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# RHEUMATOLOGY PRACTICE OPTIONS™

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*February/March 2008*

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## What Physicians Seek

By Richard L. Reece, MD, editor-in-chief

This column expands the scope of *Physician Practice Options*. The title is presumptuous, but it rests on 40 years of experience in listening to physicians' frustrations, writing for them, and consulting with major organizations tracking physician trends.

For the past 12 years, the *Practice Options* newsletters have focused on improving patient care through increased practice efficiency. And rightly so. This function is essential and we shall continue to stress this idea.

In addition, current physician concerns transcend mere practice efficiencies. Greater patient loads, declining revenue, increasing costs and paperwork, loss of respect, pressure to install costly electronic medical record systems, and health plan and government interventions demoralize doctors. Regrettably, many physicians feel the system has stacked the deck against them. Some two-thirds of physicians say they wouldn't recommend a medical career to their children.

Yet there's hope for physicians. Doctors are a guiding force for health reform and they are seeking a greater voice and visibility in the discussions about reform proposals. To date, politicians, health plan administrators, and academics have dominated the discourse. Yet most haven't spent time in clinical trenches and lack a feel for the pressures imposed on doctors.

The physician empowerment movement is underway as seen at Physicians Interactive (at [www.physiciansinteractive.com](http://www.physiciansinteractive.com)), Sermo (at [www.sermo.com](http://www.sermo.com)), and other professional networking sites. Sermo (Latin for "conversation") has 50,000 participating physicians and partnerships with the American Medical Association and the federal Food & Drug Administration. These sites track physician trends, serve as early warning sites for adverse drug effects or evolving epidemics, and allow physicians to discuss the workability of health reform measures.

Innovations that allow physicians to communicate with patients electronically have patients enter their own data and clinical histories, and allow patients increased access to retail and specialty medical clinics are developing rapidly.

The managed care wars are over. Health plans are realizing paying doctors less to do less is counterproductive. Paying doctors more for linking electronically with patients achieves better results and saves money. This linking simply requires physicians and patients to have Internet access. Indeed, under a new program developed by Bridges to Excellence, a pay-for-performance program (at [www.bridgestoexcellence.com](http://www.bridgestoexcellence.com)), physicians will be eligible for annual rewards of \$125 per patient for developing a patient-centered medical home for patients by providing coordinated acute, chronic, preventive, and end-of-life care facilitated by information systems.

Besides this personal column, in future issues we shall present a point-counterpoint section, featuring interviews with experts on both sides of controversial issues. Our aim is to make physicians active leaders of health care reform rather than passive followers.

I invite you to interact with me at [Rreece@premierhealthcare.com](mailto:Rreece@premierhealthcare.com). I will respond with my unvarnished opinion. Feel free to agree or disagree. Tell me if I'm on target. Readers can also interact via my blog (at [www.medinnovationblog.blogspot.com](http://www.medinnovationblog.blogspot.com)), which features comments on various leadership and innovation topics. ■

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# Redesign Fosters Quality Improvement

**M**any medical and professional organizations, including the Institute of Medicine, the Institute for Healthcare Improvement, and the American College of Rheumatology, have recognized that the redesign of patient care processes is critical to making necessary improvements in care quality, efficiency, and service. In its landmark 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine identified important deficiencies in quality of care and highlighted process redesign as an imperative.

In light of this imperative, practice redesign should be a priority for all medical specialties, including rheumatology, says Eric D. Newman, MD, director of the Department of Rheumatology, and vice chairman of the Division of Medicine at Geisinger Medical Center in Danville, Pa.

## Filling Gaps in Care

“All practices have quality care gaps we need to address,” he asserts. “Aside from our responsibility to our patients, physicians should understand that their practices will not remain viable into the future if they do not learn to improve their efficiency, effectiveness, and quality. Virtually every governing body and professional organization involved in patient care is scrutinizing physicians and measuring our performance, using its own metrics if we can’t provide them ourselves.”

Rheumatologists face a number of unusual challenges that they should consider when redesigning their practices. In fact, facing these challenges will clarify why improving quality and efficiency are so critical to practice success.

“Because we deal with chronic diseases, our patients tend to have

**“Physicians should understand that their practices will not remain viable into the future if they do not learn to improve their efficiency, effectiveness, and quality. Virtually every governing body and professional organization involved in patient care is scrutinizing physicians and measuring our performance, using its own metrics if we can’t provide them ourselves.”**

**—Rheumatologist Eric D. Newman, MD,  
Geisinger Medical Center**

quite complex problems that require care over the long term,” Newman explains. “In addition, while the treatments at our disposal can be very effective, they are also extremely costly and have a high potential for side effects. Furthermore, the bulk of rheumatology work is cognitive, and reimbursement levels for cognitive services are lower than those for procedural services. As a result of these factors, rheumatologists have to be as efficient as possible while striving for optimal quality of care. Process redesign can help us pursue both goals successfully.”

## Training for Redesign

Newman and his colleagues at Geisinger’s Department of Rheumatology have embraced the redesign challenge, implementing process initiatives that have improved care access, safety, and efficiency for Geisinger’s patients and physicians. In this article, Newman discusses how rheumatologists can embark upon a redesign effort and outlines the important elements of redesign. In a follow up article (in the May issue), Newman will describe several process redesign projects that Geisinger has imple-

mented successfully.

For any organization embarking on process redesign, Newman emphasizes the importance of obtaining training and education before starting. Redesign techniques are not intuitive. “Most physicians do not understand how to redesign our work processes, because we were never trained to do that,” he explains. “Therefore, rheumatologists and other clinic staff need to formally seek expertise and training as a starting point.

“However, once rheumatologists learn these techniques, they can apply them to virtually any facet of any process within their practice or department from very small processes like how patients queue up to sign in, to huge system-level, population-management programs,” Newman continues.

For several years, the Institute for Healthcare Improvement in Cambridge, Mass. (at [www.IHI.org](http://www.IHI.org)) has offered courses related to office redesign. It is planning the ninth annual International Summit on Redesigning the Clinical Office Practice March 30 to April 1 in Dallas.

