's clinically relevant to the current visit.

The automatic "pulling forward" of notes from a previous visit may seem efficient when the office is busy. But using this feature and failing to customize the note with the unique reason for the visit can be dangerous, because every encounter note must be unique.

The right way to use the auto-populated notes from a previous visit is to modify them to reflect the reason and current issues in the current visit. The "comments" field is often the most appropriate place within EHRs to express specific discussion points and details that make the encounter distinct.

### 3. DO evaluate your EHR template use.

If you haven't customized your templates, it can result in every note looking the same, which is called "cloning" of the note. A patient's documentation that looks the same, visit after visit, will not serve you well in an audit.

The fix? Customize each EHR template to accurately describe the visit. This is often easier when the visit templates are designed for granular conditions or diagnoses. Strive for a unique template for the top 20 most common conditions or diagnoses you treat.



## CODING, BILLING, AND OFFICE WORKFLOW

### 4. DON'T forget to document the use of a scribe.

Scribes may be hired by a practice to document patient encounters in the record on a physician's behalf. They never work independently. Payors expect that the physician they reimburse for services is the same person who created the note and delivered the service. Here's how to correctly reconcile these two facts in any physician documentation for which a scribe was used:

- Enter the name of the person and add "is acting as a scribe for Dr. X" in the note.
- Direct the scribe to sign the note. Everyone must authenticate his or her own entry; scribes are no exception.
- Be sure the physician signs the note indicating that it is an accurate record of all discussions and actions that occurred during the visit.

### 5. DO regularly review documentation for level 4 and 5 codes.

Payors use algorithms and analytics tools to spot outlier coding patterns and target them for review and potential take-back. Level 4 and 5 E/M codes are particularly subject to review. To make sure you've properly documented your level 4 and 5 codes, conduct a quarterly internal review.

Practices should also consider conducting peer-to-peer, "blind coding" reviews several times a year to make sure correct documentation techniques are understood and being followed. For example, physicians may review five samples of their colleagues' notes, choose the code they think supports each, and compare that with what was actually billed. You'll be surprised how much you learn from each other.

### Submitting Clean Claims

Follow these guidelines for completing and submitting claims that get reimbursed correctly and in a timely manner.

**1. When completing a claims form, list CPT codes in descending value/fee order.** The order of procedures listed on the operative note makes no difference. It's the order of codes billed that is important. Note: There are some exceptions below.

**2. Keep add-on codes "next to" (directly below) the respective parent code, or list them in descending value/fee order.** Both formats are acceptable, but you'll want to watch EOBs carefully to make sure codes are paid.

**3. Know payor preference for whether to use the units box or line-item charge entry for add-on codes.** Never report multiple units of a stand-alone CPT code.

Fee	Expected Payment
Double your single fee	200% of allowed

**4. Know payor preference for reporting bilateral procedures.**

#### Alert!

Avoid using a 50 modifier on add-on codes. Payors may incorrectly reduce the second side by 50 percent.

Line-item posting:

Fee	Expected Payment
Single fee	100% of allowed
Single fee	50% of allowed

Bundled (use this format for Medicare):

Fee	Expected Payment
Double your single fee	150% of allowed

\*Some payors may require two units to be listed.





## CODING, BILLING, AND OFFICE WORKFLOW

### 5. Bill your usual full fee for each CPT code reported when you are the primary surgeon.

Exception: See numbers 3 and 4 when you double your fee

Exception: Modifier 22—increase your fee

Modifier 80, 82, AS—decrease your fee

#### Alert!

Be sure the codes you bill are all supported by the procedure statement on the operative note. The body of the operative note should substantiate the procedure statement and codes billed.

### 6. Modifier sequencing may help prompt claim payment.

For example, one payor released the following guidelines, in order of recommended sequencing:

- i. **Pricing modifiers:** 26 (professional component), TC (technical component), 50 (bilateral), 52 (reduced services), 80 (assistant surgeon)
- ii. **Payment eligibility modifiers:** 24 (unrelated E/M in a global period), 25 (significant E/M on same day as procedure), 57 (decision for surgery), 59 (distinct procedural service)
- iii. **Location modifiers:** LT (left), RT (right)
- iv. **Statistical or informational modifiers:** GC (resident involved in service), Q6 (services furnished by a locum tenens physician)

## Patient Collections

An up-to-date, written financial policy is essential to successful collections. Here are seven important elements of this document:

**1. One policy for all physicians—**Too many different rules make execution cumbersome and will result in marginal collection success.

**2. Clarity about what patients are expected to pay for office services and surgeries—**The phrase, “You will be asked to pay your financial responsibility at the time of service,” is too vague. Remember that early and consistent education of patients about their expected payments and financial obligations will increase the likelihood that they will pay on time and appropriately. Here are a few phrases to consider:

- *All co-payments, deductibles, co-insurance, and fees for noncovered services are due at the time of service unless you have made payment arrangements in advance of your appointment.*
- *In the event you need surgery, we will provide you an estimate of your insurance-required deductible and co-insurance amounts. A presurgical deposit of [Insert Amount or Percentage] will be collected prior to scheduling.*

**Definition of self-pay—**This term can mean different things to different patients. Make sure you explain your definition in writing and that staff stick to that definition. Some examples of how you might define self-pay include the following:

- *Patient does not have health insurance coverage.*
- *Patient is covered by an insurance plan that our providers do not participate in.*
- *Patient does not have a current, valid insurance referral on file.*

**4. No-show policy and fee—**Yes, it is acceptable to charge a no-show fee, and yes, you can charge patients for no-shows—even Medicare patients. Specify your rules (for example: *We request at least a 24-hour advance notice if you are unable to keep your scheduled appointment*) and the fee (for example: *We charge an administration fee of \$\_\_\_\_ for no-shows*) in your policy.



## CODING, BILLING, AND OFFICE WORKFLOW

**5. Referral policy**—Explain the need for an insurance-required referral authorization from the primary care physician and what happens if one is not obtained. For instance: *Without an insurance-required referral, the insurance company will deny payment for services. If you are unable to obtain a referral prior to being seen, you will be rescheduled or asked to pay for the visit in advance.*

**6. Financial assistance policy**—The financial assistance policy is typically an addendum to the financial policy and covers details about patient financing options, time-of-service discounts for uninsured patients, payment plans and how you administer them (like automated monthly payments on a credit card), and the definition of *charity care*. Financial assistance is something patients must qualify for, so be sure to explain that fact, and have a financial assistance application ready to give to those who ask. Use the U.S. Federal Poverty Guidelines as a guide to qualification.

**7. Guidelines about billing, payments, and refunds**—For instance, if you haven't collected in full and must send a statement, when is the full balance due? What if patients cannot pay within that timeframe? What happens next, and what are their options? What is your policy about patient overpayments? How about sending patients to collections? What's the process, and how can patients avoid this?

### Electronic Health Records

The large scale implementation of EHRs is largely due to the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009.<sup>1</sup> Through HITECH, the Meaningful Use Program (also known as the Medicare and Medicaid EHR Incentive Program

and currently known as the Promoting Interoperability Program) became the tool through which the uptake and adoption of EHRs was incentivized. Run by CMS, Meaningful Use established foundational goals and priority outcomes for the use of EHRs in a multiphase program. The adoption of EHRs that met certain standards to help achieve these goals and priorities were the bedrock of the program; as such, incentive payments ranged from \$44,000 over five years to \$63,750 over six years in an attempt to assist physicians and health systems with the conversion to electronic systems.<sup>2</sup> It was through HITECH and the Meaningful Use program that Certified EHR Technology (CEHRT) standards were developed. Such standards are maintained and updated on a semi-annual basis by the Office of the National Coordinator for Health Information Technology (ONC), which requires vendors to update their products to meet the evolving needs and expectations of the industry. The Certified Health IT Product List website, [chpl.healthit.gov](http://chpl.healthit.gov), provides these standards as well as a list of EHR products which are aligned with current CEHRT criteria.

As of 2017, nearly 86 percent of office-based physicians used an EHR, with 80 percent using CEHRT. The uptake is higher in hospitals, with 99 percent of large hospitals and 97 percent of medium-sized hospitals using CEHRT.<sup>3</sup> These numbers have been steadily rising since HITECH in 2009, and have moved the industry toward more advanced use of EHRs, including the start of integration with wearable devices and third-party applications, and interoperability with external systems and physicians. While these uses remain challenging today, EHRs continue to be pushed through health policy levers to help meet the challenges of the 21st century.



## CODING, BILLING, AND OFFICE WORKFLOW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created privacy protections at the federal level for individually identifiable health information, or protected health information (PHI). A final privacy rule was published in 2000 and created covered entities (health plans, health clearinghouses, and health care providers) that must follow standards when reviewing and exchanging electronic health information. It is important to be familiar with this regulation, as penalties for violations can be upwards of \$50,000. While PHI can be disclosed for the purposes of treatment, payment, or operations, covered entities should have business associate agreements in place with vendors or other external organizations that have access to PHI.

While these challenges do bring to light heightened concerns with privacy and security, particularly as it becomes easier from a technical perspective to share health information between clinicians and platforms, EHR systems create opportunities for health information to be patient-centric. EHRs can follow the patient between transitions and levels of care, with the ability to create a more accurate and complete health record. When looking to purchase or switch EHR systems, it is becoming increasingly more important to understand the interoperability and data exchange capabilities of various IT products to ensure a longitudinal, patient-centric record to supplement the more traditional and expected features and functions of EHR systems.

Many EHR systems contain the ability to complete clinical workflows; document allergies, medications, and problem lists; write and/or dictate notes; and document needed data for reimbursement. Of course, there are options and configurations within different systems that can make clinical workflows and data entry more streamlined and less onerous, and it is important to view demonstrations and receive information on high-import workflows.

Further, there are functional differences between systems when it comes to workflows, documentation, and integration, and understanding the capacities and limitations of EHR systems is important before purchase.

