The information you need to improve your practice.

The ACG Practice Management Committee’s mission is to equip College members with accessible tools to overcome management challenges, improve operations, enhance productivity, and support physician leadership in their private and physician-led clinical practices.

Learn from practicing colleagues through monthly articles on topics important to you. Articles include a topic overview, suggestions, examples, and a list of resources or references.

**Toolbox topics will include**

- Alternative Payment Models (APMs)
- Merit-Based Incentive Program Systems (MIPS)
- Medicare Compliance & Preparation for RAC Audits
- Reviewing & Maximizing Revenue Cycle Efforts
- Reviewing & Negotiating Insurance Contracts
- Patient Satisfaction Surveys & Engagement
- Reviewing & Updating Informed Consent
- Developing an Infection Control Plan
- Professional Society Opportunities & Involvement
- Quality Improvement Projects in Your Practice

"Pressures are high as gastroenterologists make important management decisions that profoundly affect their business future, their private lives, and their ability to provide care to patients.” — Louis J. Wilson, MD, FACP

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Dear ACG Colleagues,

Welcome to ACG Magazine’s special issue on improving your GI practice. These articles were authored by fellow ACG colleagues and other contributors and have been published in ACG Magazine.

Please let us know if you have any ideas for future ACG Practice Management Committee articles and guidance. The ACG Practice Management Committee continues to strive to help you prepare for and succeed in this ever-changing environment of our profession, for all forms and sizes of the GI practice.

**Accessible, relevant, and practical projects to improve your practice.**

Gastroenterologists in private practice find themselves working in a time of unprecedented transformation. Pressures are high as they make important management decisions that profoundly affect their business future, their private lives, and their ability to provide care to patients. The ACG Practice Management Committee has a mission to bring practicing colleagues together to explore solutions to overcome management challenges, to improve operations, enhance productivity, and support physician leadership. It was in this spirit that the Practice Management Toolbox was created.

The Toolbox is a series of short articles, written by practicing gastroenterologists, that provide members with easily accessible information to improve their practices. Each article covers an issue important to private practice gastroenterologists and physician-led clinical practices. They include a brief introduction, a topic overview, specific suggestions, helpful examples and a list of resources or references. Each month, a new edition of the Toolbox is released, and remains available on the ACG website along with all previous editions. The Practice Management Committee is confident this series will provide a valuable resource for members striving to optimize their practices.

Louis J. Wilson, MD, FACG,
Chair, Practice Management Committee
In July 2018, the ACG Practice Management Committee gathered for a busy weekend of work in Dallas, TX to develop and deliver better educational material to ACG members and all types of GI practices nationwide. The members in attendance worked diligently, discussing and editing forthcoming Practice Management Committee Toolbox articles, reviewing plans for the 2018 and 2019 ACG Practice Management Courses—and most importantly—having fun socializing with colleagues.
THE TERM ADVANCED PRACTICE PROVIDER (APP) IS DEFINED AS a licensed non-physician health care professional and applies to nurse practitioners (NPs) and physician assistants (PAs). Over the past two decades, APPs have increasingly provided care in a variety of practice settings, including gastroenterology. APPs can benefit health care delivery by increasing access to care, improving the efficiency of practices in the hospital and office settings, improving patient satisfaction, engagement and education, and reducing physician burnout. Because services provided by APPs are reimbursable, the economics of adding APPs are usually favorable, or at least break even. The shortage of physicians in many markets is propelling APPs into increasingly important roles in health care. While integrating APPs into the practice offers multiple benefits, it may also add liability and risks. For successful integration of an APP into a practice, an atmosphere of collegiality, respect and appropriate oversight and teaching is essential.

THE INCREASING DEMANDS ON PHYSICIANS

Multiple factors have escalated the increased demand for gastroenterology services. There is a projected shortfall of at least 1,050 gastroenterologists by 2020 (bit.ly/AAMC1018). The Patient Protection and Affordable Care Act of 2010 (ACA) has improved access and universal coverage for millions of people who now need evaluation of acute and chronic medical problems. In addition, the ACA moved the health system from a fee-for-service to a value-based reimbursement system and pushed for electronic health care records (EHRs), which subsequently resulted in evaluating fewer patients per office session to improve the patient experience and meet the increased data input burden. In addition, the Medicare Access and CHIP Reauthorization Act (bit.ly/MACRAtext) has created alternative and more burdensome payment reporting requirements. According to the 2016 Physicians Foundation Biennial Physician Survey Report (bit.ly/PFReport16), 49% of providers often or always experience feelings of burnout, 80% of physicians are overextended or at capacity, 72% feel that external factors such as third-party authorizations significantly detract from the quality of care they provide, and 48% of physicians plan to cut back on hours, retire, take a non-clinical job, switch to “concierge” medicine, or take other steps limiting patient access to their practices.

