



# OPHTHALMOLOGY PRACTICE OPTIONS™

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IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

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*December 2006*

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## Newsletter Will Address Practice Concerns

This newsletter is the first issue of *Ophthalmology Practice Options*. Our aim is to help ophthalmologists, retinal specialists, and ophthalmology practice administrators improve patient care through increased practice efficiency.

The editors and writers of the newsletter will do so in a wide variety of ways, as illustrated in this issue. We understand that running an ophthalmology practice is a challenging endeavor, one that is made more challenging every day as reimbursement declines and as the cost of running a practice rises. At the same time, billing and coding has become more complicated and competition has intensified.

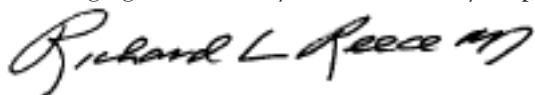
Over the past few weeks and months, the editors and writers have been working closely with the editorial advisory board to develop topics that will be of interest to our readers and will help them address these complex issues.

This issue is a good example of the kinds of topics we will address in the newsletter this year and in the years to come. For instance, we have an article based on an interview with William Constad, MD, partner in a six-member group in Jersey City, N.J. Constad describes how his group has used electronic medical record systems to enhance practice efficiency and improve patient care.

We have an article in which John Pinto, founder of an ophthalmology practice management firm in San Diego, discusses the benefits and characteristics of practice in single-specialty, multispecialty, and other settings. Similarly, we have an article by two physician career counselors who describe in detail how ophthalmologists, retinal specialists, and ophthalmology practice administrators can develop what they call a physician-centered practice. They explain how the popular wisdom suggests that practices today should be patient-centered, and they explain why this so called popular wisdom may not be best for physicians.

We also have an interview with Neil Freeman, MD, an ophthalmologist in Melbourne, Fla., who practices in a 12-member group that does surgeries in an ambulatory care center. Freeman describes his work as a coding consultant and what ophthalmology practices can expect from the new ICD-10 codes. On a similar topic, we have an article in which Ron Rosenberg, PA and MPH, the president of the Practice Management Resource Group, in Sausalito, Calif., describes a systematic and purposeful approach to charge capture and coding.

Over the more than 10 years that we have been publishing the Practice Options series of newsletters for physicians, we have found that the best newsletters are those that involve give-and-take between editors and readers. For that reason, we welcome your comments, suggestions, and criticisms as we produce each issue in the coming year. Feel free to call or write to me at any time. In the meantime, we hope you find the newsletter provides interesting, useful, and challenging material for you and those in your practice.



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This newsletter is published by Premier Healthcare Resource, Inc., Morristown, N.J.

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# Practices Adopt Systematic Approach

**C**areful practice management in ophthalmology has taken on new urgency as reimbursement has declined and practice costs have risen in recent years. Yet many physicians don't pay as much attention to some practice management tasks as they should, experts say. "Physicians wouldn't treat their patients like they treat their businesses," asserts Ron Rosenberg, PA, MPH, president of the Practice Management Resource Group, a practice management consulting and billing service provider in Sausalito, Calif.

A thorough, analytical approach to diagnosing problems and developing systems for improvement and results measurement are required to enhance the health of a business, just as they are in patient care, Rosenberg says. "Like all physicians, ophthalmologists need to apply clinical thinking to the business process to identify problems, determine their causes, and develop strategies to address them successfully," he asserts.

## Capturing All Charges

Systems are required, for example, to ensure accurate and thorough charge capture, the first step in the medical billing process. "Ophthalmologists must have systems in place to ensure that every service provided is captured as a charge," Rosenberg says. They need to capture charges for three categories of services: those provided in the ophthalmologist's office, sched-

uled surgical procedures, and unscheduled surgical procedures. Optimally, ophthalmologists should have a formal system to ensure adequate charge capture for all types of services. "These systems should be ongoing, and the ophthalmologists should perform some sort of periodic audit or check on them," Rosenberg notes.

Most electronic practice management systems produce a report (typically called a missing ticket report or appointment-billing analysis) that tracks instances in which charges were not entered for a scheduled patient, Rosenberg explains. "Physicians who do not use an electronic practice management system but who manually create superbills or charge tickets should still develop some sort of process to reconcile those charge tickets with the actual charges billed," he says. Regardless of whether the system is manual or electronic, ophthalmologists also should have a method to track and bill for hospital procedures so that an audit can determine whether every service has been billed, he adds.

As in most specialties, the largest source of lost charges in ophthalmology relates to non-scheduled services, Rosenberg explains. The scope of the problem may be smaller for general ophthalmologists than for other subspecialists because general ophthalmologists provide only a limited range of services outside the office, and when those services are provided

they are usually scheduled.

"Still, unscheduled procedures do occur in ophthalmology," he cautions, offering as an example the case of a retina surgeon who was called to the emergency room to treat a patient with eye trauma or sudden loss of vision. "In such emergencies, the physician must somehow capture information about the patient that they can take back to the office and enter into the system," he explains. While at the hospital, the physician may obtain a demographic form, or face sheet, from the hospital's patient management system, write the services provided on the form, and bring the form back to the office so that the billing staff can capture the charge.

## Collections Performance

A charge capture system facilitates another crucial step: measuring collections performance. Practices should establish practice management systems that monitor payments and then compare actual collections against a calculated target, Rosenberg says. "The system should be set up in a way that allows the practice to examine, by payer and plan, the percentage collected against the charges," he says. "For all payers, the practice should set a target for collections based on the relationship between their fees and the contracted allowable payments, and measure how closely the actual collections approach that target."

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**Ophthalmologists need systems to ensure adequate charge capture for all services. "These systems should be ongoing, and the ophthalmologists should perform some sort of periodic audit or check on them," says Ron Rosenberg, PA, MPH, of Practice Management Resource Group.**

(Continued from page 3)

Developing collections targets is a good way to measure financial performance, Rosenberg believes. “If the practice is not approaching the collections target, the administrators can accurately determine the particular causes of discrepancies and then develop targeted strategies to address them,” he adds.