### Sample workflows and functionality to consider:

1. Scheduling and registering patients; using Fact sheet; collecting co-pay
2. Scheduling at a hospital
3. Clinical intake
4. Face-to-face visits, including clinical navigators, note templates, and history and physical
5. Ordering labs, radiology, and medication (e-prescribing)
6. Operative notes (be able to pull information from other notes and other parts of the chart)
7. Functionality for building fee schedules
8. Claims processing

Like any large purchase, EHR system demonstrations and sales conversations can gloss over the challenges of the system and oversell functionalities. Doing a formal request for proposal (RFP) process can be a helpful tool to receive consistent and thorough information from vendors. The ONC has created an RFP template, available at [healthit.gov/resource/request-proposal-rfp-template-health-information-technology](https://www.healthit.gov/resource/request-proposal-rfp-template-health-information-technology), which provides the functionalities, features, and capabilities of systems that are important to consider when selecting an EHR. Adding any specific clinical tools, workflows, or exchange capabilities that your particular type of practice may need should also be part of customizing the RFP. Additionally, understanding the system's capacity for meeting and reporting to relevant regulatory programs, such as



## CODING, BILLING, AND OFFICE WORKFLOW

the Merit-based Incentive Payment System (MIPS), is particularly important. MIPS program requirements will be discussed in detail in a later section. Being aware of requirements to meet federal and state regulations is another necessary point to consider throughout the EHR system selection process.

MIPS is part of CMS' Quality Payment Program (QPP). MIPS requires eligible providers to report on four categories: Quality, Improvement Activities, Promoting Interoperability, and Cost. Performance across the categories is represented in a final score, and such final score will determine the payment adjustment for Medicare Part B payments.

Reviewing feedback from current users of various EHR systems can also be helpful when making a purchasing decision. While there are online blogs and other informal sources of feedback, companies such as KLAS Research (*klasresearch.com*) utilize user and patient feedback coupled with their own research findings to provide impartial information and data on a variety of EHR systems and related IT products. Physicians and other office staff can set up a KLAS account at no cost and review the compiled research and information, which includes usability, configurability, reporting capabilities, and interoperability.

Several other important aspects to consider when selecting an EHR system include understanding the hardware and server requirements (for example, is the system hosted elsewhere, or will it need to be hosted on-site?); user and licensing fees and volume restrictions; system support during the implementation, go-live, and post-live; training options; and staffing needs for

long-term maintenance and support. It is also helpful to understand the data rights and the process and format for data conversion, both for the possibility of needing data for a future EHR switch and for sharing data with a third-party program or application. In addition, you should review schedule of upgrades and system optimization to ensure that the system stays up-to-date with certification requirements.

Understanding the above allows physicians and their staff to better grasp the functionality and usability of the systems under consideration. Once an EHR product is integrated into the practice, however, it is equally important to stay current with new features, functionalities, and system upgrades. Relatedly, training all members of the practice who will interface with the system will further their understanding of how to best utilize the system, streamline their workflows, and stay up to date with documentation practices needed for downstream use, including for compliance with regulatory programs.

As technology continues to advance, patient-wearable devices, third-party applications, registries, and cloud platforms will quickly become integral to and concurrent with EHR utilization. The ability of EHRs to capture discrete documentation and send data using standards will be vital for generating meaningful and actionable information that can be used for patient care. Surgeons and practices are encouraged to take advantage of the available technologies and tools at hand in order to enhance the quality and accessibility of patient care and clinical data.

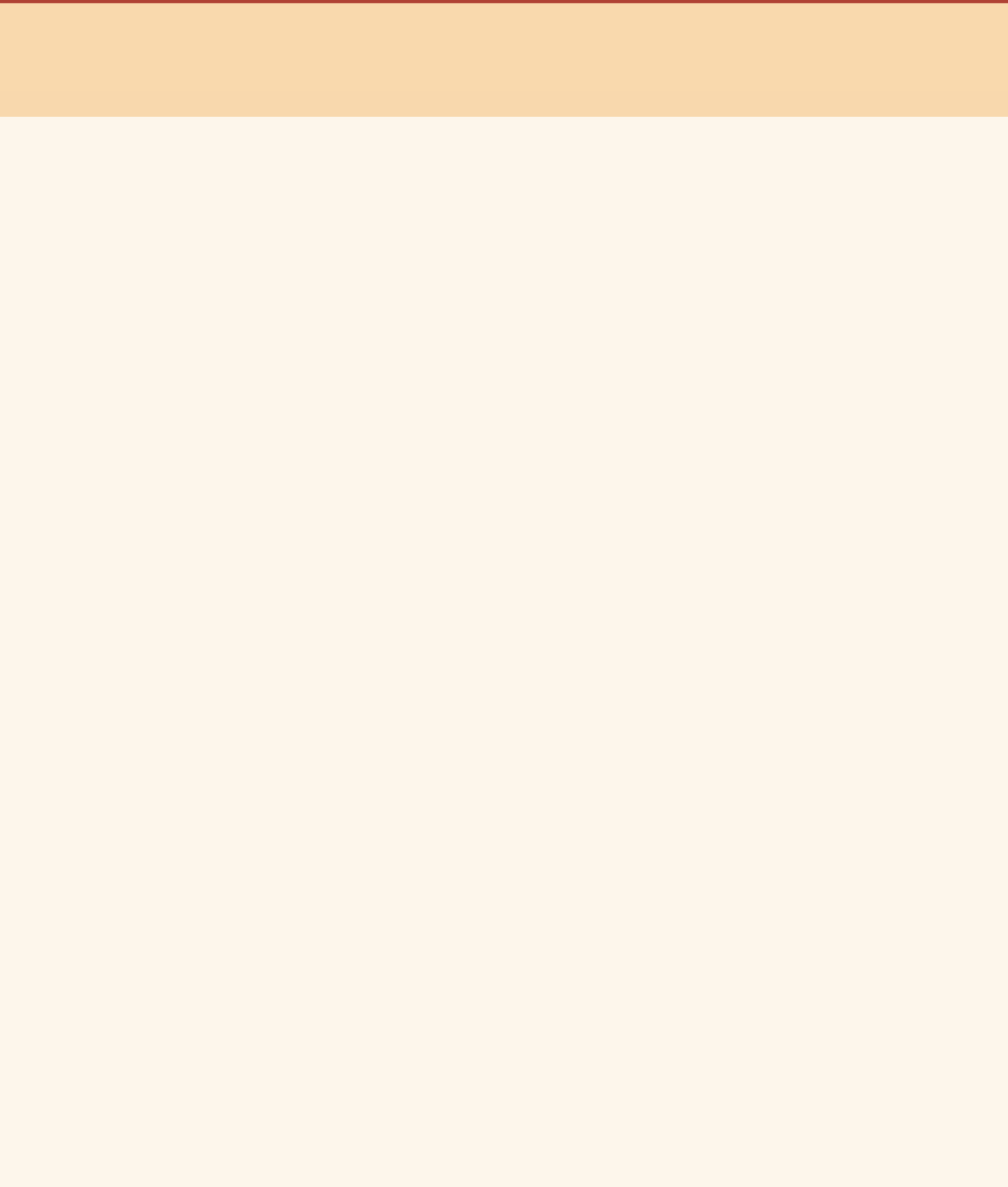
In some circumstances, practice management software—rather than an EHR system—may be sufficient to collect and utilize patient information. You should consider your practice size, finances, and other relevant factors to choose the right products that best meet your office's goals.





## References

1. U.S. Department of Health & Human Services. HITECH Act Enforcement Interim Final Rule. Available at: <https://www.hhs.gov/hipaa/for-professionals/special-topics/hitech-act-enforcement-interim-final-rule/index.html>. Accessed August 19, 2019.
2. Centers for Disease Control and Prevention. Public Health and Promoting Interoperability Programs (formerly known as Electronic Health Records Meaningful Use). Available at: <https://www.cdc.gov/ehrmeaningfuluse/introduction.html>. Accessed August 19, 2019.
3. The Office of the National Coordinator for Health Information Technology. Health IT Dashboard. Quick Stats. Available at: <https://dashboard.healthit.gov/quickstats/quickstats.php>. Accessed August 19, 2019.





IN THIS TEMPLE  
THE HEARTS OF THE PEOPLE  
WHOM HE SAVED THE UNION  
MEMORY OF ABRAHAM LINCOLN  
IS ENSHRINED FOREVER

# REGULATORY COMPLIANCE





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### Participating in Value-Based Quality Programs

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) called for major changes to the physician payment system. Many of the changes outlined in MACRA are intended to transition toward value-based care, rather than the current fee-for-service model. Value-based care incentivizes higher quality of care at a lower cost. As directed under MACRA, CMS implemented the QPP in 2017 to spur the transition from a system of volume to a system of value.

Surgeons can participate in the QPP through two tracks: MIPS, or Advanced Alternative Payment Models (A-APMs). The MIPS program aims to reward clinicians providing high-value care, as defined by performance in four categories: Quality, Promoting Interoperability (PI), Improvement Activities, and Cost. For clinicians who do not meet the MIPS performance requirements, Medicare Part B payments will be reduced. The A-APM pathway rewards clinicians who participate substantially in an “advanced” APM, which bears “more than nominal” financial risk, makes use of CEHRT, and collects “MIPS-like” quality measures. “Qualifying Participants” (QPs) in A-APMs are exempt from MIPS and automatically earn a 5 percent incentive bonus to their Medicare Part B payments until 2024, with the opportunity for gain sharing.

MACRA sets guidelines and benchmarks for implementation, but as the program progresses, CMS continues to make significant changes to the QPP requirements. **You should expect yearly changes to the reporting requirements, payment adjustments, and performance.**

Participation and reporting requirements, as well as scoring rules, differ depending on the size and type of practice (i.e., there are special accommodations for “hospital-based” clinicians, as well as rural and small practices). While many surgeons who are employed by large delivery systems are often tied to the participation decision of their employer, private practice surgeons can determine the participation option that best fits their practice and resources. While participation in an A-APM may be an option for some, many smaller to mid-sized practices are required to participate under MIPS and assessed under four defined categories.

#### **MIPS Eligibility**

Because surgeons’ practice situations vary, it is important to know and understand if, and how, you or your practice is required to participate in the QPP. CMS bases eligibility and reporting requirements on practice size and location (i.e., rural versus non-rural), your Medicare volume, and other factors. Based on these criteria, some surgeons may be excluded from MIPS altogether, be required to report less data, or receive other scoring accommodations.