These forces have propelled APPs into increasingly important roles in health care delivery to fill the physician-provider gap. APPs are often able to spend more time facing patients than physicians, thus improving the health care experience for patients and decreasing burnout for physicians.
ADVANTAGES OF ADDING ADVANCED PRACTICE PROVIDERS

Integrating APPs into the gastrointestinal practice offers multiple benefits, including improved patient access, increased provider face time, improved patient education, which leads to greater patient satisfaction, improved physician work-life balance, and increased practice efficiency and revenue. Evidence shows improved health care outcomes and patient satisfaction with NPs and primary care physicians.

Gives Physicians More Time for Procedures: APPs can reduce the physician's time spent with patients in the clinic and can increase procedure volume.

Increases Practice Efficiency: For most practices, the revenue generated by the clinical work of the APP generally exceeds salary and benefits.

Reduces Physician Competition: APPs do not increase the supply of gastroenterologists in the market the same way bringing in another gastroenterologist does.

Easier Exit Strategy: Adding physician partners results in some loss of autonomy and ownership with every new partner and can result in difficult separations when the partnership ends. APPs are employees, and the issues inherent with partnership/ownership are not in play.

CONSIDERATIONS WHEN CHOOSING AN APP

New Graduate Versus Experience: New PA/NP graduates have a base of medical knowledge but need time/supervision to learn common GI problems and approaches to evaluation and work-up, including indications/contraindications for procedures. Teaching the rhythm of patient assessments will take time e.g., may take months to accomplish. As mutual confidence and trust grow, APPs become proficient at assessing, triaging and managing common GI disorders. APPs with previous experience in surgical practices or emergency departments may be disappointed with the exclusively office and consult work that is the usual scope of practice in GI groups. Therefore, setting expectations up front is critical. Ideal candidates will have one to two years of experience in family medicine, internal medicine, hospitalist medicine or medical subspecialties that involve inpatient and outpatient care.

NP Versus PA: Both can see patients in hospital and office settings and either can be billed independently or incident-to with physician supervision. NPs have a prior work history of an RN, particularly for hospital-oriented work, which can be an asset. Most APPs work defined hours; however, some take call and work flexible hours depending on the volume of work. APPs taking call and working longer hours are compensated accordingly compared with those working fixed hours. PAs receive training that more closely resembles medical training. Regardless, both NPs and PAs can become integral to a GI practice, and the individual and supervision are more critical than whether it is an NP or PA.

SCOPE OF PRACTICE FOR ADVANCED PRACTICE PROVIDERS

The scope of practice for APPs is not clearly defined but the common roles are to see new and established follow-up patients in both the outpatient and inpatient setting. In the outpatient setting, APPs may perform patient history and physical examinations, formulate differential diagnosis and treatment plans, order laboratory and radiographic studies, and prescribe medication. APPs may also oversee counseling and education programs for chronic conditions, such as non-alcoholic fatty liver disease, hepatitis C treatment, liver cirrhosis pre- and post-transplant, irritable bowel syndrome and inflammatory bowel disease. In some states, APPs have been trained and credentialed to perform diagnostic and therapeutic procedures, such as paracentesis, liver biopsies, manometry, and assisting providers in PEG tube placements. APPs may coordinate post-hospital discharge follow-up and manage clinical trials. Incorporating APPs into a practice may increase the practice’s exposure to some liability risks. Three methods commonly used to attach liability for errors of APPs and which should be reviewed are vicarious liability, negligent supervision and negligent hiring.

APPs are incorporated into gastroenterology using one [or a combination of] four general strategies:

Limited Office-Based Practice: This means the mid-level provider’s primary function is to see patients in the office, but with a limited range—screening consults who require an office visit, low complexity (rectal bleeding, iron deficiency anemia), and hepatitis C. APPs often manage their own panels of patients, sometimes concentrated in an area of focus like hepatitis C. Downside: it may be more challenging for office staff to distinguish between APP and MD/DO patients for scheduling, and it concentrates difficult or complex patients onto the physician’s schedule. Physicians may feel like they are supervising the care of patients they never see.