(Continued on page 4)

(Continued from page 3)

Newman and J. Timothy Harrington, MD, of the University of Wisconsin School of Medicine and Public Health teach practice workshops at every annual meeting of The American College of Rheumatology. What's more, rheumatologists who have successfully implemented redesign efforts are usually willing to share best practices regarding quality improvement efforts, Newman adds.

### **An Array of Possibilities**

Once they obtain training regarding redesign techniques, rheumatologists should be open to a wide array of possibilities when identifying potential targets for redesign, Newman suggests. "Since most medical practices were set up without careful consideration of efficiency, effectiveness, quality, or safety, physicians should apply a broad brushstroke when targeting particular processes for quality improvement," he says. A hallmark of practice redesign is that further improvement is always possible.

To get started, Newman suggests assessing a practice's vital signs. These signs would indicate potential areas for improvement such as particular clinical outcomes and measures of patient safety and access to care. Examples include appointment wait time, patient backlog, patient visit cycle time, and patient satisfaction scores. Such targets also could include clinical measures such as the percentage of patients with rheumatoid arthritis who are prescribed DMARD therapy, the percentage of patients at high risk of osteoporosis who receive a dual x-ray absorptiometry (DXA) scan, and use of flu and pneumovax immunizations in patients receiving immunosuppressive medications.

"One of the biggest problems rheumatologists face is enhancing access to care," Newman explains. "So, enhancing patient access is often a good starting point for virtually all rheumatology practices and ideal for any redesign efforts." An

## Three Goals for Redesign

For any physician considering improving a practice, there is a seemingly limitless number of processes to consider for redesign. But Eric D. Newman, MD, director of the Department of Rheumatology, and vice chairman of the Division of Medicine at Geisinger Medical Center, suggests that rheumatologists limit potential practice redesign targets to those problems they can control.

When defining a problem for redesign, it is important that the problem definition meets three criteria, he says:

1. It must be within the rheumatologists' sphere of control
2. The cause of the problem should not be assumed
3. The problem needs to be stated without a solution in mind.

"As an example of a bad way to frame a problem, consider the statement, 'If I only had enough professional staff, our backlog of patients would be fine.' This statement assumes causality (that the backlog is caused by not having enough staff) and provides a solution (hire more rheumatologists)," Newman explains. "This thinking is severely constraining and likely results in wrong assumptions. A better way to frame the problem is, 'We cannot see rheumatology patients in a timely fashion.' This problem statement has no flawed premise, and opens up many more potential solutions to test."

—DJN

ACR workforce analysis shows that a shortage of rheumatologists and allied health care providers has caused the average wait time for an appointment with a rheumatologist to be 60 to 90 days.

### **A Team Approach**

Other process redesign efforts might involve improving medication safety, ensuring maximum charge capture, refining the process of how clinical information is collected and organized in electronic or paper patient records, or ensuring that technologies such as DXA scanners are used to maximum capacity.

Before redesign efforts take place, it is important to have a dedicated team of individuals who will design and implement new ideas. These individuals would include rheumatologists, nurses, and office staff. In addition, rheumatologists may want to consult with primary care referral sources and patients as well. "The team should be formed by the key member of the microsystem that provides rheumatologic care,"

Newman says.

Once the team is formed and trained in the redesign techniques, then the process can begin. The steps that are involved in redesign include: defining the problem, analyzing the problem (using methods such as root-cause analysis or fishbone diagrams), brainstorming solutions, setting priorities for solutions, and then testing a solution. This last step of testing a solution uses proven techniques such as the plan-do-study-act (PDSA) protocol.

### **Overcoming Misperceptions**

Unfortunately, quality measurement is often perceived to be negative or punitive. Instead, it should be looked upon as a positive opportunity. "When physicians measure a process and find that it is not working, they can take the opportunity to improve it," Newman explains.

Consider this example, he adds. At Geisinger, the Rheumatology Department started a project to improve the ordering process for follow-up DXA scans. "We set up a

process to encourage physicians to order timely follow-up DXA scans for patients at high risk for osteoporosis, but never bothered to examine that process," Newman recounts.

"We just figured it made intuitive sense. We assumed we were doing it effectively. But when we actually measured the results, we found that only 18% of our at-risk patients had received a referral for a follow-up DXA scan," Newman says.

The problem resulted from establishing the process in isolation, without considering the effect it would

have on Geisinger's primary care physicians, who found the process burdensome. "Discovering our low yield was the first step in becoming successful," he says. After collecting comments from primary care physicians and results from using PDSA when it tested different process improvements, the rheumatology department increased the testing rate to 88%.

A final consideration for successful process redesign is commitment. "At Geisinger, we have very significant senior administrative support,"

Newman asserts. "Quality improvement will not happen unless the top people believe it is important and dedicate the tools and resources necessary for successful process redesign. Ultimately, both physicians and administrators must be willing to devote the resources to process redesign, believe it is an important issue, create the team and the infrastructure, and then stick with it."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

## Using the Plan-Do-Study-Act Method

Typically, groups test solutions via rapid-cycle process improvement, also known as the Plan-Do-Study-Act (PDSA) method.

"PDSA is a well-defined process for solving a problem," says Eric D. Newman, MD, director of the Department of Rheumatology, and vice chairman of the Division of Medicine at Geisinger Medical Center. Newman has used the PDSA method extensively in process redesign in Geisinger's Rheumatology Department. "Many times in health care delivery, we skip right to the solution without fully analyzing the problem or testing possible solutions," he comments.

PDSA is characterized by multiple short cycles of testing and measurement that are implemented until an optimal result is achieved. As the name implies, each cycle involves four steps:

1. The identification of a problem to solve and a plan to solve it
2. The test of a possible solution
3. The measurement and analysis of results
4. The modification of the test based on those results.

Once the practice makes the modifications, the cycle is repeated.