The first step in determining the best option for how an individual practice should participate in the QPP is identifying how CMS has classified your provider status. This can be done by entering your NPI number into CMS’ QPP Participation Status tool. The tool indicates special designations (such as small or rural practice), program eligibility based on the low-volume threshold, and/or

#### **You must participate in MIPS if you:**

- Bill more than \$90,000 for Part B covered professional services;
- See more than 200 Part B patients; and
- Provide 200 or more covered professional services to Part B patients.





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participation in an A-APM. Small practices are eligible for bonus points in the Quality performance category and abbreviated reporting requirements for Improvement Activities to recognize the hardships they may face. In addition, small practices can apply for an exception and reweighting of the Promoting Interoperability performance category. If you are considered a QP in an A-APM, you are not required to report data through MIPS; instead, you would be eligible for a bonus payment based on your QP status.

### Special Statuses

- **Small Practice**  
Surgeons in solo practice or a practice of 15 or fewer MIPS-eligible clinicians reporting under the same TIN
- **Rural or Health Professional Shortage Area (HPSA) Practice**  
Practices with more than 75 percent of the NPIs billing under the individual MIPS-eligible clinician or group TIN are designated in a ZIP code as a rural area or HPSA

### MIPS Reporting Requirements

Surgeons who exceed the low-volume threshold are required to report MIPS data for the Quality, Improvement Activities, and Promoting Interoperability categories. There is no reporting requirement for the Cost category, as CMS calculates that score using data from Medicare Part B claims. The maximum MIPS overall score you can achieve is 100 points, and performance in each category accounts for a certain percentage of the final score.

### Small Practices

(Surgeons in solo practice or a practice of 15 or fewer MIPS-eligible clinicians reporting under the same TIN are considered small practices)

- **Quality**  
Six points will be added to the overall Quality performance score for any small practice physicians who report data for at least one Quality measure.
- **Improvement Activities\***  
Points for this category are doubled; therefore, only one high-value or two medium-value activities are required to receive full credit.  
*\* The same rule applies to rural and HPSA practices*
- **Promoting Interoperability**  
Surgeons in small practices may submit a Hardship Exception Application. If approved by CMS, the PI category will be allotted zero weight and the PI category weight is reallocated to the Quality performance category.

### Quality

Clinicians and groups are required to report on a minimum of six measures, including one outcome or high priority measure, to meet the requirements of the Quality category. Points are awarded for these measures based on clinicians' performance against benchmark data from CMS. Benchmark data are typically based on historic data from a prior performance year; however, for measures that lack historic data, CMS will attempt to calculate benchmarks based on performance year data. To maximize your performance score on a measure, you must report Quality data for at least a minimum



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percentage of all patients to which each measure is applicable over the course of the calendar year. This percentage is subject to change every calendar year.

You can choose from numerous MIPS measures, including CMS Specialty Measure Sets, or specialty-specific measures offered by a Quality Clinical Data Registry (QCDR). Depending on the measures selected and the make-up of your practice, you will have the option to report measures via claims, a QCDR, Qualified Registry, or through CEHRT. For more information about Quality reporting requirements and the options to participate in MIPS, visit the “Reporting for Quality” webpage in the ACS QPP Resource Center.

### Improvement Activities

The Improvement Activities component of MIPS aims to measure provider engagement in activities that improve clinical practice. Each year, CMS updates, adds, or removes activities based on stakeholder feedback and relevance to the program’s objectives. The QPP website offers a comprehensive list of the available activities at [qpp.cms.gov/mips/explore-measures/improvement-activities?py=2019&measureSubcategoryName=Care%20Coordination](http://qpp.cms.gov/mips/explore-measures/improvement-activities?py=2019&measureSubcategoryName=Care%20Coordination). To receive full credit, most surgeons are required to select and attest to having completed between two and four activities depending on the weight of the activities selected. The reporting requirement for the Improvement Activities category is fulfilled by simple yes/no attestation of completing the activity for a minimum of 90 continuous days. The attestation can be submitted through a qualified registry, a QCDR, CEHRT, or the QPP portal. Supporting documentation is currently not required at the time of attestation, although CMS encourages clinicians to keep documentation records on file in the event of an audit. For more information about Improvement Activities reporting requirements and ways to participate in MIPS, visit the “Reporting for Improvement Activities” webpage in the ACS QPP Resource Center.

### Promoting Interoperability (PI)

The PI category is designed to encourage and reward the use of CEHRT for data exchange and to increase patient engagement. There are four broad objectives for PI, each containing a measure set: public health and clinical data exchange, electronic prescribing, health information exchange, and provider to patient exchange. There are also requirements related to protecting patient health information (previously known as the security risk analysis). If providers do not meet any of the PI exceptions for the measure categories, they are required to select measures from within each category and submit measure data to CMS for a continuous 90-day period.

### Promoting Interoperability Exceptions

A clinician or group participating in MIPS may submit a Hardship Exception Application. If approved by CMS, the PI category is reweighted to zero, and the remaining points are reallocated to the Quality category. CMS cites the following reasons for a possible exception:

- MIPS-eligible clinicians in a small practice
- MIPS-eligible clinicians using decertified EHR technology
- Insufficient Internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT

More information about Hardship Exception Applications can be found on the QPP website, [qpp.cms.gov/mips/promoting-interoperability](http://qpp.cms.gov/mips/promoting-interoperability).

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## Cost

CMS will calculate scores for the Cost category automatically from Medicare claims data. In other words, although Cost is a weighted category, **there are no reporting requirements for Cost**. The Cost score is based on two broad total cost measures: the Total per Capita Costs (TPCC) measure and Medicare Spending per Beneficiary (MSPB) measure, as well as more specific episode-based cost measures. Points are awarded for these measures based on clinicians' performance against a benchmark. The benchmark in the Cost category is determined based on the current years' cumulative national performance.

CMS began adding episode-based Cost measures to MIPS for the 2019 performance period, and it continues to develop additional episode-based measures each year for implementation in the program. Physicians should become familiar with the Performance Feedback reports they receive from CMS for the previous year.

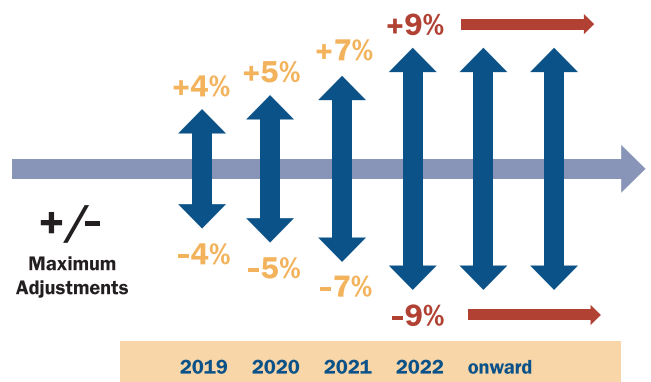
## Performance Feedback Reports

CMS will provide feedback reports to all clinicians who participate in MIPS in July following the performance year, allowing clinicians to understand the scores and to benchmark performance against other participants. These reports will include essential information about how you performed on all measures and data you submitted to MIPS, the overall score you will receive, and your payment adjustment. It is important to become familiar with these reports, because they will help you predict your performance scores for following years and the amount of resources you may need to allot for MIPS participation in the future. MIPS Feedback Reports are available in your QPP portal and can be accessed by logging into your account on the QPP website.

## MIPS and Medicare Reimbursement

Payment adjustments for Medicare Part B associated with MIPS reporting are applied to the reimbursement that physicians receive two years following the performance/reporting period. For example, your Medicare Part B reimbursement in 2019 is based on your 2017 MIPS performance score. As the program progresses, CMS will continue raising the overall performance score required to avoid a payment penalty. Payment adjustments based on 2017 MIPS performance were +/- 4 percent and will increase to +/- 5 percent for payments based on 2018 performance, +/- 7 percent for payments based on 2019 performance, and +/- 9 percent for payments based on 2020 performance or thereafter. However, based on performance, the actual positive adjustments participants received in the first two years of the program were significantly lower. Negative adjustments associated with the program are set to gradually increase until the 2020 performance year, which affects 2022 Medicare Part B reimbursement; following 2022, the adjustment is set to remain at +/-9 percent. Since MIPS is a budget neutral program, where the total amount of positive payment adjustments must equal the total amount of negative

### How much can MIPS adjust payments?



(Graphic from the Centers for Medicare & Medicaid Services.)



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payment adjustments each year, CMS will not know the extent of the positive payment adjustments until after the completion of each performance year. As the performance threshold and penalties rise, it is important to consider the resources required to participate in the program relative to the potential positive or negative payment adjustment each year and what impact that might have on your practice. If you exceed the low-volume threshold and are eligible for MIPS, then you are required to participate. Choosing to not report at all in 2020 will result in the maximum negative adjustment, which will be -9 percent in 2022 and beyond.

Many surgeons have voiced concerns about the unnecessary burden and expense associated with MIPS participation and opted out of reporting in the early years of MIPS because penalties and positive adjustments were low. For example, the maximum positive adjustments participating clinicians will receive in 2019 is +1.88 percent (based on 2017 performance).<sup>1</sup> These small positive adjustments made it hard for many surgeons to justify the cost of participating in the program. However, as MIPS moves out of its transitional phase and into full implementation, increased negative payment penalties could be detrimental to small and private practices' reimbursement. To avoid penalties or earn points to minimize the impact of negative adjustments (without spending extensive time or resources), you should consider the following strategies:

- **Avoid purchasing expensive EHR systems and explore PI exceptions.** Given the cost of implementing or upgrading to CEHRT, it may not be cost-effective for small private practices to purchase CEHRT for the purpose of fulfilling requirements of the PI category. You should be aware of all your options, such as the ability of eligible clinicians to apply for a PI exception and potentially qualify for a reweighting of the PI category points allotted to the Quality category.
- **Understanding and performing well in Cost.** Although there is no reporting requirement for Cost, you will still receive points for this category based on your Medicare claims data. These data are shared with physicians through yearly MIPS Performance Feedback reports, and understanding these may help you lower your costs or better predict Cost category scores in the future. CMS is required to gradually increase the weight of the Cost category so that it equals the weight of the Quality category in the 2022 performance year, making high performance in Cost increasingly important over time.
- **Attest to Improvement Activities.** You are likely completing activities in daily practice operations that meet the requirements for various Improvement Activities that are part of MIPS, such as promoting the use of patient-reported outcome tools, Enhanced Recovery After Surgery (ERAS) protocols, or the ACS Surgical Risk Calculator. Attesting to the completion of Improvement Activities during a consecutive 90-day period will result in earning full credit and 15 points toward the MIPS final score.