### Hitting the Target

As an example, Rosenberg poses a situation in which an ophthalmology practice generates its fee schedule at twice the local Medicare fee schedule. Consequently, when a \$100 charge is submitted to Medicare, the most the practice will collect is 50%, or \$50, of the charge. Medicare pays 80% of charges (in this case, \$40), while the patient or his or her Medicare supplemental insurance would be responsible for the remaining 20%, or \$10. “The collection target analysis should actually distinguish among three categories of Medicare patients,” he explains. “Some Medicare patients have supplemental insurance, some Medicare patients do not, and still other Medicare patients have Medicaid as their secondary insurance. If all of those patients are lumped together in the practice management system, the data on percentage of target collections will be meaningless. The practice will not know if shortfalls in collections are due to the inability to collect from Medicaid, a limited ability to collect from patients, or a problem with pursuing collections from the secondary insurers. Staff can tar-

get their collection activities to the real problem, and often find out that the problem is preventable.”

### Outsourced Services

Another way to manage practice finances involves outsourcing. “Ophthalmologists should consider whether they can handle billing as economically and expertly in-house as an outside billing service,” Rosenberg says. Some practices may not have an expert billing staff. Solo practitioners or ophthalmologists in small groups may not have the patient volume to keep one billing staff member busy. Another consideration is that employing one billing staff member increases the risk of embezzlement. Other practices simply may not want the hassle and labor expense involved with billing. Young ophthalmologists beginning their practices may not be able to afford the requisite computer systems. By outsourcing billing, they can reduce start-up costs.

For practices that do not outsource, technology can facilitate billing and other business functions, but manual labor is still required. “In medical billing, 20% of the effort involved in submitting clean claims will bring in 80% of the revenue, while 80% of the effort is expended to bring in the remaining 20%,” Rosenberg observes. “That last 20% is tough to collect, and is largely a manual process. Staff members will need to develop an ongoing process to ensure that they promptly follow up on all denied claims.”

Regardless of how a practice manages billing and collections, ophthal-

mologists will want a charge capture system. These systems fall into two categories: first is to ensure that services provided to each scheduled patient are captured, and second is to ensure that all services that the group provides are captured. “This second issue is closely related to coding,” Rosenberg notes. “Physicians and their billing staffs must ensure that they understand the coding rules so they know what services are billable, and how they should be billed. For example, some services may not be bundled with another related service and so therefore must be billed separately. Ophthalmologists should be sure to factor into the codes each service that was provided.”

### Cracking the Code

Undercoding and overcoding are both concerns when assigning evaluation and management codes. “Ophthalmologists have the advantage of being able to use the eye codes, which have somewhat looser requirements,” Rosenberg says. “Still, we often see ophthalmologists who undercode. Overcoding is rarer in ophthalmology. Like all physicians, ophthalmologists need to understand the coding rules and documentation requirements, and code accordingly,” he adds.

For example, physicians must understand when they can charge a procedure and a visit on the same date. “Ophthalmologists can virtually always charge for both on the same date,” Rosenberg explains. “However, ophthalmologists may not charge for both if the patient is told to return for a procedure at a later date and the only

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interaction during that second visit is related directly to the procedure, not to the underlying disease.”

The primary strategy to ensure proper coding is to have ongoing training. “I highly recommend that at least one physician and one staff member from the practice attend the American Academy of Ophthalmology’s coding seminars every year,” Rosenberg says. “The annual changes to the codes can be subtle, but it is virtually guaranteed that enough new information will be gleaned to compensate the practice for the time and financial cost involved in seminar attendance.”

### **Minimizing Risk**

In addition, Rosenberg notes that the American Academy of Ophthalmic Executives, the AAO’s administrators’ network, has a listserv that practices can use to pose questions that arise in practice.

“Staff members who are responsible for coding should also have some exposure to the services these codes represent,” Rosenberg suggests. “Without understanding the services, it would be like trying to learn a foreign language without having any immersion in it.”

For small practices, gaining knowledge about coding can be difficult in part because the practice may not be able to hire dedicated coding staff. “Nevertheless, whether it is the practice administrator or the billing manager, someone should be devoting a lot of time to learning and staying up to date on the codes,” Rosenberg says.

It is also important that ophthalmologists have an outside auditor audit their E&M coding practices periodically, Rosenberg offers. “This will help

ensure minimal risk of audit exposure and prevent chronic and costly patterns of undercoding,” he explains.

Documentation is another business challenge ophthalmologists face. “If physicians tried to document everything they do for a patient or think about a patient, they would create documentation that would be pages long,” Rosenberg notes. “The challenge in documentation is to mark down the critical elements that represent every service provided.” The two keys to thorough documentation are to understand the codes and to use tools that help capture all clinical content of services provided.

Often, ophthalmologists undercode because they do not fully understand the rules, Rosenberg says. “Here’s a simple example: They may provide a level 3 service and code it as a level 2,” he offers. “But other mistakes are based on more nuanced rules. For instance, ophthalmologists may combine a level 3 service with a level 4 service but code only at level 3.”

The most efficient way to capture clinical content is to use a template for documentation, he says. “Whether on paper or in an electronic medical record, the template enables the physician to document the whole thought process of a particular element of the history or exam quickly and easily,” he says. “Physicians can undercode their services just because they do not have a good tool for documenting all the services they provide that they might not want to write in longhand.”

The hardest part of documentation is identifying all pertinent negatives, Rosenberg observes. “These are the things the physician considers and then excludes either in the history or

during the physical exam,” he continues. “Generally, these considerations are not documented in free text. Unfortunately, neglecting to document these considerations can have serious consequences for the doctor during an audit.”

### **Prompt Attention**

As with coding, understanding the documentation rules is important. “Ophthalmologists must have a clear understanding about what information is required to justify each code,” Rosenberg counsels. Physicians tend to think about what type of documentation is required to achieve a certain code, but theoretically they should evaluate a patient, consider the clinical content provided, and then choose a code based on the clinical content. “That’s why templates are important,” Rosenberg says. “They prompt physicians to document for each and every service so that they can assign the proper code.”

All providers performing services for patients should understand the codes and use templates to capture clinical content, Rosenberg suggests. “For example, technicians may take the patient history and perform certain elements of the eye exam,” he says. “Therefore, they should be fully trained on proper coding and documentation. Also, some ophthalmologists use scribes during the eye exam. It is critical that the scribes understand ophthalmology so that they will know what the physician is saying and what boxes to check on the template.”

—Reported and written by Deborah J. Nevelev, in North Potomac, Md. More information on physician practice strategies is available on our Web site, [www.MDOptions.com](http://www.MDOptions.com).