Newman highlights a number of critical underpinnings of both the PDSA method and process improvement in general. First is the concept of teams. "Health care is a very physician-centric world, but that is the old world," he says. "That type of hierarchical structure is not set up to foster successful process improvement. Rather, process improvement recognizes that each physician practice is a microsystem that is part of a larger system of care, and that all members of the microsystem can have an effect on, and can be affected by, the

system. Therefore, team members must be included in change efforts so that the plan for change takes into account all viewpoints. Team members should devote the time and resources to process redesign, and should meet on a regular basis to review the PDSA cycles."

Geisinger's Rheumatology Department would not have enjoyed its many successes in process redesign had it not been for the innovative ideas and hard work of the physicians, nurses, secretaries, office staff members, and others in the department who have been committed to improving patient care, Newman explains.

A second critical component is a patient-centered philosophy. "The work effort of each team member is geared toward serving the patient," Newman explains. "Therefore, the effect on patients should be kept in mind when problems and solutions are identified."

Third, measurement is implicit in any redesign effort. "The adage is, we don't understand what we don't measure," Newman says. "Typically, physicians are very data-driven, yet they often do not understand or emphasize the need for measurement in quality improvement and process redesign."

The measures used in each PDSA cycle should be identified with the issue or problem at hand. "For example, when testing solutions to insufficient access to care, rheumatologists can use a standard industry measurement such as good backlog (all new and returning patients), bad backlog (those return patients whose follow-up appointment was excessively delayed), or third available appointment (typically considered to be an accurate measure of appointment wait time because it is not influenced by last-minute cancellations).

—DJN

# New Book Outlines Innovations

By Regina E. Herzlinger

**R**ichard L. Reece, MD, is that rare breed of physician commentator who admires his colleagues. How long has it been since you read an article in a medical or health policy journal applauding the skill and compassion of doctors, scientists, and administrators and/or bemoaning their increasing loss of autonomy to health insurers and governments? Well, you won't read about how greedy and incompetent they are in *Innovation-Driven Health Care: 34 Key Concepts for Transformation*.

What you will read is an intelligent, knowledgeable analysis of the innovations on the future of U.S. health care, and it's supportive, too. As Reece says, God love him, "Being a physician is being part of a sisterhood and brotherhood."

But why should you read yet another health care future book? Because Reece has nailed it: His view of the future is exactly right. If you want to continue what you are doing, this book will enable you to access how you fit into this new world and to adapt yourself if needed.

## Innovative Issues

I had the good fortune to meet Reece some 30 years ago at the Harvard Business School's Program for Health System Management. Then, as now, he was a big man with a gruff affect,

*Regina E. Herzlinger is the Nancy R. McPherson Professor of Business Administration at the Harvard Business School. This article is republished with permission from Innovation-Driven Health Care: 34 Key Concepts for Transformation (Jones and Bartlett, Publishers, 394 pages, 2007) by Richard L. Reece, MD, editor-in-chief of Physician Practice Options.*

**If you want to continue what you are doing, this book will enable you to access how you fit into this new world and to adapt yourself if needed.**

piercing intellect, heart of gold, and a sunny, bemused view of life.

I learned of the qualities because I taught Reece accounting in the program, a course that quickly separates the intellectual and emotional wheat from the chaff—the analysts from the analyzed; the "let's-cut-costs" types from the "let's-increase-productivity" ones; and those with a sense of humor (believe me, you need this quality in an accounting course) from the deadly serious.

These qualities inform *Innovation-Driven Care*.

However, Reece is not merely a cheerleader. He believes that innovations will increase the productivity of the U.S. health system so that it can provide better services, at a better price, to more people. What a contrast to the usual dour prescribers who contend that innovation is impossible and improved productivity is a myth. Their cure? Uncle Sam rations health care. Hello, Canada!

To make the importance of this point of view concrete, consider the following excerpt: Almost immediately (after the introduction of CT scanning), political objections arose to widespread use of this new imaging technology. Federal Health Secretary Joseph Califano rose on his political haunches in 1977 and declared, "There are enough CT Scanners in Southern California for the entire United States."

Not to be outdone, Howard Hiatt, MD, dean of the Harvard School of Public Health, compared the use of

CT scanners to overgrazed medical commons in which too many were foraging for too little. He said a national center for technological assessment and suppression of new technologies should be established and argued: "There is little doubt that the scanners provide additional diagnostic information, and frequently with less discomfort and hazard to the patient. However, it is not clear the diagnostic information very often leads to a better outcome for the patients. Until this important information is available from careful studies, would we not be better served limiting the use of such expensive technology?"

Califano and Hiatt overestimated the power of federal regulations and underestimated the thirst of doctors and the public for this clearly superior technology. Neurosurgeons immediately embraced CT scans. Their enthusiasm soon spread to orthopedic surgeons, who saw the potential of MRIs for joint, bone, and soft-tissue imaging. More recently, oncologists have welcomed PET scans to check for subtle cancer spread. CT and MRI scanning has become the modus operandi for all manner of physiological anomalies.

In 2001, 225 internists, when asked to evaluate the relative importance of 30 medical technologies, rated CT and MRI scans as the number one innovation, according to an article in *Health Affairs*, (2001; 20(5): 30-42), "Physicians' views of the relative importance of thirty medical innovations."

However, Reece is no ideologue. He is a pragmatist. With illuminating case studies, he provides news you can use, as illustrated by the following examples:

- How stand-alone, onesie-twosie practices can thrive.
- How to make your intellect, training, and experience work for you, if you leave medicine.
- How to empower consumers and embrace new high-deductible health plans without disemboweling yourself.
- How large groups—Mayo, Kaiser—have avoided “mid-life” crises.
- How to flourish in insurer-physician and hospital-physician relationships, which are typically more akin to the relationship between a salmon and a bear.

I have merely mentioned only five of the 34 topics in this book. If you want to know more, read on!

Why am I so sure Reece’s views of the future are right? It’s not only that he agrees with my views, but also, and more important, because he has been so right so often before. For example, a dozen years ago, as chairman of a physician-hospital organization, he created the case-based pricing that payers are finally coming to years later. And while in the midst of managed care-loving Minnesota, he predicted the threat HMOs posed to physicians. The observation, which now seems obvious, was radical when he made it—a quarter century ago.