For more detailed information about the QPP and how to participate, visit the ACS QPP Resource Center, [facs.org/advocacy/qpp](https://facs.org/advocacy/qpp).





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### Health Care Laws, Rules, and Regulations

**Please note:** The following material should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general informational purposes only, and you are urged to consult your own lawyer on any specific legal questions you may have concerning your situation.

#### **Fraud and Abuse**

There are several federal laws that aim to prevent fraud and abuse in federal health care programs such as Medicare and Medicaid.

In some industries, it is acceptable to reward those who refer business. In federal health care programs, however, it is considered a crime. The **Anti-Kickback Statute (AKS)** prohibits paying and even offering to pay any remuneration (directly or indirectly) in return for referring patients or inducing purchases, leases, or orders for goods or services that are covered by federal health care programs. The AKS also prohibits the receiving or soliciting of such remuneration. *Remuneration* is defined broadly to include cash, bribes, rebates, and discounts in any form. The purpose of the AKS is to prevent overutilization, patient steering, and improper influence on medical decisions, which the government believes can all lead to increased costs to federal health care programs.

The AKS is a criminal law that requires the government to prove the conduct was “knowing” or “willful.” However, this does not mean that the government must prove that the person had actual knowledge that there was a violation of the AKS or had specific intent to violate the law. Also, courts have held that if one purpose of remuneration is to induce referrals, the AKS is violated even if the remuneration was also intended to compensate for professional services. Because the AKS is so broad, it can be implicated in any arrangement where referrals are involved—for example, when a physician rents office space or equipment from a hospital.

There are criminal and civil penalties for violation of the AKS. The criminal penalties include imprisonment for up to five years for each violation and a money penalty of up to \$25,000 for each violation. Civil penalties include a money penalty of up to \$50,000 per violation and exclusion from participating in any federal health care program. Any person or organization can violate the AKS; the law is not limited to health care providers.

The AKS includes twenty-eight safe harbors. Each safe harbor has specific and detailed requirements. If an arrangement meets all of the safe harbor requirements, the government will not prosecute the organizations and/or individuals involved in the arrangement. The following is a summary of the safe harbors most likely applicable to surgeons:



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Safe Harbor	Description
Space Rental	This allows, for example, a hospital that receives referrals from a physician to rent space to the physician. Key requirements include that the agreement be in writing, and the rental charge must be set in advance, commercially reasonable, and fair market value.
Equipment Rental	This is similar to the space rental safe harbor and allows, for example, a hospital that receives referrals from a physician to receive payments from the physician in exchange for renting equipment to the physician. The requirements are similar to the space rental safe harbor.
Personal Services and Management Contracts	Under this safe harbor, a hospital may hire and compensate a physician as an independent contractor to provide services to the hospital, even if the physician refers patients to the hospital. One key requirement is that the compensation be fixed in advance and not based on the volume or value of referrals.
Sale of Practice	A provider that purchases another provider's practice may compensate the selling provider. There are also specific requirements when a hospital is purchasing a provider's practice.
Employees	This protects payments an employer makes to its bone fide employees.
Practitioner Recruitment	Under this safe harbor certain payments can be made to a physician in practice less than one year to entice the physician to locate or relocate to an area designated as a health professional shortage area.
Investment in Group Practices	This allows a physician to receive investment income for an equity interest in a group practice.
ASCs	Under this safe harbor a physician can receive certain investment interest payments for ownership in ASCs. There are a number of requirements, which differ depending on whether investors are (1) surgeons in the same specialty or general surgeons, (2) physicians in the same specialty; (3) physicians in multiple specialties, or (4) physicians and a hospital.
E-Prescribing Items/Services	This allows a physician on staff who refers to the hospital to receive from the hospital hardware, software, or IT services used to receive and transmit electronic prescription information.
EHR Items/Services	Similar to e-prescribing, this allows an entity such as a hospital, to donate to a physician hardware, software, or IT services necessary and used predominately for electronic medical records.



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The **Stark Law** prohibits a physician from referring patients for certain “designated health services” to an entity with which the physician (or his or her immediate family member) has a “financial relationship” if those designated health services are covered by a federal health care program. For example, the Stark Law prohibits a physician from referring a Medicare patient to a lab that is also owned by the physician (or his or her immediate family member), unless an exception applies. The Stark Law defines immediate family as including children, siblings, spouses, in-laws, stepchildren and stepsiblings, grandparents, grandchildren, and spouses of a grandparent or grandchild.

The designated health services covered by the Stark Law are as follows:

- Clinical laboratory services
- Physical therapy and occupation therapy services
- Radiology or other diagnostic services (including MRI, CT)
- Radiation therapy services
- Durable medical equipment
- Parenteral and enteral nutrients, equipment, and supplies

- Prosthetics, orthotics, and prosthetic devices
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

A financial relationship includes (1) an ownership interest and (2) a compensation arrangement, which is any form of direct or indirect remuneration, such as personal services contracts, medical directorships, lease arrangements, and consulting arrangements. For example, if a physician receives payment from Hospital X under a consulting agreement, the Stark Law prohibits the physician from referring a patient to Hospital X for clinical laboratory services, unless an exception applies.

The Stark Law contains thirty-seven exceptions.

These exceptions are specific to whether the financial arrangement is a compensation arrangement or ownership interest. Like the AKS safe harbors, each Stark Law exception involves a number of specific requirements. The following is a summary of some of the Stark exceptions most likely relevant to surgeons, and that apply to both compensation and ownership arrangements.

Exception	Description
In-Office Ancillary Services	This allows a physician to refer a patient for designated health services within a group practice. There are a number of specific requirements regarding who can provide the services, where the services are performed (for example, in the same building), and how the services are billed.
Academic Medical Centers	This provides an exception when the referring physician is an employee of the academic medical center, has a faculty appointment, and provides substantial academic or clinical teaching services.
Implants Furnished by an ASC	This covers implants implanted by the referring physician or member of the referring physician's group practice in a procedure in an ASC with which the referring physician has a financial relationship.
Intra-Family Rural Referrals	This allows a limited exception for referrals of designated health services to immediate family members when the patient resides in a rural area as defined by federal law, and no other person or entity is available to provide the services within a certain distance from the patient.



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The following is a summary of some of the Stark exceptions that apply only when the financial relationship is a compensation arrangement:

Exception	Description
Space Rental	This is similar to the AKS safe harbor.
Equipment Rental	This is similar to the AKS safe harbor.
Employees	The requirements for this exception are different than the AKS safe harbor. It requires that the employment be for identifiable services and that the amount of compensation be consistent with fair market value.
Personal Services Arrangements	This is similar to the AKS safe harbor.
Practitioner Recruitment	This exception allows a physician to refer patients for designated health services to a hospital even if a hospital pays the physician to recruit the physician. The requirements are fairly extensive and are generally similar to the AKS safe harbor.
Charitable Donations by a Physician	This allows charitable donations by physicians to tax-exempt entities if the donations are not offered or solicited based on referrals.
Nonmonetary Compensation	This exception permits, for example, a hospital to provide items or services (not cash or cash equivalents) to physicians in an amount not to exceed a certain aggregate amount per calendar year. The current aggregate annual limit is around \$400, which is adjusted for inflation each year.
Medical Staff Incidental Benefits	Under this exception, hospitals are allowed to provide items or services valued at not more than \$35 (not cash or cash equivalents) to all members of the medical staff. The item/service must be used on the hospital's campus.
Compliance Training	Entities such as hospitals are allowed to provide compliance training to physicians if the training is held in the local community or service area. Compliance training includes subjects such as federal requirements for billing, coding or documentation.
Professional Courtesy	This allows hospitals to provide free or discounted health care items or services to all physicians on the medical staff if the items/services are routinely offered by the hospital.
EHR, E-Prescribing, and Community-Wide Health Information Systems	The Stark exceptions, which allow hospitals to donate to a physician hardware, software, or IT services necessary and used for electronic medical records and electronic prescribing, are the same as the AKS safe harbors. In addition, Stark contains an exception that allows entities to provide IT items or services to a physician to allow access to and sharing of electronic medical records, complementary drug information systems, general health information, medical alerts, and related information for patients served by community providers and practitioners with the goal of enhancing community health.





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Sanctions for Stark Law violations include denial of payment or refunding amounts already paid related to the referral, money penalties of up to \$100,000, and exclusion from federal health care programs. Unlike the AKS, proof of intent is not required to prove a Stark Law violation.

The **False Claims Act (FCA)** prohibits the submission of false or fraudulent claims to the government, including government health care programs such as Medicare, Medicaid, and Tricare. Generally, a violation occurs when

1. A person submits a claim for payment to the government or causes the claim to be submitted;
2. The claim is false or fraudulent; and
3. The person knows of its falsity.

The government need not prove specific intent to defraud—instead, the government only has to prove that the person had actual knowledge of the information or acted in “deliberate ignorance” or “reckless disregard” of the truth or falsity of the information. As an example, if a physician submitted a bill to Medicare without performing some research to determine if the bill was appropriate under Medicare, that might be considered acting in reckless disregard of the truth or falsity of the claim. Common examples of claims that likely violate the FCA include the following:

- Submitting a claim for a service that was not rendered
- “Upcoding” a claim
- Submitting a claim reporting that one physician performed a service when a different physician performed the service

In addition, the FCA requires physicians to repay the government within 60 days after the physician discovers that he or she has received an overpayment. Failure to

repay the government within 60 days can also become a false claim and is sometimes referred to as a “reverse false claim.”