**Ophthalmologists often neglect to document pertinent negatives especially when using free text. Unfortunately, neglecting to document these considerations can have serious consequences for the doctor in an audit.**

# EMR Improves Efficiency, Quality

**M**any ophthalmologists are reluctant to adopt an electronic medical record (EMR) system, fearing the high cost and a reduction in practice productivity at least initially as physicians and staff members learn the system. Ophthalmologists are like all technology buyers in that they have a desire to wait for additional advances in technology.

Despite these reasons to hesitate, EMR adoption in ophthalmology practice is growing. A recent survey on technology use by the American Academy of Ophthalmology and the Medical Group Management Association found that almost half of all respondents either have or are planning to implement an EMR within two years.

## Increased Efficiency

One medium-sized ophthalmology practice reports that its adoption of an EMR has enhanced provider efficiency and improved quality of care. "An EMR is valuable for any community medical practice, for a number of reasons," says William Constad, MD. Constad is a partner with Hudson Eye Physicians and Surgeons, a practice with six physicians in Jersey City and Millburn, N.J.

"First, practices with EMRs do not have to worry about lost or misplaced records or a frustrating delay in accessing patient information," Constad says. "Second, because physicians, nurses, and billing staff can retrieve information more quickly using an EMR, practice efficiency is enhanced. Finally, the ability to easily track health trends among patients helps physicians improve their quality of care."

The same issues a large group faces are those a small group confronts, especially in a specialty such as ophthalmology, Constad adds. "We all have to review vast amounts of information: patient histories, diagnostic test results, letters from referring physicians," he says. "This information is much easier to organize and locate when it is in an electronic format, regardless of practice size."

Constad believes the benefits of EMR adoption are greater in a large practice setting, however. "The incidence of lost and misplaced charts is higher in a larger practice, particularly if the practice runs multiple office locations," he says. "When charts are in paper format, someone must physically carry the chart from one office to the other, increasing the risk of misplacement. In contrast, electronic patient charts are complete and

available anywhere at any time."

In addition, in practices with many providers, reading colleagues' handwriting can be challenging. "The EMR eliminates the whole issue of having to interpret someone else's scribble," Constad notes.

Of particular interest to ophthalmologists is that EMRs can consolidate patient testing information taken from a variety of diagnostic equipment ophthalmologists use in their offices. "Being able to review diagnostic data and easily pass the data to a subspecialist or to the patient's referring physician are significant benefits of an EMR," Constad explains.

## Benefits of Implementation

Hudson Eye adopted an EMR in the mid-1990s, when few ophthalmologists were using such systems. "The factors that drove the purchase of the EMR included the desire to enhance our record-keeping and documentation and to enable us to review patient information quickly," Constad says.

All six physicians supported the idea. "However, when we first used it, I was the only one who accessed its full functionality," Constad adds. "The other physicians participated by entering only limited data related to

**"The EMR has enhanced our quality of care, primarily because the system enables us to more easily track results. And it's much easier to review those results. Unlike a paper record system, the EMR gives us the ability to review a history of the patient's condition instantly. Whether we need to monitor blood pressure, blood sugar values, or any other test result over a given time, the physicians can generate a summary sheet quickly to review at a glance."**

**—William Constad, MD, Hudson Eye Physicians and Surgeons**

prescriptions for medications, eyeglasses, and contact lenses. However, over a year, all physicians in the practice migrated to full EMR use because they recognized how valuable it was and how easy it was to use."

The practice adopted its current EMR in 2000 when it purchased a system from NextGen Healthcare Information Systems in Horsham, Pa. It needed a new system when the company that produced its original EMR withdrew from the market. Many companies offer ophthalmology-specific EMRs or EMRs that can be customized for ophthalmology practice.

"When we purchased the NextGen system, the EMR did not include a standardized knowledge base for ophthalmology, meaning that all of the input fields were left up to the individual practitioner," Constad says. "So our version of NextGen is customized for our practice. Currently, NextGen's EMR includes advanced design input screens for most subspecialties, including ophthalmology."

### Extensive Customization

One of the reasons Constad chose NextGen was the program's flexibility. "The EMR was sufficiently flexible to allow the practice to create ophthalmology-specific functionality, including templates, guidelines, protocols, and checklists," he says. "Everything is run by template, which can be customized to the specification of the practice and even the individual practitioner. Furthermore, we can build as much content into the knowledge base as we want. We can include assistance with diagnosis and test reminders. I can input a particular timeframe for follow-up testing of my glaucoma patients, so that when a patient comes in for an office visit the system will alert me that another test should be done."

Significantly, the EMR is integrated with Hudson Eye's NextGen

practice management system. "It is vital that a practice's EMR and practice management system can communicate," Constad explains. "Practice revenue are driven by the medical record, because that's how charges are determined. I wanted a practice management and medical records product from the same company because I felt that would eliminate any issues related to interfacing, although NextGen products interface with products developed by other manufacturers."

Furthermore, test findings generated by the practice's diagnostic tools can be sent directly into the EMR system, to a varying degree. "Unfortunately, many instrument manufacturers take a proprietary view of their equipment output, limiting the interface between some of

our tools and the EMR," Constad says. "However, over time manufacturers have recognized that diagnostic products today must interface with medical record products in order to make the entire system more complete."

### Efficiency Benefits

Constad is definitely more efficient since adopting the EMR. "For example, my reports to referring physicians are generally sent within 12 hours of the patient's office visit," he says. "Also, retrieval of patient records is much faster. So, for example, if a pharmacy calls about a medication renewal, I can look up the status of the medication in the patient's electronic record quickly."

The practice has a computer in each exam room so that physicians

## Survey Shows Increased Use of EMRs in Ophthalmology

A survey of ophthalmologists shows that 12% of respondents have an electronic medical record system fully implemented for all physicians. The same survey shows that 7% of respondents report that implementation is in process or that an EMR is partially used. About 31% of responding ophthalmologists are planning to adopt an EMR within 24 months. About 41% of practices that have an EMR have implemented their systems in the past two years.

The American Academy of Ophthalmologists (AAO) in San Francisco and the Medical Group Management Association (MGMA) in Englewood, Colo., conducted the survey of AAO members in March about the adoption of information technologies. A report on the survey, *Summary of AAO Membership Survey on Electronic Health Records*, is available online (at [www.aao.org](http://www.aao.org)).