CONTRACT NEGOTIATION WITH AN ADVANCED PRACTICE PROVIDER

The Medical Group Management Association (MGMA) will give you the salary ranges for APPs in your region. In general, salaries for APPs in GI are similar to those in primary care, but lower than salaries for APPs in dermatology, surgery, emergency medicine, etc. It is not uncommon for contracts to have a base salary plus bonus for productivity based on revenue generated or relative value units (RVUs), similar to physician contracts. Contracts will also often contain an expectation as to number of patient encounters performed or RVUs generated a week. As with physicians, CME time and stipend in addition to vacation time is often offered. In addition, employment contracts for APPs often contain a “scope of practice” describing the range of services the provider will provide and the extent of the supervision in place.
**Full Office-Based Practice:** This allows APPs practicing primarily in the outpatient setting to see the same range of patients that the physician sees. While this makes scheduling easier and reduces patient backlog, referring providers and patients may feel they are not getting the appropriate level of care for a subspecialty practice. This is often overcome as the patients and referring providers gain confidence in the APP and/or have confidence in the group employing the APP to provide appropriate and adequate supervision.

**Hospital-Based Practice:** Many practices have their APPs based in the hospital part or all of the time. Most commonly, they will see hospital follow-up patients after the initial consultation. Some practices have APPs see simple inpatient consults, such as to screen for contraindications for requested procedures. In this role they also manage communication with inpatient providers, increasing efficiency of patient care in the hospital setting. This also frees up more time for the gastroenterologist to perform add-on procedures.

**Physician Extender:** In some models, APPs work alongside physicians as assistants, without independently seeing their own patients. In this setting, they respond to patient phone calls, assist with triage, and compose notes while physicians see patients. This can be an expensive option because much of this work can be done by less-expensive staff.

**BILLING COMPLIANCE**

Many practices experience difficulty incorporating APPs due to problems with billing compliance. Each payer has a different policy as it relates to APPs, and a few will not credential APPs at all. Most have specific criteria that will need to be met in order for the APP to bill under the physician’s name. The criteria used by the Centers for Medicare and Medicaid Services (CMS) is referred to as “Incident to.” It is beyond the scope of this document to provide billing and coding advice, but in general CMS allows a practice to bill a patient seen by a mid-level under a physician’s name if they are continuing a plan of care established by a physician. This means that new consults or new problems assessed by an APP should always be billed under that APP’s NPI and not the physician’s NPI. For patient follow-up visits billed under the physician, a physician should be on site, and it is prudent practice to demonstrate some supervision by the attending physician (co-sign note, etc.) It is good practice to review billing guidelines for each payer with your billing staff or billing company every one to two years to ensure compliance.

**STATE-BY-STATE VARIATIONS**

Your practice should review all credentials and references and take into account the specific state’s supervision requirements. Be sure to properly train and supervise APPs and review work regularly. One of the challenges is different styles/approaches of different physicians that supervise and work with the APPs. Planning for those differences and emphasizing evidence-based best practices and using resources available from the GI societies to help train and integrate APPs is crucial. Subspecialty work by APPs requires an environment that encourages regular interaction with physicians, sets high standards of care, and stresses documentation and compliance monitoring.4

**CONCLUSION**

The use of APPs in practice can provide many tangible benefits, including an increase in patient access and satisfaction, improving physician quality of life, and increasing practice productivity. Clearly delineating the role of the APP, understanding the state licensure requirements, implementing a supervision policy, and establishing a well-defined standard of practice will help avoid the pitfalls of working with these valuable professionals.

**REFERENCES**


Hiring & Keeping the BEST STAFF

Human Resource Management and Staff Development in Your Practice

THE STAFF OF A MEDICAL PRACTICE PLAYS A CRITICAL ROLE IN THE HEALTH OF THE BUSINESS and may have dramatic effects on the patient experience. Despite that, many physicians were never trained to properly manage the people they employ or be the best leader for their staff. A happy staff means happy patients. Some of the most crucial elements of this process involve the hiring, training, appraising and compensation of employees. This ACG Practice Management Toolbox article focuses on the important aspect of staff management and development.

Creating a strategic plan for your practice involves setting a goal (likely a mission statement stating that goal) and creating the map on how to get to that place. Medical practices that can find and retain great employees who believe in that strategic goal will be crucial in creating success or failure. Hiring the right employees, who are engaged to work effectively in your practice culture, is paramount and should be one of the highest priorities. Excellent employees can accelerate and grow your practice, while poor employees can not only stunt growth and destroy good morale, but also potentially land you in the court house. »
ASSESSING MANPOWER
A structured assessment of manpower is the first step of properly hiring staff. The principles of a manpower review are listed below:

✔ Start with a review of the organizational chart. Does everyone have an immediate supervisor? Is the supervisor structure adequate? Do supervisory positions need to be created or enhanced? Is there a clear chain of command?