The government can recover fines in the amount of \$5,500 to \$11,500 for each FCA violation. In addition, the government can recover three times the amount of damages it sustained.

The FCA also includes a “whistleblower” provision that allows a private individual to bring an FCA case against a physician. The government may become a part of the whistleblower’s case, and they can work together to pursue the case against the physician. If there is a recovery, the whistleblower receives 15–25 percent of the proceeds. Current and former employees are common whistleblowers under the FCA.

### **Data and Privacy**

The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** is a federal law that protects the confidentiality of patient information, called protected health information (PHI). HIPAA applies to individuals and organizations that meet the definition of “covered entity,” which includes physicians who transmit any health information in electronic form in connection with a HIPAA transaction. Physicians who submit electronic claims to third parties, such as insurance companies, for payment are subject to HIPAA. The HIPAA requirements are found in the Privacy Rule, the Breach Notification Rule, and the Security Rule, described below.

The **HIPAA Privacy Rule** applies to any form of PHI: written, oral, or electronic. The Privacy Rule limits when a covered entity can access PHI within its own organization and when a covered entity can disclose PHI to an outside party. Generally, a covered entity cannot access a patient’s PHI or disclose PHI to a third party unless (1) the patient signs an authorization allowing the access or disclosure or (2) a HIPAA exception allows access or disclosure. The



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most common exceptions allow covered entities to access and disclose PHI for treatment and payment purposes.

The Privacy Rule also does the following:

- Specifies what is required in a written authorization for release of records
- Requires the covered entity to give patients a Notice of Privacy Practices, which explains to patients how the covered entity can use and disclose their PHI
- Gives the patient a right to obtain access to his or her PHI in a covered entity's possession
- Gives the patient a right in certain circumstances to amend PHI in a covered entity's possession
- Gives the patient a right to obtain from a covered entity a list of some of the covered entity's disclosures of the patient's PHI to third parties (an "accounting of disclosures")
- Requires the covered entity to enter into a written business associate agreement with any individual or organization that provides services to the covered entity and in doing so will create, receive, transmit, or maintain PHI for the covered entity
- Requires the covered entity to take reasonable measures to safeguard PHI
- Requires the covered entity to train its employees on HIPAA requirements upon hire, periodically thereafter, and when there is a material change to the policies and procedures
- Requires the covered entity to sanction employees who violate HIPAA
- Requires the covered entity to implement written policies and procedures that cover all Privacy Rule requirements
- Requires the covered entity to designate a Privacy Official who is responsible for overseeing compliance with the Privacy Rule and implementing the required policies and procedures
- Requires the covered entity to implement a process for receiving and investigating complaints regarding HIPAA compliance
- Requires the covered entity to document the actions required in the Privacy Rule (for example, the covered entity must document the designation of the Privacy Official, its training materials, and proof that employees received training)

The **HIPAA Breach Notification Rule** requires a covered entity to report a breach of unencrypted PHI to all affected individuals, the government, and, in some cases, the media. A breach is presumed to occur when a covered entity uses or discloses PHI in a manner that is not permitted by the Privacy Rule, unless the covered entity can show that there is a low probability that the PHI has been compromised, based on a risk assessment of several factors.

The **HIPAA Security Rule** applies to PHI in electronic form and requires a covered entity to take certain administrative, technical, and physical measures to protect the integrity, availability, and confidentiality of electronic PHI (ePHI). One of the most important and often-overlooked requirements of the Security Rule is that the covered entity must periodically perform a risk analysis to thoroughly assess the potential vulnerabilities and risks to the covered entity's ePHI. This is not a "gap analysis" to determine whether the covered entity is in compliance with the Security Rule requirements; instead, it is a general assessment of the risks and vulnerabilities that exist on the covered entity's information systems that contain ePHI. A risk analysis is therefore technical and can be performed by third-party information technology vendors. For covered entities that perform their own risk analyses, the Office for Civil Rights, an agency within the U.S. Department of Health and Human Services, has



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developed a Security Risk Assessment Tool to assist with the process. The Tool can be found online at [healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool](https://healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool).

In addition to performing a risk analysis, there are a number of additional Security Rule requirements to be aware of, including the following:

- Implementing a risk management plan
  - Having procedures to terminate access to ePHI when an employee separates from employment
  - Limiting access to ePHI to those who have a need for access based on their job responsibilities
  - Guarding against malware
  - Implementing a data backup plan and disaster recovery plan
  - Implementing a plan for workstation security
  - Disposing of ePHI properly
  - Tracking inventory of hardware and electronic media
  - Assigning unique user IDs for tracking user identity
  - Implementing a procedure to automatically terminate user sessions after a certain period of inactivity
  - Implementing encryption (or alternate protections) for PHI at rest and in transmission
  - Implementing audit controls
  - Monitoring activity on information systems (for example, monitoring for the removal of large amounts of PHI from the system, identifying suspicious activity outside of business hours, and identifying failed logins)
  - Implementing a process for identifying and investigating security incidents
- Implementing written policies and procedures that cover all Security Rule requirements
  - Designating a Security Official who is responsible for overseeing compliance with the Security Rule and implementing the required policies and procedures

The Office for Civil Rights enforces civil violations of HIPAA. Penalties range from \$100 to \$50,000 per violation, with a limit of \$1.5 million for violations that occur within one calendar year. The U.S. Department of Justice enforces criminal violations of HIPAA, which typically involve intentional actions.

### **Employment and Labor**

The federal **Occupational Safety and Health Act (OSHA)** was passed in the 1970s with the goal of ensuring safe working conditions for all American workers. Generally speaking, OSHA can be divided into two primary components that outline an employer's responsibilities:

- A. The "general duty clause" provides that each employer must establish and maintain working conditions that are free from recognized hazards that could lead to death or serious physical harm.
- B. Specific provisions the employer is obligated to comply with created by the Department of Labor. These OSHA standards fall into two primary categories:
  1. General industry standards, which govern all work sites
  2. Industry-specific standards (for example, standards for the medical field)

It is critical that every practice group have someone designated to ensure that the group is both aware of and following any and all such standards applicable to their field and site. Failure to follow these standards can lead to significant penalties.



## REGULATORY COMPLIANCE

The federal **Americans with Disabilities Act (ADA)** is predicated on one basic principle: allowing disabled individuals the fullest opportunity to interact with and participate in society. The public accommodation provisions of the ADA mandate certain access and physical facility provisions for any office or facility; however, to be covered by the ADA's employment provisions, the employer must employ 15 or more employees (including part-time employees) who work 20 or more calendar weeks per year.

The basic mandate of the employment provisions of the ADA is to ensure equal opportunities to a qualified individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the job. Therefore, for an employer to adequately address its legal obligations, it must go through an analysis of four key questions:

1. Is the individual disabled, as defined by the ADA?
2. Is the individual qualified for the job?
3. If not qualified, could the individual perform the essential functions of the job with an accommodation?
4. Would the accommodation constitute an undue hardship on the practice?

Accommodations can include adjusted work schedules, small changes to nonessential functions, and equipment to make the workplace more accessible for employees. Although an employer is entitled to gather this information, if the need for an accommodation arises, it is critical to note that any questions asked of an employee must be narrowly tailored and directly related to the position at issue. Applicants cannot be asked any specific questions regarding a disability until after an offer of employment has been made.

Any analysis under the ADA must be fact-specific, and the employer must engage in an interactive process of determining if there is a reasonable accommodation available.

The federal **Fair Labor Standards Act (FLSA)** mandates the federal minimum wage and also provides the overtime mandate that requires most employees to be paid 1.5 times their hourly rate for work in excess of 40 hours in any given work week (with the exception of a few narrowly tailored exemptions). To qualify for an exemption, the position must:

1. Be paid on a salary basis (meaning the amount of hours worked has no impact on pay)
2. Have a salary of at least \$455 per week
3. Require duties that fit under one of the handful of FLSA exemptions (for example, professional, administrative, executive, computer professional)

The default is that all employees are entitled to overtime, so the burden is on the employer to establish that the exemption requirements are met.

The FLSA regulations include special rules for some hourly workers in health care facilities that allow overtime to be calculated over a 14-day period (rather than a seven-day period) to account for unique schedules (if set in writing and accounts for daily overtime). The FLSA exemptions and applications are often misunderstood by employers, so if any deviation is to be made from the standard hourly and overtime approach, an analysis must be conducted to confirm that the job qualifies for the exemption.

The federal **Family and Medical Leave Act (FMLA)** requires covered employers to provide up to 12 weeks of unpaid leave during a 12-month period for employees for the purposes of caring for a new child, for a family member with a serious health condition, or for the





## REGULATORY COMPLIANCE

### **Tips to Ensure Regulatory Compliance**

The following activities are key to ensuring regulatory compliance:

1. Know the requirements. This means providing staff with educational opportunities to learn about the laws and to stay informed of changes. When it comes to compliance, ignorance is not a defense. In addition, if employees are not aware of the laws, it makes it difficult to expect them to comply with such laws.
2. Prepare and implement practical written policies and procedures so that the practice's day-to-day policies further compliance.
3. Prepare and implement a compliance plan to direct how compliance issues are identified, reported, and addressed in the practice. The government has issued guidance to physicians for components of effective compliance plans, which can be found online at [oig.hhs.gov/authorities/docs/physician.pdf](https://oig.hhs.gov/authorities/docs/physician.pdf).
4. Designate a compliance officer responsible for the compliance plan.
5. Train employees upon hire and periodically (usually every year).
6. Enforce disciplinary standards when employees violate policies and procedures.
7. Conduct internal monitoring and auditing of compliance issues.
8. Consult an experienced health care law attorney if any compliance issues arise.

employee's own serious health condition. Additionally, eligible employees are allowed up to 26 weeks of unpaid leave to care for a covered service member with a serious injury or illness.

The initial (and critical) question for many practice groups is whether or not they are covered by the FMLA. To be covered by the statute, the employer must have a total of 50 or more employees (including part-time employees) at any work site within a 75-mile radius of each other during 20 or more calendar weeks in the current or prior year. Further, for an employee to be covered, he or she must have been employed for at least 12 months and worked at least 1,250 hours over the previous 12-month period.