Best of all, Reece’s sunny belief in the transformative powers of innovation are mirrored by his bright, witty writing style. Here are some samples: “Question: What do you call farmers who convert fallow into fertile ground? Answer: Farmers with a sense of humor.” And on pay for performance: “An ounce of performance is worth a pound of lucre.”

It’s great to laugh, especially when the laughter is accompanied by such useful advice.

—More information on physician practice strategies is available on our Web site (see page 16).

## Preface: Book Contains Six Parts

By Richard L. Reece, MD, editor-in-chief

This book contains six parts:

1. Small Practice Innovations
2. Large Group Innovations
3. Hospital-Physician Joint Venture Innovations
4. Employer and Health Plan Innovations
5. Constraining Costs and Expanding Market Innovations
6. Consumer Innovations

Each chapter kicks off with a brief prelude and quote or quotes. The prelude sums up the essence of what follows. Sometimes the quote comes from an historical figure. More often the source is a recent newspaper account. Most quotes are contemporaneous. Following the quote is a discussion of the innovation involved: its background, relevance, and impact.

On occasion, I describe a commercial company’s innovation. In medical journalism, it is a “no-no” to highlight a single company, but innovative ideas may start with entrepreneurs who launch small companies. They sense a niche; they want to make a difference; and they go for broke—often the consequence of risk-taking ventures.

A tongue-in-cheek entrepreneur once said, “There is nothing mysterious about innovation. It’s about niches—and sons of niches.”

Consider the entrepreneurial spin-offs from Healthcare Corporation in Nashville. Nashville now has more than 300 for-profit innovative health care-related enterprises. Think of Boston’s medical industrial complex with its nexus of academic medical centers and health care firms sprouting around Route 128. Look at Minnesota’s Medical Alley stretching from Rochester to the Twin Cities with the Mayo Clinic, Medtronic, St. Jude Medical Inc., United Healthcare Group, MinuteClinic, and 800 registered medical device manufacturers.

Innovation breeds replication and transformation. A section titled, “Innovation Talking and Action Points,” highlights what has been said, what lies ahead, and what type of innovation was discussed.

Most chapters end with one or more case studies. I have written a few of these case studies; mostly, however, I call upon others more informed on the topic. The studies vary in style and format. Some are classic health studies while others are commentaries and company profiles. In soliciting case studies, I did not seek sameness. I simply asked case study authors to, “tell your story in your own words.”

**The Glue:** As you read through these six parts, information technologies’ central role in innovation takes shape. These technologies glue together health care innovations, reduce costs, ease use, and improve care and outcomes. For example, today’s doctors submit 75% of claims online, thereby improving payment rates, turnaround time, and accuracy. Four years ago, that figure was 44%.

**The Book:** This is not a health policy, health reform, or politically correct book. It is the view of one man who sees U.S. health care as it is, not the way it ought to be; who has been there, done that, and seen that; and who has talked, listened to, and observed those who have seen it and done it.■

# 5 Keys to Hiring Billers, Coders

By Linda Hallstrom, CPC-E/M, and Kevin Solinsky, CPC

**H**iring qualified billers and coders is one of the most challenging endeavors in a practice. Employing an effective medical billing and coding team can greatly affect practice success. Mismanaging claims, denials, and aging receivables can result in delayed reimbursement, affecting the practice's ability to meet payroll and pay expenses. Coders are obligated to code all procedures and services accurately and confirm that provider documentation supports the charges submitted. Federal fines can be as much as \$25,000 per line of incorrect coding or documentation and violations can result in jail time and sanctions against a practice.

The medical coder assigns alphanumeric codes to the services a physician renders during each patient visit. The biller uses the codes to bill insurers and is often considered the practice's income manager.

## Specialization by Payer

The size of one's practice determines the type of coding and billing staff the practice should hire. Large offices tend to divide accounts receivable by payer, meaning coders and billers are assigned to individual payers, such as Medicare, Medicaid, and commercial insurers. In smaller offices, one person may do both billing and coding

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**Many offices have a panel of interviewers, giving a number of individuals a chance to participate in interviews.**

for all types of claims. Billers prefer to specialize by payer type, but it is important for a medical biller to understand how to process claims for all payers.

Medical billers need to appreciate the importance of accurate data entry when submitting a claim. It is worth the extra effort to verify insurance benefits and eligibility. The integrity of the data being submitted is paramount to ensure a clean initial claim. Taking time at this step will reduce the time the office waits for payment and could mean the difference between receiving reimbursement in 30 rather than 60 days. Another important aspect of billing successfully involves understanding each insurer's appeal process, which requires the medical biller and coder to work together.

Accuracy and integrity are key elements of the coder's job as well.

## Interviewing and Hiring

When reviewing resumes, it is best to find someone who has experience and then check references. If the applicants have little or no experience, seek someone who has trained at a reputable school or training program. Once you are ready to interview candidates, follow these general guidelines to ensure selection of the best employee.

Many offices have a panel of interviewers, giving a number of individuals a chance to participate in the interviews and helping to minimize mistakes. Getting potential co-workers involved in the process will improve the thoroughness of the

interviews, and provide existing staff members the opportunity to assist in the selection.

Some practices have developed a short quiz or test for candidates for each position. For a medical biller, this quiz can include questions about candidates'

- Knowledge of NPI numbers and their use on claim forms
- Ideas for managing receivables
- Experience in filing appeals.

When interviewing medical coder candidates, inquire about:

- Their involvement in the local coding chapter
- The most recent continuing education seminar they attended
- The resources they would use when encountering a coding challenge.

Ask all candidates:

- Where do you see yourself in five years?
- What are your strengths?
- What are your weaknesses? (This question can tend to be difficult to answer, and makes interviewees think a little.)
- How do you handle conflict with coworkers?
- What is your definition of team work?

## Evaluating Skills

Excellent communications skills are vital in every position in a medical practice, and these skills are critical for medical billers and coders. These individuals must engage in challenging conversations with patients, their family members, payer representatives, co-workers, and health care providers.