Not surprisingly, implementation is more common among larger groups; nevertheless, about a third of groups with 10 or fewer physicians are planning to implement an EMR.

The good news is that about three-quarters of respondents were extremely satisfied with their EMR, and one-third reported that physician's productivity increased as a result of EMR adoption.

As expected, respondents said EMR adoption can be expensive. Respondents said the average purchase and implementation cost was about \$50,000 per physician and the monthly per-physician maintenance costs totaled about \$1,066.

—DJN

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can enter information during each patient visit. Contemporaneous data entry ensures that records are immediately up-to-date. "The EMR has slowed down the examination room process just a little bit, because we enter information as we go, but it only lengthens the visit by a minute or two," he notes. "However, the time savings after the fact is very significant."

As a result of greater efficiency, the EMR has allowed the practice to increase its patient flow, and patient wait times are shorter. "We have also been able to increase our practice's patient load," Constad adds.

The group has never measured the cost savings as a result of using the EMR. "It is difficult in today's medical marketplace to measure cost savings over a period of time, because all of our costs, such as insurance, rent, and salaries, increase every year, regardless of EMR use," Constad explains. "Unfortunately, our income does not grow to keep pace with cost increases. The only way we can maintain our profitability is to be more efficient and treat more patients, two results that the EMR has made possible."

Constad does see cost savings in discrete practice functions such as billing. "The system allows a higher percentage of our claims to go out clean, meaning that there is less follow-up required by the billing staff to collect our reimbursement," he says. "As a result, we don't have to work as hard to get the claim dollars in."

## Boosting Quality

One of the most significant benefits of using the EMR is improved quality of patient care. "The EMR has enhanced our quality of care, primarily because the system enables us to more easily track results. And it's much easier to review those results," Constad says. "Unlike a paper record system, the EMR gives us the ability to review a history of the patient's

## Vendors Offer Ophthalmology-Specific EMR Systems

Many vendors offer ophthalmology-specific electronic medical record (EMR) systems. Some of the EMRs offer ophthalmology-specific solutions or can be customized to meet the needs of ophthalmology practices. The systems include:

- NextGen EMR, NextGen Healthcare Information Systems, Horsham, PA ([www.nextgen.com](http://www.nextgen.com))
- Intuition Ophthalmology EMR, Amicas, Inc., Boston, ([www.amicas.com](http://www.amicas.com))
- AllMeds for Ophthalmology, AllMeds, Inc., Oak Ridge, Tenn. ([www.allmeds.com](http://www.allmeds.com))
- ChartLogic Ophthalmology Medical Office, ChartLogic, Inc., Salt Lake City ([www.chartlogic.com](http://www.chartlogic.com))
- MaximEyes Electronic Medical Record, First Insight Corp., Hillsboro, Ore. ([www.first-insight.com](http://www.first-insight.com))
- OphthalmicSuite, Medflow, Inc., Charlotte, N.C. ([www.medflow.net](http://www.medflow.net))
- EyeDoc, Penn Medical Informatics Systems, Inc., Altoona, Pa. ([www.pennmedical.com](http://www.pennmedical.com))

—DJN

condition instantly. Whether we need to monitor blood pressure, blood sugar values, or any other test result over a given time, the physicians can generate a summary sheet quickly to review at a glance."

Furthermore, the system generates automatic reminders so that patients who require periodic testing to monitor their conditions consistently receive that care. "I don't have to work so hard to remember," he says. "The machine does the remembering for me."

And, finally, the timeliness of care, which is another important element of care quality, has improved due to easy access to clinical information.

## Advice to Physicians

"Physicians need to remember that in the world outside of medicine, a significant percentage of a business's dollars goes toward purchasing and maintaining information technology such as computers and related electronics," Constad notes. "This has

never been the case in medicine, so physicians balk at IT investment. But it is important for doctors to recognize that you don't get anything for nothing. Unless you put the dollars in, you will not get the results out."

Therefore, Constad counsels, "Physicians should not be cheap when shopping for an EMR or practice management product. Sometimes there are good bargains from smaller companies, but physicians should be wary when buying a product such as an EMR from a vendor that's too small. The risk is that at some point, they will have no support for a product that may quickly become completely unusable. Physicians should carefully select a company that's large enough and experienced enough that it will not go out of business in the near future."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site, [www.MDOptions.com](http://www.MDOptions.com).

# Expert Outlines Benefits, Challenges Found in Various Practice Settings

Ophthalmologists can consider a variety of potential private practice models, including single-specialty group practice, multi-specialty group practice (in which various ophthalmology-related subspecialists work together), and multi-specialty practice incorporating physicians of different specialties. Any model offers the opportunity for a gratifying and successful career, but, of course, each setting has benefits and risks.

## Single-Specialty Group

Most ophthalmologists immediately recognize the benefits of practicing only with other ophthalmologists. One of the main advantages of this model relative to a multispecialty group is ease of resource allocation, because all the physicians in a single-specialty practice understand the technologies and the financial benefits at stake. And, once they agree on a purchasing strategy for technology, all physicians can use it.

"In an ophthalmology-only practice, all physicians will benefit when the practice buys a particular device or new technology," says John Pinto, president of J. Pinto & Associates, Inc. ([www.pintoinc.com](http://www.pintoinc.com)), ophthalmic practice management consultants in San Diego. Pinto is the author of several books on ophthalmology practice management, including *The Efficient Ophthalmologist: How to See More Patients, Provide Better Care and Prosper in an Era of*

*Falling Fees*. (American Society of Ophthalmic Administrators, January 2004).

In a single-specialty group, resource-sharing benefits extend beyond capital equipment. "For example, if an ophthalmology practice hires a new technician or medical assistant, that individual's labor can be shared across all physicians in the practice," Pinto says. "In contrast, in a multispecialty clinic, an individual trained specifically in ophthalmology care is unlikely to be able to bring meaningful value to urologists or cardiologists in the practice."

In general, operations and governance can be more efficient in a focused specialty practice, given the physicians' commonality of purpose. Nevertheless, other factors may be more important for successful governance, Pinto notes. "The most relevant factors affecting successful practice governance are the personalities of the individuals involved and the financial success of the organization," he says. "A practice run by a group of doctors who are good team players and that is at no immediate financial risk is usually an easy environment in which to manage. The addition of just one or two doctors who do not get along with the others, or the introduction of financial difficulties, can turn that situation around quickly."