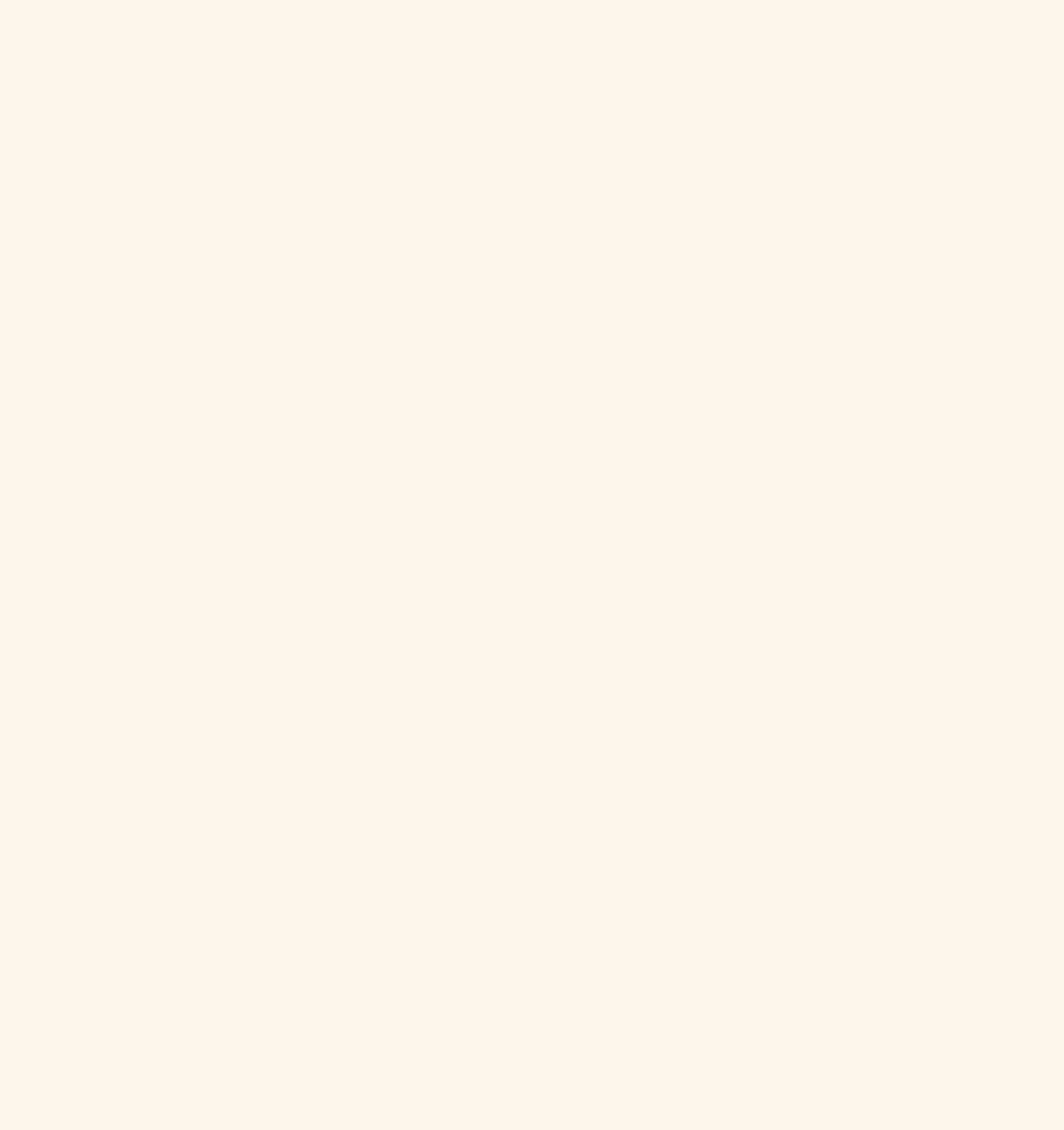
The FMLA involves a very detailed set of regulations that covered employers must follow. Any practice group that determines it is a covered employer will want to ensure that it interacts with a resource knowledgeable in this area (either in-house or via a service provider).

### **State-Specific Laws**

Many states have their own versions of laws that are similar to the federal fraud, abuse, data, and privacy laws. Many states also have laws that track the FMLA, ADA, OSHA, and FLSA, which are often applied to smaller employers than their federal counterparts. If a state law conflicts with federal law, typically the federal law prevails. On the other hand, if the laws do not conflict, physicians and practices must comply with both state and federal laws.

### **Reference**

1. Centers for Medicare & Medicaid Services. Quality Payment Program (QPP) Year 1 Performance Results. Available at: <https://www.cms.gov/blog/quality-payment-program-qpp-year-1-performance-results>. Accessed September 4, 2019.





# ENSURING THE FUTURE SUCCESS OF YOUR PRACTICE



## ENSURING THE FUTURE SUCCESS OF YOUR PRACTICE

### Building Your Brand: Strategy and Organizational Development

#### *Alternative Revenue Streams*

Traditionally, surgeons have generated income via professional service billing for direct patient care, both in the office and in the OR. Over the last few decades, the reimbursement for professional fees has steadily decreased, leading physicians and their practices to seek other means of generating revenue to supplement their income stream. There are a number of alternative revenue sources that may be profitable for private practices.

- **Nonphysician practitioners (NPPs)**—As more work is needed to maintain the same level of income over time, it may make sense to hire an NPP, such as a physician assistant or nurse practitioner, to help manage the increased workload. NPPs can be utilized in many different capacities. For example, they can see established patients, generating their own professional fees and potential procedures for you. In addition, they can assist in surgery, making procedures go more smoothly; perform hospital rounds; and see postoperative office patients, opening up your time to see more new patients.
- **Real estate**—Real estate can sometimes be a risky investment, but if you have guaranteed “renters,” the risk is much lower. Owning the building(s) in which you practice is one way to both save money and build equity. In addition, the money you collect as a landlord is typically considered capital gains and taxed at a lower rate than regular income. As equity is built in the building(s) you occupy, you can potentially leverage that equity to buy other buildings and generate rental income from those properties. Like other real estate investments, however, these other properties do not have your practice group as guaranteed renters and therefore have more risk.

- **Ambulatory surgical centers (ASCs)**—The two broad ways patients and insurers pay for procedures are through professional fees and facility fees, the latter of which go to the facility where procedures are performed. Office visits generate professional fees only, but most procedures requiring an OR generate a facility fee as well. Owning and operating your own ASC can have two significant advantages. First, operational efficiency is dramatically better than in the hospital setting, which lowers turnover times and allows for more procedures to be done per hour of time spent, producing more in professional fees. Second, the ASC collects the facility fee, and an efficiently run ASC can generate significant additional income.

#### *Establishing Community Relationships*

Surgeons are often perceived by the public to be the experts in many major health problems, including cancer, traumatic injury, and other illnesses, and they can use this public perception to build relationships and goodwill in a community. Activities that involve contributions of time and expertise to their local area (for example, volunteering at health fairs or free screening events) show that the surgeon truly is interested in the betterment of the community and its members, rather than just looking to add to their clientele and augment their income.

In addition to finding ways to fill a need and contribute to their communities, new surgeons should also work to establish relationships with other physicians in their state. Relationships between surgeons in a state can help facilitate easy transfers of patients with complex problems from smaller communities to academic or urban tertiary centers. Tertiary specialty surgeons who make the effort to interact with rural surgeons will receive more referrals from those surgeons. ACS state chapters offer an excellent opportunity for statewide collaboration and collegiality among surgeons in all types of practices, which results in better patient care.





## ENSURING THE FUTURE SUCCESS OF YOUR PRACTICE



### Additional Opportunities to Generate Income for Private Practices

**Timothy Bax, MD, FACS**

President, Columbia Surgical Specialists  
Spokane, WA

- **Hospital call relationships**—Traditionally, taking hospital calls for emergency patients was required for all members of the medical staff; however, many institutions have hired hospitalists to take over such care, as the burden of emergency room work on top of a busy surgical practice was becoming untenable. My group practice was able to show our local hospital that a surgical hospitalist service could provide the facility and patients in the community with some of the same advantages as medical hospitalists and that, rather than bringing a whole new group of surgeons to the community, my group could provide those services. This collaboration allowed us to dedicate time to our acute care and trauma services instead of trying to provide all of that care in addition to an already busy elective practice. My group's contract with the hospital has also proven to be profitable, as there is very little overhead associated with the care of hospitalized patients. We began providing a surgical hospitalist service at one hospital in our area, and because of the success of this service line for both the hospital and our practice, we now provide all emergency and trauma care for three of the four hospitals in our community.
- **Administrative services**—My practice group employs about 35 providers, resulting in both the need for and the resources required to hire our own CEO, CFO, and head of IT. Those three individuals have created a company that is 51 percent owned by the doctors in our group, and they also provide administrative, financial, and IT support to many practices in our community that are too small to hire their own staff for those positions. Your group may seem too small to retain these kinds of experts, but if you give them the latitude to start a co-owned company, you may find your group benefiting from their knowledge as well as their entrepreneurship.
- **Ancillary services**—My group of general surgeons has merged with a group of ENT surgeons, which has led to more creative ways of generating income through ancillary services. We employ several audiologists and provide the majority of the hearing testing in the region, including for newborns in the hospital that need a hearing screen. We also have a robust allergy testing and treatment division, own a CT scanner used for the evaluation of sinus and ear problems, and recently opened a physical therapy office that specializes in balance and vestibular problems, serving not only ENT patients with dizziness but also trauma patients who have suffered falls. Practices can also consider providing in-house lab services or becoming involved in retail sales of products pertinent to your areas of expertise; for example, my group owns and manages several hearing aid stores in our region. All of these additional divisions are profitable and offer additional income to the physicians in the practice.