Before hiring a medical coder, test the candidate's ability to relate his or her knowledge to your desired specialty. The practice can do so by developing a pre-employment test for all candidates. This test can be as simple as pulling five patient chart notes and asking the candidate to code the services provided. Be sure to test a candidate's knowledge of evaluation and management (E/M) documentation requirements, the single most important area for every coder since all practices provide some volume of E/M services.

It is also important that the coder stay abreast of coding updates, compliance rules, and government regulations. Federal reimbursement rules require every office to file a compliance plan that must include a process to remain in compliance with all coding regulations. While not required, the OIG highly recommends that every practice has a certified coder. Ask each coding candidate how he or she stays up to date on CPT, ICD-9, and regulatory changes. Participation in a coder's local professional chapter and continuing education are essential. Chapter involvement provides a coder with a wealth of networking opportunities and indicates the coder's interest in furthering the medical coding profession.

### **Experience Preferred**

In addition to having communication skills and staying up to date, candidates should ideally have some experience, but experience does not always guarantee a strong work ethic. Always request references from a candidate's previous positions and contact those references. Previous employers are limited in the information they can provide, but they can answer the question, "Is the candidate eligible for rehire?" Provider-to-provider or office manager-to-office manager contact will often yield useful information as well. When considering any candidate who is seeking

## Coders Offer Expertise That Practices Need

While having a medical coder is important in practices today, it will become even more important in 2011. That's when physician practices will be required to use ICD-10-CM diagnosis codes. Under ICD-10-CM, the number of available diagnosis codes will rise from 13,500 to 120,000, meaning coders will require additional specificity. Many medical coders who are not certified are proficient, but a certified coder is likely to have more resources available than a non-certified coder and thus may be able to help the practice integrate the new codes smoothly and efficiently.

Hiring a certified coder confirms that the individual has been trained to the highest standards and will work to keep your practice in compliance with current rules and regulations. To earn certification, a coder must demonstrate a measurable level of knowledge and expertise in coding of services, procedures, and diagnosis and is well versed in medical terminology.

The American Academy of Professional Coders (AAPC) and the American Health Information Management Association (AHIMA) are two organizations that certify medical coders. AAPC certifies physician-based office coders as Certified Professional Coders (CPCs). While AHIMA focuses on hospital-based coding, it also offers a physician-based certification, Certified Coding Specialist-Physician (CCS-P). Both the CPC and CCS-P specialize in physician office CPT and ICD-9 coding. Currently the AAPC has more than 65,000 members, of whom 50,000 are certified. AHIMA's membership is 50,000 (member certification data was unavailable).

In addition to its core credential (CPC), the AAPC also offers specialty credentials in evaluation and management, CVT surgery, internal medicine, orthopedics, pediatrics, general surgery, ob-gyn, cardiology, family practice, and emergency medicine. AAPC also plans to offer specialty certifications in anesthesia, ENT, urology, and plastics/reconstructive surgery.

his or her first job, contact the administrator or teachers at the school or training program and ask about the candidate's work habits, punctuality, and ability to work with others.

Due to the structure of the interview process, some interviewees may be able to manipulate the interview. Many candidates will tell you what they think you want to hear, so counsel the interview panel to assess the genuineness of responses.

The practice also should outline its expectations for potential candidates and support those expectations with appropriate compensation. Depending on the location and the

candidate's experience, medical billers earn between \$14.50 and \$21 per hour. Non-certified medical coders earn \$13.25 per hour, while their certified counterparts earn an average hourly rate of \$15.86. Specialty certified coders earn an average of \$18 per hour, according to the AAPC 2007 *Salary Survey* (at [www.aapc.com](http://www.aapc.com)) and the AHIMA 2007 *Salary Survey* (at [www.ahima.org](http://www.ahima.org)). Any practice seeking to hire the most qualified candidates should be prepared to pay at the higher end of the scale.

—More information on physician practice strategies is available on our Web site (see page 16).

# Avoiding the Retirement Tax Trap

David B. Mandell, JD, MBA, and Jason M. O'Dell, CWM

A common expression holds that there are two certainties in life: death and taxes. For any person of substantial means, the federal government has combined the two so that upon death, a tax bill almost certainly follows soon thereafter.

In fact, physicians and others may get more than one bill. If Congress passes a compromise bill that it has been considering regarding estate taxes, a physician who leaves his or her family with an estate of more than \$7 million will need to pay federal estate taxes. That same physician in a state with a state estate tax may also pay an additional tax. A physician in a state with a state inheritance tax may pay another tax, and a physician who has an individual retirement account (IRA) or a pension will pay income taxes.

## A Timely Death?

If Congress fails to pass a compromise

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**Under tax law, qualified retirement plans, such as pensions, profit sharing plans, 401(k)s, and IRAs (excluding Roth IRAs) are characterized as items of "IRD" or "income with respect to a decedent." As such, when a taxpayer dies, these assets are not only subject to federal (and sometimes state) estate taxes, they are also subject to federal and state income taxes as well.**

bill, then a physician who has a large estate will get a \$2 million exemption and pay a 46% estate tax rate this year and next. In 2010, the estate tax is fully repealed, but will be re-instituted in 2011 with a \$1 million exemption and a 55% tax rate. In other words, if you don't die in 2010, the tax rates will be higher than they would be under any likely estate-tax reform legislation.

## A Typical Case

Under tax law, qualified retirement plans, such as pensions, profit sharing plans, 401(k)s, and IRAs (excluding Roth IRAs) are characterized as items of "IRD" or "income with respect to a decedent." As such, when a taxpayer dies, these assets are not only subject to federal (and sometimes state) estate taxes, they are also subject to federal and state income taxes as well. Federal and state income taxes can be as high as 45% in some states, meaning the combined taxes (federal-state and estate-income) can escalate quickly. In fact, with these four different taxes to be assessed, the total tax on assets characterized as IRD assets can reach levels of over 70%.