Compensation design is another oft-cited benefit of single-specialty practice. "If all the physicians are in the same specialty, compensation

design is certainly easier, but not necessarily easy," Pinto cautions. "Compensation is only simple in a very small single-specialty group in which the physicians work similar hours, treat about the same number of patients, and generate approximately the same amount of revenue. But even in a two-physician ophthalmology practice, differences in productivity or surgical density can make it a challenge to ensure that the compensation method is not only fair today, but will be fair into the future."

Another benefit of single-specialty practice is the ability to remain relatively small. "There are well recognized economies of scale and efficiency that occur in an ophthalmology clinic at between three and five physicians," Pinto asserts. "In smaller groups, ophthalmologists must shoulder the high fixed-cost burden associated with ophthalmology practice, while larger groups tend to experience diseconomies of scale. In fact, I receive many calls from doctors in single specialty groups of eight to ten physicians who report that their practice growth has been associated with a decline in per-physician profitability and has made governance more difficult."

Conventional wisdom holds that payers are interested in the contracting ease that multispecialty groups offer, but in some locales or situations, a large ophthalmology-only practice with an established reputation for

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**"The most relevant factors affecting successful practice governance are the personalities of the individuals involved and the financial success of the organization," says John Pinto, J. Pinto & Associates, Inc.**

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quality can win contracts by virtue of its expertise. "The environment has changed over the past 15 years," Pinto observes. "In the early 1990s, the expectation was that, in order to survive, physicians had to either build or join a large practice. With the passage of any-willing-provider legislation in most states and acknowledgment of patient demand for wide provider access and geographic diversity, most payers now offer broader panel membership."

### **Multisubspecialty Practice**

A multisubspecialty practice is one in which general ophthalmologists and ophthalmology subspecialists (such as a retinal specialist, a glaucoma specialist, a pediatric specialist, and an oculoplastic surgeon) work together to provide a full spectrum of eye care.

The advantages of this practice context are manifold, Pinto states. "This practice setting is often what's best and most convenient for the patient," he notes. "It also can be extremely satisfying professionally for the physicians, who have colleagues with complementary specialties and expertise just down the hall or in an adjoining office."

In a typical multisubspecialty practice, physicians can share resources and afford a sophisticated administrator as well as business support staff with specific expertise, such as a full-time information technology expert. "Furthermore, from a contracting standpoint, there are certainly advantages to being able to do it all," Pinto observes. "This point can also be compelling when marketing to patients as well as to payers."

Still, some disadvantages to multisubspecialty practice exist. "For exam-

ple, a comprehensively oriented ophthalmologist who enjoys doing a little bit of glaucoma care and some plastic surgery and a little bit of retinal work may not be happy in a multisubspecialty context because of the obligation to refer patients with subspecialty needs to colleagues," Pinto notes.

In addition, it may be more difficult to solicit referrals from outside the practice. "Other ophthalmologists may not want to risk the loss of a patient by referring to a multisubspecialty group that also includes general ophthalmologists," observes Pinto.

### **Multispecialty Practice**

Multispecialty practice is a less popular option for ophthalmologists. Ophthalmology is typically one of the last departments a multispecialty clinic will add, Pinto says, and there are several reasons ophthalmology would be added last. "First, ophthalmologists are expensive to hire as associates," Pinto comments. "Second, in order to practice effectively, ophthalmologists have a great need for equipment, dedicated staff, and facility space, meaning that it is costly for a clinic to get an ophthalmologist up and running. Finally, a community often already has sufficient ophthalmology care. Without significant unmet patient demand, a multispecialty group may determine that adding an ophthalmologist would not be a wise business strategy."

Still, multispecialty practice is a viable option for ophthalmologists in some locations. Pinto estimates that about 30% of multispecialty practices include ophthalmology. Typically, these practices are quite large. "A multispecialty clinic will likely have between 20 and 50 physicians by the

time it adds an ophthalmologist," Pinto says.

The typical driver for an ophthalmologist moving beyond a single specialty context to a large multispecialty group is the local reimbursement environment. "Large practices tend to be formed either by the consolidation of existing soloists or by the accretion of members to an existing group, usually in response to reimbursement pressures in the marketplace," states Pinto. "A multispecialty group has an advantage during contract negotiations because it can commit to a full range of care with a single stroke of the pen."

Several other advantages to multispecialty practice exist. "A practice of that scale normally has strong administrative coverage, meaning that physicians have fewer administrative duties," Pinto points out. "These practices also typically have a long tenure in the market as well as strong contract access. Furthermore, for physicians with extensive clinical and intellectual interests, it can be a wonderful environment in which to discuss medicine with colleagues."

For an ophthalmologist, the disadvantages of joining a multispecialty practice, though, are significant. "Frequently there is a subsidization of the primary care providers in a multispecialty group that draws profit away from specialists such as ophthalmologists and orthopedists," Pinto observes. "Every clinic is different, of course, but that is a common concern."

Another concern involves sharing resources. "The ophthalmologist may want the clinic to purchase a \$50,000 laser, but at the same time the other physicians will be arguing the case for their own device needs," Pinto explains. "In a large multispecialty

**In a typical multisubspecialty practice, physicians can share resources and afford a sophisticated administrator as well as business support staff with specific expertise, such as a full-time information technology expert.**

practice, the decisions about which new technologies to fund can be difficult, slow, and can easily become political.”

### **Market and Personal Factors**

Pinto emphasizes that there are many other options for ophthalmologists, and that a well run, successful practice is possible in any practice format.

“Ophthalmologists can choose from among several profoundly different professional settings,” Pinto notes. Ultimately, the optimal practice context will depend on the individual market, practice, and physician. “Physicians should decide on a practice setting in the context of the market,” Pinto counsels. “If you’ve seen one market, you’ve seen one market. The circumstances in the market will drive ophthalmology group choices. Physicians also must consider financial, operational, and cultural factors of any particular medical group they consider joining. Finally, a physician should know his or her own personality and temperament. An ophthalmologist may be unhappy unless he or she is part of a larger team, or may enjoy the small group setting and feel more comfortable being largely in control of the practice.”