## ENSURING THE FUTURE SUCCESS OF YOUR PRACTICE



### 5 Tips to Build Relationships and Goodwill in Your Community

**Michael D. Sarap, MD, FACS**

Chair, ACS Advisory Council on Rural Surgery;  
Southeastern Ohio Physicians, Inc.  
Cambridge, OH

- 1. Focus on education.** Surgeons are truly the local experts on a variety of disease processes and in the treatment of illnesses and injuries. Use that to your advantage by offering presentations for the public and for community physicians, EMS personnel, and other professionals. Stop the Bleed® is one excellent educational program that would be applicable to every segment of a community. This initiative is a proven lifesaving program that will leave a lasting legacy in a community. Other popular topics are cancer prevention and screening, firearm safety, talks about new techniques and services that you bring to the community, and updates about nationwide trends such as robotic surgery and new cancer treatments. Submit articles to the local news media, and offer to do radio or TV interviews. Local newspapers always have space for well-written articles on health care. Facebook and other social media sites are excellent modalities to disseminate accurate health-care-related information.
- 2. Invest in the youth of the community.** Communities place a high value on any investment in their young members. Establish a relationship with the schools in your community. Participate in career days at the local high school. Offer to mentor students who have an early interest in the medical field. Despite recent hospital leadership actions to ban students from shadowing in the operating room or clinics, patients absolutely love seeing their physicians taking the time to host students who may be future professionals in their community. An excellent way to interact with larger groups of students is to partner with the local Scouting organization to organize a Medical Explorers program. Our facility runs a several-week-long program with once-a-week evening sessions at several different hospital departments and with different specialists. The surgical session utilizes an actual operating room with very simple laparoscopic trainers set up for participants to “operate” in teams on foam organs. The anesthesia crew is in another room and lets participants intubate a model of a patient. This yearly event is so popular that parents tag along to watch the activities. Fostering relationships with local high school, college, and medical students can also be an excellent way to recruit future partners and other future community physicians.





## ENSURING THE FUTURE SUCCESS OF YOUR PRACTICE

- 3. Join a service club.** Community service clubs are usually groups of vibrant and engaged community members who have a passion for their community. Membership often includes individuals involved in local businesses, government, law enforcement, and education, as well as retirees. Joining a club instantly gives you a connection to a wide segment of the community and another venue to promote your services. These groups are always looking for interesting presentations for their lunch or evening meetings. Many of these organizations have relaxed attendance requirements that allow busy professionals to miss meetings and still retain membership.
- 4. Offer free or reduced-cost community screenings.** Participating in community screening events obviously benefits the community but can also reap significant benefits for your local reputation and your practice. It is relatively easy to set up an event like a skin screening, where all you need is a room with good lighting and some moveable curtain barriers for patient privacy. More planning is involved for a breast screening, offering breast exams, on-site mammograms, and perhaps even a breast cancer risk assessment calculation. You could also host a vascular screening event, providing ankle-arm index testing. Surgeons can even offer free or low-cost colonoscopies by partnering with their local surgery centers or hospitals. The use of signed waivers can decrease the issue of liability for these activities, and hospital-based patient financial counselors can help with determination of need. Patients with positive screening tests can choose where they want to receive follow-up care but almost always ask to see the surgeon who donated his or her time to provide the screening event.
- 5. Join or organize a coalition that fills a need in the community.** Every community has health-care-related needs or issues that may be commonplace to all communities or unique to a specific location. Hospitals and health departments are required to carry out regular community needs assessments that can identify these specific problem areas. At the top of every community needs assessment are the opioid crisis, psychiatric and behavioral health needs, cancer-related issues, and problems with access to care. Surgeons can truly make a difference in several of these areas. Efforts led by surgeons in several facilities and communities have significantly decreased the levels of opioids utilized by surgical patients both inpatient and after discharge. The American College of Surgeons has a plethora of physician and patient resources to help decrease the use of opioids in surgical patients and thereby decrease the potential of abuse in their communities. Surgeons have also organized very effective community cancer- or trauma-related coalitions and taskforces involving not only physicians but also community members in the areas of business, law enforcement, social services, government, education, and other segments of the community. These coalitions truly raise the standard of living and level of health of their communities and also build lasting relationships and a feeling of goodwill between the surgeons and other coalition members and the community.



## ENSURING THE FUTURE SUCCESS OF YOUR PRACTICE



### The Value of ACS State Chapter Membership for the Rural Surgeon (and Everyone Else!)

**Michael D. Sarap, MD, FACS**

Chair, ACS Advisory Council on Rural Surgery;  
Southeastern Ohio Physicians, Inc.  
Cambridge, OH

I practice in a town of 15,000 in southeastern Ohio and serve a population of 50,000 or more. Seven counties in SE Ohio have no health care facilities, and two have only critical access hospitals. As a rural surgeon, my hospital privileges allow me to perform general, vascular, laparoscopic, endocrine, pediatric, and thoracic procedures. My caseload also includes diagnostic and therapeutic endoscopy, PillCam, endoscopic retrograde cholangiopancreatography, carpal tunnel release, and pacemaker insertion. Caring for a small community is incredibly rewarding and fulfilling.

However, numerous studies and surveys have highlighted the downsides of rural surgery, including excessive call coverage, difficulty in recruiting and retaining young associates, difficulty in acquiring Continuing Medical Education (CME) and training in new techniques, malpractice issues, and the feeling of professional isolation. Many rural surgeons are nearing retirement age, and only 12 percent of general surgical residents are electing to practice as a general surgeon after their five years of training. I have had alternating periods of sharing call with only one or two other surgeons over my 25 years of practice. I have experienced the difficulties of not knowing other surgeons trained in Ohio and practicing in the area. Critical shortages of surgical manpower have developed in rural America.

Fortunately, I discovered an organization in my state that helped me work through the hardships of a small-town practice and encouraged involvement in leadership, advocacy, and surgical collegiality: the American College of Surgeons. The College's Ohio Chapter is a dynamic, dedicated group of academic, large-community, and rural surgeons from all four corners of the state. The advantages of membership are very obvious to all participants, and the networking opportunities in the ACS and its chapters are without bounds. For example, my partner and I were able to arrange temporary help with our call coverage through interaction with a group of chapter member surgeons in another community. In addition, interaction with a group of academic surgeons facilitated our recruitment of a newly trained resident from that academic program. No recruiting firm was involved! Ohio Chapter membership has translated into real improvements in the care we provide for our patients and our community.

The Ohio Chapter is very involved with the state Committee on Trauma (COT), the Commission on Cancer (CoC), the Women in Surgery group, and the American Cancer Society. The CoC Cancer Liaison meeting is part of our annual chapter meeting, and information and interaction with this group helped me twice earn CoC Cancer Liaison Physician Outstanding Performance Awards. Involvement with the state COT, which also convenes at our annual chapter meeting, helped form relationships with adult and pediatric centers that facilitate our ability to do lifesaving damage-control surgery on local unstable trauma patients and immediately transfer them to Level I centers for definitive care. I have participated as a panelist during statewide trauma conferences hosted by those tertiary centers, describing how we have developed our small-town trauma services. I was asked to participate in a Surgical Grand Rounds dedicated to improving





## ENSURING THE FUTURE SUCCESS OF YOUR PRACTICE

communication and cooperation between tertiary and community surgeons at the Ohio State University. Chapter contacts allow me access to major centers to observe new surgical techniques. In addition, annual meetings offer opportunities for CME, practice improvement, and exposure to renowned experts from across the country speaking on various pertinent topics. Perhaps the most important benefit of attending chapter meetings is the collegiality of the participants. It is routine to share meals with the surgical chairperson or trauma director from a university program, a solo practitioner from a tiny town, and an endocrine or oncologic surgeon from a major institution. The group has partied at a professional baseball game and mingled in a planetarium. Everyone is an equal at these outings, and there is amazing conversation and fellowship. This fosters an incredible bond between Ohio surgeons from all walks of life. These casual interactions can lead to much bigger and better things.

Professional isolation means not knowing, both before and perhaps after a surgical procedure, where to send complex patients who are beyond the capabilities of a small hospital. There is always concern that residents or tertiary surgeons will demean the care rendered by the rural physician. This leads to increased risk of eventual malpractice issues and loss of credibility for that rural physician in his or her community. Statewide collegiality and social relationships between surgeons allow the rural surgeon to more easily transfer difficult patients to tertiary surgeons who understand the limitations of those in small towns.

More familiarity and better communication between surgeons translates to better patient care and much less misunderstanding between all parties involved. These relationships also lead to a greater referral base for new surgeons looking to build a practice. Through my Ohio Chapter contacts, I can call specialists whom I know and respect at any center in Ohio for a second opinion about a complex patient, for advice in the OR in the middle of the night, or for transfer support when things go badly after a surgical procedure requiring advanced care. I can also offer local follow-up care for patients referred to subspecialists in remote cities. Both the rural surgeon and the tertiary surgeon benefit from the bonds developed at the state level.

From the standpoint of a tertiary surgeon, there are reciprocal benefits of chapter membership. In some centers, surgical resident exposure to endoscopy is minimal, and relationships with community surgeons could provide an opportunity for residents to get a wealth of experience with endoscopy, which is a large component of rural practice. Community surgeons can also provide surgical clerkships for medical students. Telemedicine opportunities could be developed with small towns to improve patient care statewide, decrease inappropriate transfers, and generally encourage better communication between facilities. We are doing this in our small community for stroke care and pediatrics and are in the process of extending it for burn care.

Lastly and most importantly, the Ohio Chapter has made me a better citizen of the surgical community. I started out traveling to the annual meeting to attend the cancer and trauma sessions and ended up staying for the entire meeting. I participated in the social events and met surgeons who were long-established members. Instead of ignoring an unknown, young attendee who was trained out of state, many chapter members invited me into their conversations and dinner groups. Soon thereafter, I was wrestled into chairing a mostly ineffective Community Hospital Committee. I subverted it into a Rural Surgeons Committee to serve as a bully pulpit for my real concerns about critical issues facing rural surgery. The chapter drew me into and educated me about advocacy efforts, which should be part of every surgeon's armamentarium. Finally, and most amazingly, I was nominated to be President of the Ohio Chapter for a year; this group was asking a rural surgeon from a tiny community to lead an organization representing all the surgeons in Ohio. Clearly, ACS state chapters represent all facets of the statewide surgical community, and all surgeons should participate and contribute. The benefits for members are limitless.