Consider the hypothetical case of

James Doctor, MD, a single physician in Ohio whose non-qualified plan assets exceed the current estate tax exemption (\$1 million after 2011). Assume when he retired from his practice, Doctor rolled his profit-sharing plan containing \$1 million into a roll-over IRA and then dies sometime after 2011.

His estate would first pay \$70,000 in Ohio state estate taxes (at the 7% rate) on the value of the IRA. On the remaining \$930,000 value, federal estate taxes would be assessed at an effective rate of 46%, costing \$427,800. At this point, his estate has paid almost \$500,000 in taxes, but the real pain comes next.

To pay the state and federal estate taxes, the estate would likely take the funds from the IRA itself. Let's assume that all \$1 million was taken out of the IRA at once. When each withdrawal is made from the IRA, state and federal income taxes are due. Given the size of these withdrawals, and the income tax situation of Doctor's heirs, the estate could well reach the top federal (35%) and state (7.185%) income tax brackets.

With these taxes also levied on the IRA, Doctor's heirs could get less than 28% of the IRA. While this

amount may seem egregious, Doctor's situation actually would be worse in other states, such as New York, where the state estate tax is much higher (16%). (To examine how these numbers were calculated see table: Tax Implications.)

### Tax Strategies

There are a number of ways physicians can avoid this tax trap, or diminish its effect on one's estate. These include:

- Non-qualified plans
- A capital transformation strategy
- An enhanced liquidate and leverage strategy.

**Non-qualified plans** have been used for more than 30 years, yet few physicians or their advisers know how to implement them properly for medical practices. It is a serious mistake not to use these plans because they are much more flexible than qualified plans such as pension and profit-sharing plans and 401(k)s in how they can be structured for IRD and estate tax treatment. In addition, non-qualified plans may have much higher contribution limits than traditional qualified plans.

**A capital transformation strategy (CTS)** essentially transforms wealth from the worst IRD or estate tax position to a position in which the taxes are not as onerous. Doing so may involve using a rollover or creating a special-purpose qualified plan. It may also involve the use of investments or insurance vehicles that are not taxable as income. In addition, the CTS could involve the use of an irrevocable trust that may allow funds to pass to heirs with a reduced or eliminated estate tax liability. This technique can often reduce taxes upon death by 50% or more.

**An enhanced liquidate and leverage strategy** was explained in the book *Wealth Protection, MD*. This strategy essentially involves distributing the funds from an IRA that are not likely to be needed in retirement, paying the income taxes, and then,

## Tax Implications

The estate and income taxes of the hypothetical doctor's IRA account for nearly 73% of his assets.

IRA value	\$1,000,000
Less: estate tax	(\$460,000)
Income with respect to a decedent (IRD)	\$1,000,000
IRD deduction	(\$460,000)*
Taxable IRD	\$540,000
Less: state income tax (7.185%)	(\$38,799)
Less: federal income tax (35%)	(\$189,000)
Total taxes paid	\$687,799
Effective tax rate (estate and income)	68.8%
Amount left for beneficiaries	\$312,201

*\*Note: The IRD deduction will be even less (and the income tax consequences more severe) for taxpayers subject to the Section 68 phase-out.*

*Source: O'Dell Jarvis Mandell, LLC, Cincinnati (www.ojmgroupp.com)*

through a combination of an investment and premium financing structure making up those lost taxes as an investment for heirs. Typically, this technique generates 2 to 5 times more after taxes to one's heirs than they would receive by leaving funds in the retirement plan. This technique would help to minimize the risk if one is concerned that income tax rates may increase over one's lifetime.

A number of factors limit any discussion involving tax strategies in a newsletter article. That's why tax

advisers will almost always say that figuring one's way through retirement planning dilemmas requires expertise in financial planning, forecasting, tax and pension law, and estate planning. Therefore, it is important for physicians to consult a professional with experience in dealing with retirement plans and techniques for preserving plan assets from all types of federal and state taxes.

—More information on physician practice strategies is available on our Web site (see page 16).

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# Reports Show EMRs Improve Results

**N**orth Fulton Family Medicine, P.C., is a practice with 10 physicians and 10 physician assistants in Atlanta. The providers see more than 400 patients a day in four clinics. After exploring several electronic health record (EHR) systems, North Fulton Family Medicine selected HealthMatics EHR from Allscripts, in Chicago, and saved almost \$254,000 for chart pulls per year.

In 2006, the Certification Commission for Healthcare Information Technology certified the HealthMatics EHR. CCHIT<sup>®</sup> certifies electronic health records and their networks, and is an independent, voluntary, private-sector initiative dedicated to accelerating the adoption of health information technology by creating an efficient, credible, and sustainable certification program. CCHIT recommends that physicians use its certified systems.

CCHIT has collected case studies on physician groups that use these certified systems. North Fulton Family Medicine is featured in one of its case studies. Advanced Health Care, PLC, a two-physician internal medicine practice in Arlington, Va., is another.

## More Coordinated Care

The North Fulton practice found that its EHR allows it to deliver to physicians phone messages, prescription refill requests, lab results, and other information quickly and efficiently. The implementation took less than three months and the physicians all began using the system at once, CCHIT reports.

As a result of using the system, the physicians in the practice are providing better patient care than they were when using paper charts, says James Morrow, MD, vice president and chief information officer. A CCHIT commissioner, Morrow received the HIMSS Physician IT Leadership

award last year from the Healthcare Information and Management Systems Society (HIMSS).

"Before I began using an EHR, I thought I was a good doctor providing great patient care," Morrow comments. "But I was wrong. You just can't provide great, coordinated patient care using paper records."

The practice found that the results from converting from paper records to an EHR were dramatic. As a result of not having to use paper charts, the staff at the North Fulton practice documented the following:

- A savings of 44 staff hours per day and 11,968 such hours per year
- The elimination of \$934 per day and \$253,978 per year for pulling charts, preparing new charts, finding missing charts, transcribing, handling lab results, preparing referral letters, and purchasing medical chart supplies

Like the physicians in the North Fulton practice, the two doctors at Advanced Health Care, PLC, wanted to implement an EHR system to improve patient care and productivity.