The most important selection criteria are often factors that physicians do not consider sufficiently, Pinto adds. “For example: Within that marketplace, are the provider-to-population ratios favorable?” he asks. “What is the availability of physicians in your subspecialty interest? What is the age distribution of competing physicians in the market and of colleagues within the practice? All of these factors must be considered when deciding among practice settings, because the answers will affect the next 20 to 30 years of the ophthalmologist’s career.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site, [www.MDOptions.com](http://www.MDOptions.com).

## Ophthalmologists Can Consider Numerous Practice Options

Single specialty, multisubspecialty, and multispecialty group practice are only a few of the practice settings ophthalmologists can consider, says John Pinto, president of J. Pinto & Associates, Inc., ophthalmic practice management consultants in San Diego.

Ophthalmologists often choose a small, solo practice as an option. “Such a practice may either be maintained intentionally for lifestyle, life stage (such as peri-retirement), or child-rearing reasons, or may be held back by marketplace or provider-related limitations,” Pinto says. “From a lifestyle perspective, nothing beats a small, solo practice, unless the physician is in such a practice involuntarily. With just two or three loyal staff, and a slow clinical pace, this model resonates back to a bygone era of longer exams and more intimate patient relationships.” The high fixed costs of ophthalmology practice create pressure to ensure ongoing patient volume, and call schedules can be a burden in this setting, he adds.

A larger solo practice is one in which the ophthalmologist practices with two or three other (often junior) ophthalmologists who have no ownership position in the group. In this setting, the ophthalmologist can maintain control of the practice while still growing and managing higher patient volumes, Pinto adds.

An itinerant practice is yet another option. “A small number of subspecialists and even generalists practice largely—if not entirely—out of host clinics,” Pinto says. “These physicians avoid the complexity of business ownership and still enjoy the pleasure of independence.” However, the desire for a settled practice dissuades most ophthalmologists from this practice option.

A single subspecialty practice is one representing only one subspecialty of ophthalmic care, such as retinal care, glaucoma care, or pediatric ophthalmology. “In a pure subspecialty practice, there are fewer resource squabbles and less discord among the partners over compensation methodologies,” Pinto notes. The most prominent weakness of this practice model involves access to patients. “In fact, it may be necessary to stretch satellite locations hundreds of miles from the main office in order to generate sufficient patient volume to support all of the subspecialists,” he adds. “Also, generalist practices may add their own subspecialists, thereby reducing the referral stream.”

Almost all major urban markets have an eye institute, Pinto notes. An eye institute includes all general ophthalmology and subspecialty services as well as an ancillary ambulatory surgery center, all under one roof. The benefits of this practice setting include practice stability, access to patients, and contracting leverage, but decision-making can be bureaucratic, resulting in a slow response to market changes, Pinto explains.

Other private practice options do exist. Governmental, military, educational, staff-model HMO, and similar institutions offer non-private practice options, but in these settings, entrepreneurial opportunities are limited, Pinto says.

—DJN

# Physician-Centered Practices Take Hold

By T. Robert Mestas, MD, and Robert F. Priddy, MSM

**T**he concept of the physician-centered practice is taking hold. More and more physicians and administrators are coming to realize that without the support and enthusiasm of highly motivated and happy physicians, medical practices are doomed. And while this concept may sound as if it flies in the face of some popular theories about how practices must be “patient-centered” or team focused, it doesn’t really, and we’ll explain why.

But first, we would ask ophthalmologists to consider the matrix we prepared (on page 13) and how you fit, or would like to fit, into it. By the nature of its variability, the practice of ophthalmology can lend itself to a variety of organizational models. The question is which options are right for you?

## Assessing Practice Type

The left column of the matrix, “Practice type,” depends on two sets of variables. First, what type of practice do you want and what is available? Second, what is the best fit for your work style? The first question is more subjective and usually reflects stronger business overtones involving your opinions concerning what you want to achieve, your ideal call schedules, use of your skills, and market opportunities. However, the best fit is more of an objective question that may require serious introspection or actual career testing to deter-

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mine accurately.

Physicians actually do fit practice size. And career counselors can test your fit for some of the underlying issues of practice type. A high tech practice, for example, has different demands for personal marketing, how decisions are made, pace and activity levels, than a practice oriented toward solo medicine. You can measure objectively how you fit with those differences.

Regardless of how these practice types are overtly questioned and decided, the answers don’t come by chance. In other words, ophthalmol-

the individual roles each person in the practice is to play. It’s also about the simple fact that if you feel rewarded, satisfied, and happy in your practice, staff and patients are more likely to believe they will be well treated and respected.

For the process to succeed, it must begin with you, the physician. First, you must know your needs, how you want to practice, and how you want your practice to run. Second, you must know how your needs shape the responsibilities of your staff and how they treat you, one another, and your patients. And, finally, you must know

**Establishing a physician-centered practice involves determining which roles fit you best and building your practice around them. The process involves taking control and deciding your own fate.**

ogists are likely to choose their type of practice.

The same can’t be said about your role in your practice, however. While ophthalmologists often can choose the role that is best for them, the actual “choice” usually happens either by accident, or is assigned to them by other members of the practice. Or, it could be that their role evolves over time.

## Analyzing Practice Roles

The basis of the physician-centered practice involves determining which roles provide the best fit for you and then taking definitive steps to build your practice around them. The process is about being in control and deciding your own fate. Physician-centered is all about the corporate culture of the practice and who decides

the expectations you have of your patients, and what expectations they have of you. Clearly enumerating your expectations for your patients will help them communicate with you, and allow you to meet their needs more effectively.

When we think of successful corporations, we’re most usually thinking of those in which CEOs have actively driven the culture. In medical practices, we usually have culture by default. Physicians are too often consumed by being physicians—seeing patients and dealing with hospital or clinic demands—to tackle the culture of their practices. So, what happens is that a dominant player, such as a practice manager, head nurse, or business office clerk takes the lead and sets the culture. This arrangement usually meets their needs, but it may not meet

your needs or those of the practice or your patients.

### The Star Player's Role

Your second choice is the star player model. Physicians are to their practices what star athletes are to their teams, and star athletes set the tone for the entire team. In that setting, the team asks each member what he or she can do to improve the performance of the star and in return, the star improves the performance and standing of every member of the team.