## ENSURING THE FUTURE SUCCESS OF YOUR PRACTICE

### *Surgeon Recruitment, Retention, and Succession*

**Recruitment**—Successful recruitment of well-trained, highly motivated surgeons is the lifeblood of any long-term, successful private surgical practice. Typically, the best candidates are found through networking with colleagues at the institution where members of your own group have trained. Returning for an annual surgical society meeting at that institution is often a good place to meet young residents. It is helpful to identify recruits in their third or fourth year of residency to establish a relationship. Use of a physician search firm is possible but expensive. Recruitment letters to the program directors of surgery programs in your region are also helpful. Determining the opportunities for growth in your area will guide your decision on whether a broad-based general surgeon or a specialty-trained (colorectal, bariatric, surgical oncology, and so on) surgeon is best for your group.

It is very important in recruiting young surgeons to be clear as to the compensation and work hour structure of your practice. Gone are the days of a guaranteed salary for three years with a buy-in to become partner within a practice. A standard employment contract, vetted by an experienced attorney and understood by all, will limit conflict.

**Retention**—Ensuring that young surgeons are engaged and stimulated is critical to keeping them in your practice. Even with glowing letters of recommendation from program directors and other instructors at their training programs, it is very important in the first few months to gauge the confidence and the skills of the young surgeon. Experienced surgeons within the group should scrub frequently with the new surgeon in the early part of his or her employment with the practice. It is also helpful to take time to debrief with the surgical team after a particularly difficult case and to work through the decision-making process when facing complex clinical situations.

**Succession**—When surgeons leave private practice or retire, the workflow within the practice can become disrupted. Surgery is not a part-time profession, and if, for example, a practice member stops taking call, that burden must be shared by the other members of the group. Again, this is an area where complete transparency and a written plan of succession are very important. A buy-sell agreement lays out the terms for leaving the practice. Each group must determine how to handle these changes.

### *Integrated Delivery Systems*

As a private practitioner physicians, your engagement with integrated delivery systems will be an important part of your practice. Most large hospitals have a health care network and require participation in this network in order to see patients with certain insurance companies. Reimbursement for specific CPT and ICD-10 codes are usually negotiated by the hospital with the insurance company, and employed physicians typically accept whatever is negotiated. As a private practice surgeon not employed by the hospital, you will be asked to accept the reimbursement rate given by the health network. Your acceptance of this rate depends on your leverage from how many cases you are doing and the size of your group. You will have to decide whether negotiating a different reimbursement rate is worth your time and effort.

In some locations, private practice groups may have an opportunity to participate in an ACO. It is important to identify a physician within your group who understands ACO concepts and risk sharing. Courses offered by the ACS and other organizations can help surgeons understand these issues. As bundled payment for certain services will become more prevalent, insurers will pay a single fee to an institution for an episode of care, and it will be up to the institution to determine how this reimbursement is divided among the providers. If this is occurring at your institution, it is absolutely critical that someone from your group be at the table for these discussions.



## ENSURING THE FUTURE SUCCESS OF YOUR PRACTICE

### Physician Leadership and Advocacy

For a private practice to be successful, physician leadership within the group is critical. The physician should be involved in the daily management of the practice including regular review of A/R, budget variances, and cash flow. This allows for timely intervention when a problem arises to prevent disruption of service to patients and paychecks for employees and practitioners. The physician leader should also be prepared to deal with behavioral problems of employees within the practice.

The private practice surgeon should also serve in positions of leadership at affiliate hospitals. If your group works with multiple hospitals, choose different members of your group who may have more business at one hospital than the other to involve themselves in various committees (for example, trauma committee, surgical services committee, ACS National Surgical Quality Improvement Program committee, peer review and credentialing committees) and demonstrate a commitment to the hospital. Often, these are volunteer positions, but allow you an opportunity to become an influential and valued member of your local health care community.

### Advocating with the ACS

Because the ACS represents several surgical specialties, its members bring a unique perspective, level of expertise, and voice to the public policy process. ACS members' in-depth knowledge of surgery, particularly a surgeon's role within his or her community, helps leverage important advocacy priorities.

To be an effective surgeon advocate, it is important to develop personal relationships with elected officials. Conversely, to elected officials, there is nothing more valuable than input and support from their constituents. Meeting with lawmakers and/or their staff is extremely

valuable to help advance the College's surgical advocacy agenda and provide opportunities to develop key contacts with legislators. There are numerous ways for surgeons to get involved in the ACS' efforts to advocate for meaningful, practical health policy proposals at the federal and state levels, such as:

- Attending the annual ACS Leadership and Advocacy Summit
- Becoming educated about ACS health policy priorities
- Visiting the American College of Surgeons Professional Association's (ACSPA) *SurgeonsVoice* online and participating in grassroots "Calls to Action"
- Joining the Health Policy Advisory Council (HPAC)
- Participating in the DAHP Advocate at Home Program
- Hosting a facility tour or conducting a site visit for elected officials
- Engage in social media activity via @SurgeonsVoice

All surgeon advocates are encouraged to become more involved, and learn more about ACS advocacy and health policy priorities, on the ACS advocacy and *SurgeonsVoice* websites ([facs.org/advocacy](https://facs.org/advocacy) and [facs.org/advocacy/surgeonsvoice](https://facs.org/advocacy/surgeonsvoice), respectively).









# ADDITIONAL RESOURCES





## ADDITIONAL RESOURCES

### Coding, Billing, and Documentation

# Bulletin



[bulletin.facs.org](http://bulletin.facs.org)

**Abdomen, Stomach, Liver, Gallbladder**

**Hernia**

**Intestines, Rectum, Anus**

**Breast**

**Lymphatic System**

**Skin, Integumentary System**

**Trauma and Critical Care**

**Vascular System**

**Modifiers**

**Evaluation and Management**

**ICD-10**

**The Inpatient Only List**

**Understanding Medicare Part B Incident to Billing**

**Billing for Services Performed by Nonphysician Practitioners**

**Unlisted Procedures: Strategies for Successful Reimbursement**

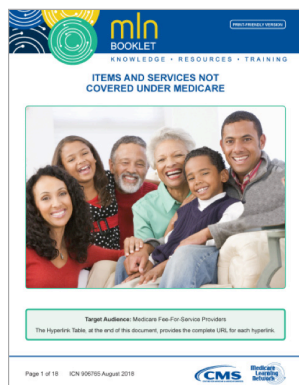
**Health Insurance Audit Processes, Penalties, and Appeals**

**Medicare Participation and Enrollment**

# ADDITIONAL RESOURCES

## Practice Management

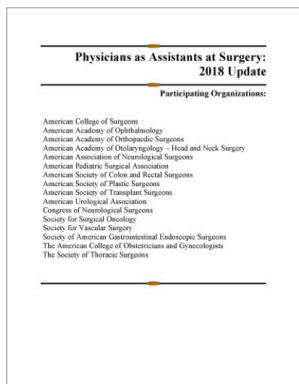
### Items and Services Not Covered Under Medicare (2018)



### Global Surgery Booklet (2018)



### Physicians as Assistants at Surgery Report (2018)



### The Medicare Learning Network®

- Publications & Multimedia
- Events & Training
- News & Updates
- Continuing Education



### Medicare Basics: Commonly Used Acronyms (2018)

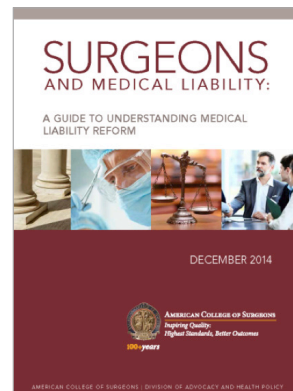


### Medicare Quarterly Provider Compliance Newsletter Archive



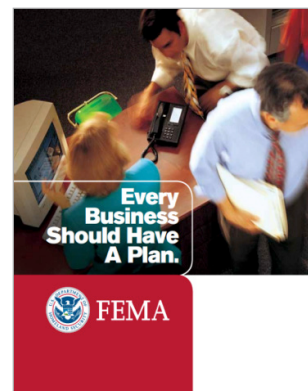
### Surgeons and Medical Liability: A Guide to Understanding Medical Liability Reform (2014)

by Kathleen M. O'Neill; Nakul Raykar, MD; Charles Bush; Shilpa Murthy, MD; Matthew Coffron, MA; John H. Armstrong, MD, FACS; John G. Meara, MD, FACS; and Don Selzer, MD, FACS



### Emergency Preparedness Resources for Businesses

- Emergency Supplies
- Emergency Response Plan
- Insurance Coverage
- Business Continuity Plan





## ADDITIONAL RESOURCES

### Physician Leadership, Advocacy, and Wellness



**Nurturing Wellness and Fostering Resilience during a Surgical Career: An Introduction** (2019)  
by Rebecca L. Hoffman, MD, MSCE

**A Sense of Belonging and Community Can Mitigate Physician Burnout** (2019)

by Yewande Alimi, MD, MHS; Maria S. Altieri, MD, MS; Jeremy D. Kauffman, MD; Pridvi Kandagatla, MD; Patricia Martinez Quinones, MD, PhD; Madeline B. Torres, MD; and Rebecca L. Williams-Karnesky, MD, PhD

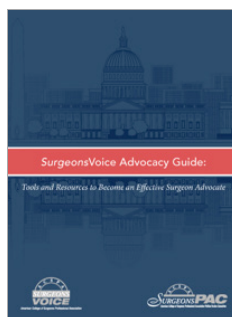
**Training Resilient Surgeons: Where Do We Go from Here?** (2019)

by Rebecca L. Williams-Karnesky, MD, PhD; Rachel Hanke, MD; Erica K. Ludi, MD; Christopher L. Kalmar, MD, MBA; Meghana V. Kashyap, MD, DIM&PH; Ravi Viradia, MD; Franki Boulos, MSc, MD; and Kaitlin A. Ritter, MD



**Talking the Talk: The Keys to Effective Workplace Communication** (2015)

by Raphael C. Sun, MD; Erin M. Garvey, MD; Jessica Hogan, MD; and Konstantinos P. Economopoulos, MD, PhD



**SurgeonsVoice Advocacy Guide: Tools and Resources to Become an Effective Surgeon Advocate** (2019)

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