## Quality Improvements

"The financial benefits were important, but our primary objective for implementing an EHR was to improve the quality of care we provide to our patients," says R. Michael Amedeo, MD, a member of the two-physician practice. "The ability to instantly access critical patient information and improve patient compliance with prescribed therapies really sold us on the need for an EMR.

"Making these quality improvements has not come at the expense of productivity. In fact, we have enjoyed a boost in productivity since the implementation of the EHR system," Amedeo added. "We have been able to see more patients and increase annual revenue by an estimated \$40,000 without the need for

additional office staff."

For the two physicians, it was important to find an EHR system that would allow better patient care without adding staff and one that would have a short learning curve so that patient appointments would not be disrupted. The physicians chose Practice Partner Version 9 EHR software, a suite that includes patient medical records, physician order entry, an appointment scheduler, and billing functions. The Practice Partner Program was CCHIT certified<sup>®</sup> in 2006.

## Better Patient Care

Practice Partner Version 9 EHR allows the physicians to produce customizable health maintenance templates that automatically alert doctors about overdue lab tests and medications for patients with particular problems such as diabetes. The program generates reminders to prompt staff to call patients who have not received recommended therapies.

Among the improvements the physicians documented as a result of using the EHR are:

- The percentage of diabetes patients who had kidney function tests increased from 4% to 75% in a year
- The percentage of coronary heart disease patients on lipid-lowering medications rose from 58% to 95%.
- The percentage of hypertensive patients with controlled blood pressure rose from 45% to 84%.

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# Trainers Say Physicians Are Getting More Involved in Staff Education

*The Practice Management Institute in San Antonio, Texas, was founded in 1983 to provide continuing education for physicians. Originally, the founders aimed to train physicians who worked as medical staff members for hospitals and to train office staff members. The institute started with one seminar for general office management. Today, the institute offers more than 2,500 educational sessions annually in all non-clinical aspects of medical practice. It works with all staff members including receptionists, office managers, and insurance processing professionals. In this interview, Douglas O'Dell, PMI's president and chief executive officer, and David Womack, PMI's executive vice president, discussed with Editor-in-Chief Richard L. Reece, MD, the challenges physicians face in practice.*

**Q:** Are physicians today more involved with what they want their staff to learn from your courses and seminars than they were in the past?

**W:** Over the past 10 to 20 years, physicians have learned how to organize and move forward as a group better than they did years ago. So, yes, as a result of being more organized, they are more specific about what they want their staff members to learn than they were in the past. For years, we would hear people say that doctors aren't good at

business. Well, they're not businessmen or businesswomen. They're intelligent individuals who have focused on medicine. Had they focused their attention on business, they'd be terrific businessmen and businesswomen.

In the past decade or two, the market has changed in such a way so that more physicians are focusing on the business side of medicine. As a result, they're hiring better people. You've got a much more talented workforce out there running the physician practice and running medicine overall.

In hospitals, we see more effort geared toward business development systems. Hospitals are trying to partner with physicians because hospitals don't want to be cut out of the revenue mix.

**Q:** How does your company educate doctors who may work in many different settings, such as surgeons who operate at multiple facilities?

**W:** Admission splitters are no longer common. Physicians typically gravitate toward a facility where they're comfortable. Their staff is usually connected with the appropriate departments at the hospitals to facilitate coding and documentation of procedures. Even if a physician goes to numerous facilities, technology allows them to interact with his or her office more efficiently than that doctor could in the past. Many physicians

have a personal digital assistant (PDA) that allows them to code on the spot even when they're away from the office. Many hospitals also provide ways for those physicians to interact with their offices.

Our company serves two audiences: the hospital and the end user. The hospital provides a mechanism for us to provide for continued education on a local basis in a cost effective way. But ultimately, 100% of our actual product line centers around the physician practice.

**Q:** Our certifications are proof or diagnostics, if you will, about a participant's level of competency in a given area, whether it be medical office management or diagnostic and procedural coding. Our exams show whether the participant is doing his or her job.

We have preparatory courses that range from 30 to 40 hours so that participants are ready to sit for an exam. After taking the course, they're prepared for a 4- to 6-hour exam depending on the certification. Once a participant passes the exam, he or she is demonstrating a certain skill level.

**Q:** What is the mission of the Practice Management Institute and how many courses do you offer?

**W:** Our curriculum covers every aspect of the business side of the medical practice, and we do about 2,500 seminars or courses

*(Continued on page 14)*

**Care is migrating to outpatient settings, and some doctors are abandoning hospitals in search of more income outside of traditional hospitals. Physicians are practicing in ambulatory surgery centers, for example. As a result, hospitals are much more conscious of physician outflow and are focusing more on physician relationships.**

(Continued from page 13)

es every year. Much of our growth in the last 10 years has been in developing certification classes for medical office managers, medical insurance specialists, and medical coders.

These three certification classes have been a huge part of our growth. We also try to get that curriculum into people's hands even if they aren't able to attend a class. We have self-study or self-paced versions enabling people to become certified even if they can't attend live classes. For the last couple of years we've made our curriculum available in audio conferences. These forums allow a participant to be at his or her desk in an office and receive training typically during a lunch break.

In addition, we have online seminars. We have a relationship with a technical college and provide extensive curriculum courses online. Some of those classes are in an instructor-led format. Some of our classes are online at the participant's own pace. Some are instructor led as one would have in a classroom.

**Q:** *What about physicians who work only in ambulatory care practices? Is that a significant part of your audience and is it growing?*

**W:** It certainly has grown over the last several years. We've seen an increase in the amount of training for employees of physician-owned or non-system owned entities. Generally these are more sophisticated customers. Forward-looking physicians run these enterprises and invest their time and money in staff training because they recognize the importance of training.

**Q:** *What's changed about the way physicians and hospitals relate to each other?*

**W:** Market forces are changing how hospitals relate to doctors. Care is migrating to outpatient settings, and some doctors are abandoning hospitals in search of more income outside of

## Office Staff Seek Coding Expertise

David Womack, the executive vice president of the Practice Management Institute, finds that staff members in physician offices are increasingly interested in learning about billing and coding.