If the team is helping the physician, then the team, staff, patients, and others are working well and being successful. For the star athlete, working well means putting points on the board, and for a medical practice, it means treating patients well. This analogy pulls others into the mix more strongly than does the CEO model. Teams need coaches, and excellent player coaches are hard to find. So a practice manager or other practice leader often needs to assume the role of coach and help the other team members support the physician. Obviously, a high performing and highly astute practice manager is necessary for this arrangement to succeed.

Physicians who don't take such active leads fall into one or more of two other categories: team member or bit player. Now the matrix gets a bit more challenging. It may appear that if you aren't a CEO or a star player, you're relegated to the back bench. And, you may be. Physician office workers are like all people in that they want leaders, and are likely to seek out them out. So, if you don't lead, someone else will. Then, if you're a team member or a bit player, you won't make decisions. Other staff members will, with or without your guidance. Such arrangements create dysfunctional practices.

In a physician-centered practice, the physician is a combination of the CEO and the star player. Those are big responsibilities, and the physician

owes it to herself, her staff, and her patients to shoulder these responsibilities properly, meaning meeting her needs and building the practice around those defined needs. Determining your needs as a physician CEO and star player is a complex and demanding process. It will take more than cloistering yourself in your office for 30 minutes before you can develop a well defined set of marching orders for everyone to make your practice run the way you want.

Making these decisions requires considerable introspection, objective analysis, discussion, and outside testing. Begin by asking yourself what type of practice you want, what you want to do in your practice, and how you want to be viewed and treated in your practice. Answer these questions with specificity and with examples. Saying, "I want a successful practice in which I am the lead person setting the tone for operations," and, "I want to be seen as a caring and respectful physician," may sound like you've answered the questions, but in reality, you've only scratched the surface. How do you define a "successful practice?" What is a "lead person?" How will you "set the tone?" How will "caring and respect" be defined?

After you've answered these questions, discuss them with people who will give you candid and honest criticism. It's unlikely anyone meeting

those criteria works for you. Talk with people who know you. It may be your attorney or accountant, the risk manager for your malpractice insurer, a spouse, or close friend. Even if you request candor, you may not get it.

### Objective Assessment

Consider outside counsel and objective testing. A good consultant wields a velvet hammer. Through objective assessments, interviews with your staff, and discussion with you, a consultant skilled in organizational and career development for physicians can clearly define and understand the roles necessary for everyone in your practice to be successful. Objective testing isn't a personality quiz, but an analysis of your behavioral approach to work issues, communication, organization, and decision making. This approach helps you become an effective CEO and provides structure for responsibilities and relationships with staff and patients.

The outcome is a practice in which the physician, staff, and patients are all working in harmony through the leadership of an appropriately focused and happy physician CEO and star player. What's more, patients feel understood, well cared for, and respected. That's the essence of a physician-centered practice.

—More information on practice strategies is available on our Web site, [www.MDOptions.com](http://www.MDOptions.com).

## Analyzing the Physician's Role

Practice Type	Role			
	(Check all that apply)			
	CEO	Star Player	Team Member	Bit player
Solo practice				
Small group practice				
Large group practice				
Technology based				
Medicine only				
Traditional med/surg based				
Ancillary services				

Place an "X" in all the boxes that apply to you. You can have more than one role in any practice setting. For example, you may have a large group, technology-based practice with ancillary services. And, you may have a different role or multiple roles in each.

# Physician Develops Coding Expertise

**Q:** *What moved you to start Coding and Physician Reimbursement Analysts, Inc.?*

**A:** I recognized the significant need in the marketplace for information on coding and physician reimbursement, given the complexities in the area and the impact of changes initiated by the payers. I decided that it would be important for physicians and other organizations to receive credible advice from a physician knowledgeable in the area. I'm glad to say we've been widely accepted as providing a useful service.

**Q:** *Do most ophthalmologists do the coding themselves or do they delegate this to a coding clerk?*

**A:** In most practices with which I am familiar, the physicians make the code selection. In some practices, a coding or billing clerk assigns codes. Regardless, the physician maintains ultimate responsibility for the codes reported. Interestingly, it is with surgical procedures where coding responsibility is often delegated to non-physicians. This is surprising to me because surgi-

cal coding can be the most complex type of coding.

And, what's more, the CPT codes are reviewed frequently and updated annually. As a member of the CPT Advisory Committee, I regularly receive what are known as "code change proposals." When a physician or an organization, including the pharmaceutical and device manufacturers, are interested in adding a code or seeing a code revised, they submit a code change proposal and then the advisers review the proposal for ultimate adjudication by the CPT Editorial Panel.

**"No one is going to applaud you for not claiming all the reimbursement you appropriately deserve."**

**Q:** *I have heard from colleagues that about 5% of physicians overcode and 20% undercode. Do you find many doctors leave money on the table by undercoding?*

**A:** Absolutely, and this has been shown repeatedly. Doctors tend to be conservative, which is probably a good inclination. However, no one is going to applaud you for not claiming all the reimbursement you appropriately deserve.

**Q:** *Do you recommend an annual coding audit for practices?*

**A:** Generally, we recommend an initial audit to help practices ascertain where they are with their coding processes. An initial audit provides a useful overview. After that we advise a re-evaluation every year to ensure that the recommendations have been implemented properly and that further questions can be addressed as they arise.

**Q:** It's been reported that Medicare will decrease reimbursement to physicians by 5% in 2007. Is that correct and does that apply to all specialties?

**A:** A 5% across-the-board cut was in the works, but last-minute action in a lame-duck Congress session appears to have prevented this action. Despite this congressional action, however, many specialties are still anticipated to take sizeable hits in 2007.

**Q:** *Does it seem that these cuts appear to be targeted at the high tech specialties?*

**A:** That is correct. The reason that specialists are being asked to take a disproportionate cut largely relates to the changes for evaluation and management services (the E/M codes) which primary care physicians use predominantly. For example, CPT codes 99213 and 99214, the office visit codes for primary care, will be awarded increased value. Any physician can use these office visit codes, but mostly physicians in primary care use them. In order to fund the increases in the office visit codes, many of the procedural codes will go down in value. The specialties that are principally involved with procedural services will by and large feel the greatest cuts. The medical fields that use principally E/M codes may see less of a cut, or in some cases a small increase.

**Q:** *How are the procedural specialists responding to all this?*

**L. Neal Freeman, MD, MBA, FACS** is a practicing ophthalmic surgeon and the president and founder of Coding and Physician Reimbursement Analysts, Inc. ([www.cpranalysts.com](http://www.cpranalysts.com)), a coding, reimbursement, and practice management firm, in Melbourne, Fla. He is a frequent instructor, writer, and speaker to physicians, administrators, and coders on topics of coding, reimbursement, and the business of medicine. The American Health Information Management Association has certified Freeman as a Coding Specialist/Physician-based (CCS-P). Readers may contact Freeman at 321-253-2166 or [nfreeman@cpranalysts.com](mailto:nfreeman@cpranalysts.com). He discussed coding and reimbursement strategies with contributing editor Richard L. Reece, MD.

**A.** There's not a lot that many ophthalmology specialists can do. The average ophthalmology practice depends on Medicare for more than half of its revenue and so the effect on ophthalmology could be significant. Well over 90% of ophthalmologists participate in the Medicare program, and this rate is the highest among specialists. As a result ophthalmology practices depend on Medicare revenue so much that bailing out of Medicare is an unrealistic option. Most of the efforts to deal with reimbursement issues are being made through the specialty organizations such as the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgery, whereby the position of ophthalmologists is made known to the payers.

**Q.** *What steps can specialists take to legitimately maximize their coding revenue?*

**A.** Primarily, all specialists need to be aware of their fee schedules and appropriate ways to code for their services, and then they should take advantage of the opportunities that arise legitimately. For example, the use of modifiers is not maximized and money is lost because of that omission. Doctors need to be aware of the national correct coding initia-

keep doing things the way they've always done them. Although they might become aware about approaches other practices use, they often fail to investigate some of the ideas that have been successfully employed elsewhere.

**Q.** *Do you find that some doctors are interested only in clinical practice and feel it's beneath them to deal with coding and reimbursement issues?*

**A.** Traditionally there's been almost no training in coding or documentation of services in either medical school or during residency. Even as physician reimbursement has declined, there has not been sufficient interest expressed in learning about this important aspect of practice.

In addition, all people are typically afraid of unfamiliar things. A certain paralysis sets in. They might decide that it's just an area that's going to be too difficult for them to pick up during mid- or late-career and they decide to leave decision-making to others.

**Q.** *Concerning coding, does it make any difference where one operates, such as whether it's a hospital, an office, or in an out-patient facility?*

**A.** Yes. There are significant coding issues depending on where a physician operates. For example,

mon, of course. The federal Centers for Medicare & Medicaid Services (CMS) has proposed changes for ASC payments that are most likely going to have a major effect on payment as we go forward. These changes have both positive and negative effects. For example, CMS has proposed that starting in 2008 there's going to be a more extensive list of procedures that physicians can perform in an ASC. This proposal will essentially allow all services that don't require an outpatient hospital stay and can be safely performed within an ASC to be performed in that setting. However, the negative effect is that ASC facility payments will be cut to 38% less than the outpatient hospital rate for the same procedures.

Ambulatory surgery centers are managing patients with less severe illness than those that hospitals manage. For this and other reasons, hospitals incur higher costs than ASCs do. Consequently, many believe hospitals deserve to be compensated more for taking care of their patients than ASCs do.

**Q.** *Does the hospital industry have a more powerful lobby than the ASC industry?*

**A.** Hospitals are the dominant health care entity in many cities and often have direct access to local, state, and federal legislators. This is one reason the hospital industry is winning some battles in the certificate of need approval process. There are states that are implementing certificate of need requirements, which discourage the construction of new ambulatory surgery centers.

**Q.** *Does your group operate mostly in hospitals or in an ASC?*

**A.** We are like many ophthalmology groups in that we prefer to perform our outpatient surgery in an ASC setting. It is much more efficient and comfortable for many of the procedures we perform, such as cataract surgery. It can be chaotic try-

**“Ignorance of the process results in the loss of potential revenue that could otherwise be legitimately obtained.”**

tive edits so that they can handle bundling and unbundling issues properly. Basically, ignorance of the process results in the loss of potential revenue.

**Q.** *Do you find that some practices operate in a vacuum in that they are unaware of what other practices are doing or what they could do?*

**A.** What happens is that inertia dominates and physicians just

there is a concept known as the site of service payment differential in which physicians receive higher payment for certain services when carried out in the office. These payment differentials were established to compensate physicians for the practice expense of providing a service in their office rather than in a facility.

The use of ambulatory surgery centers (ASCs) is now extremely com-

*(Continued on page 16)*

ing to do surgery in the hospital. They may rotate different specialties through the same operating suite and the support staff is not necessarily dedicated to a specific specialty.

**Q:** *Are you optimistic about the future or do you see a gradual down shifting of physicians' fees during the coming years?*

**A:** We have to be realistic. This country spends more of our dollars per capita for health care than many industrialized nations spend, and yet we cannot demonstrate better outcomes. Our health care payment system is strained.

In the future, we'll see a major shift in the way payments are delivered. For example, the area of performance measurement is new, and pay-for-performance is inevitable, not only from federal payers but from private payers as well.

Pay-for-performance programs will reward providers who can demonstrate better outcomes. Efforts are being made to define how to reduce base payments to allow for the creation of a bonus pool. The bonus pool can then be used to direct money to physicians who report better outcomes based on a set of quality indicators. There are already voluntary programs in place and some of the specialty societies are developing their own performance measures. The American Academy of Ophthalmology has developed eight measures, including indicators for glaucoma, macular degeneration, cataracts, and diabetic retinopathy.

**Q:** *Pay-for-performance requires an electronic health record system within a given practice to record the data that will be used in judging pay for performance. Has your group implemented a system for handling this type of data?*

**A:** We do not have an electronic health record (EHR) and many of my clients with whom I consult also do not have an EHR. The cost of implementing an EHR system is currently too great for many practices to afford comfortably. Its widespread use, though, is almost certain in the relatively near future.

**Q:** *Are you optimistic about the future of health care?*

**A:** The future will be bright for those who are nimble on their feet and ready to respond. The health care system will not look the same 10 or 20 years from now as it does today, but providers who are willing to take chances, move with the times, and are willing to accept newer approaches may well succeed.

—Edited by Michael Bihari, MD. More information on physician practice strategies is available on our Web site, [www.MDOptions.com](http://www.MDOptions.com).

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December 2006



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