"In our courses, we focus on coding because it's so complicated and crucial to a physician office's case flow," Womack explains. "After all, coding is how physician practices get reimbursed. And many practices have staffers who are dedicated to coding. But in other practices, the physicians do the coding for themselves and many of the younger doctors do their own coding.

"The reason many younger doctors do their own coding is that some residency programs have started coding training and practice management training as part of their overall curriculum," Womack adds. "The result is that more physicians are coming out of school who understand the business implications of running a practice. They understand the value of coding, not only for payment but also for compliance with federal rules on reimbursement. In that sense, coding has been ingrained into the curriculum of medical schools and so younger physicians are learning it before they start practicing. That's important, because in the past, physicians leaving school were not taught about the business implications of running a practice and certainly were not taught about coding and billing.

Douglas O'Dell, PMI's president and chief executive officer, says physicians understand the inherent liability that results from inappropriate diagnostic and procedural coding. "Given the gravity of the effect that coding has from a liability perspective and from a cash flow perspective in their practices, it's only natural for physicians to step into a coding role on the front lines," he says.

O'Dell recognizes that improper coding is common. Some experts believe that about 5% of physicians up-code, and 25% down-code. "I don't know the percentage, but I know it happens both ways," he comments. "It's an exception for physicians to knowingly up-code. They've read horror stories of what can happen if they are audited. If anything, they tend to be conservative and down-code. But doing so costs them in terms of lost revenue. That's why organizations such as ours exist, to train the physicians and their staff as well as possible so that coding is accurate.

Womack agrees, adding, "Many physicians who aren't comfortable or confident in their coding skills or their documentation methods tend to down-code. Down-coding happens much more than up-coding.

"It's not unusual for us to hear from our audiences, 'I wish my physicians were here so that they could hear this,'" Womack continues. "There's too much under-coding, and physicians' staff want their doctors to be more comfortable, confident, and accurate in their coding."

—RLR

traditional hospitals. Physicians are practicing in ambulatory surgery centers, for example. As a result, hospitals are much more conscious of physician outflow and are

focusing more on physician relationships.

When we founded PMI in 1983, our job was easy. Hospitals were geared toward doing anything they

# Practices Transitioning to Electronic Systems

More physicians today are using personal digital assistants (PDAs) and electronic medical record (EMR) systems, and so more practices are interested in learning about how these systems can help practices. In the future, more practices will use them as younger students who are trained in their use enter the workforce. But for now, adoption is not universal.

"EMRs are supposed to be the thing to do, but few physicians are using them," says David Womack, the executive vice president of the Practice Management Institute. "I read an article by a consultant recently who observed the implementation of an EMR in a physician practice. He noticed physicians spent more time figuring out the technology rather than on patient care. He was sounding an alarm: EMRs will take time to catch on.

"Residents coming through school are being taught the concepts of electronic systems and using EMRs at every stage along the way," he adds. "So, ultimately EMRs may provide a more efficient system. But we're not there yet, and EMRs today don't necessarily make things more efficient. In fact, the opposite is often true.

"In many ways, the health system is transitioning toward an electronic environment," Womack explains. "Physicians and health care consumers in general have the mentality that they can get what they need, when they need it today. So, for us, we're transitioning our overall business to be more practice-centric. One way we can do that is by getting closer to our customers."

Douglas O'Dell, PMI's president and chief executive officer, explains that PMI started an electronic network for those who have taken its courses. "It's called Network PMI," he says. "We're trying to let anyone in any region on the business side of a practice from the receptionist to the physician participate in Network PMI. In that way, everyone who has ever attended our programs can be a resource for each practice. The network can provide information, education, and an opportunity to interact with others who are in similar

practices or similar positions to help our participants build relationships.

"If you are a biller or a coder in Dallas, Texas, for example, and you have a problem with a certain insurer, you can log on and can find someone else in the community or state who is dealing with that same insurer," he continues. "Initially, the network will be electronic only, but it could lead to live events in different cities around the country where members can interact on a somewhat social and educational basis as well.

"It's a community of users that started spontaneously in a couple of markets," O'Dell adds. "Some of our graduates, such as certified office managers and certified medical coding experts, had spent a significant amount of time together while studying for their exams and wanted to maintain their ties with one another. In Greenville, South Carolina, the PMI network has 500 folks at their monthly meetings. There are 32 of these networks in different places around the country. They're made up of office managers, coders, and others who work in practices. Using this network, we have incorporated some additional features for our participants, such as a job bank.

"Like any forum, it has had a life of its own because it's a form of social networking that can be a powerful tool for improving practice performance," he comments. "It's turning practice management from a job into a profession of users interacting on a regular basis with their peers."

Recently Womack attended the first meeting of Network PMI members in Seattle. "It was an incredible evening," he says. "There were receptionists, billers, coders, and administrators of practices who had gone through our classes. And there was a physician as well. They were there to interact and learn. These people demonstrated that they have passion for their jobs. They were completely engaged in what was going on."

—RLR

could to improve their relationships with physicians. The typical hospital CEO had an army of physician relations experts in marketing and public relations.

With the growth of managed care, the pendulum swung completely the other way. Over the past 15 years, we have seen physician rela-

tions and marketing departments in hospitals disappear because hospital administrators could contract with a managed care plan to care for patients.

But today, when plans have most physicians and facilities in their networks, the pendulum has swung back once again.

Now we are seeing hospitals paying much closer attention to the physicians in their communities and what they can do to meet their needs more effectively.

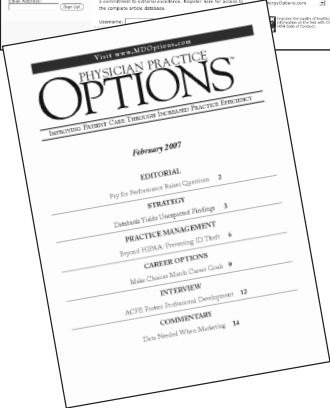
—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

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