✔ Match staff positions to important tasks. Is the number of FTEs adequate to accomplish all necessary tasks? Are there important secondary tasks being neglected due to inadequate staffing?

✔ Adjust the staffing plan to resolve issues in the manpower review. Consider the most cost-effective and efficient solutions to manpower needs. This might mean hiring temporary versus permanent employees or unlicensed employees for tasks that do not require a license.

✔ Cross-training should always be considered as a less disruptive way to meet staffing needs. Each employee can be trained to function in a variety of roles. This increases flexibility and improves communication between staff members who will better understand the critical tasks and work demands of their colleagues.

THE NEEDS ASSESSMENT: THE 360-DEGREE APPROACH
Before practices can adequately train employees, there should be a comprehensive needs assessment for the workplace. There has to be recognition of what is needed against what skills your current staff already possesses. HR experts tout a “360-degree” evaluation and feedback process. This 360-degree concept can be applied to both the review and also the evaluation process. It entails more than simply acquiring an in-house manager’s view of employee skills. Rather, ideally feedback is obtained from those who work “above,” “below” and “with” the employees. These reviews would also include input from patients and customers, and would give an assessment to the medical practice trying to design the training programs in order to improve employee skills. Managers can organize 360 feedback using published, standardized assessment tools or customized organization-related tools, or hire an outside HR professional or training consultant.

STAFF TRAINING
Once the employee and employer needs are assessed and reviewed, an action plan for training can be developed. Adults learn in different ways. Practices should develop training plans that are both economically feasible and suitable for different learning styles. This might include creating a course in house, buying off-the-shelf training manuals or computer programs, PowerPoint lectures or presentations, identifying an in-house trainer, and hiring outside trainer(s) or even consultants to develop the work staff in the desired direction. Another training method that should not be forgotten is the possibility of mentoring. Frequently physicians or managers are an ideal position for this type of training, which can be formal or informal.

Training Areas
Training in important areas should occur periodically. These might include:

✔ Customer service
✔ Telephone call etiquette and protocol
✔ Infection-control practices
✔ Patient confidentiality and the Health Insurance Portability and Accountability Act
✔ Communication and conflict resolution
✔ Electronic record system optimization

INTERVIEWING PROSPECTIVE EMPLOYEES
When interviewing job candidates for a new position, save everyone’s time and let the job seeker know the salary range at the beginning of the process. During the interview, to avoid hiring the wrong person for the skills needed, use behavioral interviewing. The behavioral interview is carefully planned and based on the principal that past job performance will predict future behavior and the likelihood of success. Good behavioral interview questions are open ended, for example: tell me about a time when...; give me an example of when you...; describe for me...; etc. Interview questions should be tailored to the position being filled. Access a list of excellent interview questions for prospective managers on page 13 of the online version of this article: bit.ly/HR-StaffDev

FINDING EMPLOYEES
In the past, hiring employees might have involved posting ads in the newspaper and reviewing applicants by mail or in person. Now employees are more likely to be found online. They are searching job websites like monster.com, careerbuilder.com or even your own practice website. When posting for a new position, include the job requirements, expectations, the dates by which the application must be completed, and multiple ways for the applicant to contact you (including online through your website). Do not forget to highlight the benefits of working for your organization, and perhaps something that sets your practice apart from others that might be filling the same or a similar position. Another excellent and cost-effective way to find employees is through your current employees. Consider offering a cash bonus to current employees who refer a friend. Staying in touch with valued former employees who might return—or send new recruits—is also recommended.
PROPER COACHING OF STAFF
According to author Leigh F. Branham, “Lack of feedback is the number one reason for performance problems.” Most employees want to do a good job, but also expect to be told how they are doing within the practice. To be most effective, managers must give not only annual feedback, but rather frequent, ongoing communication to their employees. If this is done correctly, there is feedback throughout the year, and then the formal annual or semi-annual performance appraisal offers no significant surprises. There still should be a formal performance evaluation, which for the employee can set guideposts for their work and allow for discussion about future goal setting. For managers (or physician managers in many cases), the assessment helps develop rapport with employees, allows assessment of good and poor performance, and likely identifies employees that should be given raises or further compensation.

PRINCIPLES OF PROPER COACHING
✓ Coaching conversations should promote learning. It is best to use words like improve, learn, develop and grow. Doing this will help your staff develop their own insights.
✓ Coaching conversations should start with a statement of your positive intention. You can do this by saying something like “I want to improve how we work together” or “I want to help you think creatively.”
✓ During coaching conversations, always try to put your staff at ease and build trust. Try to make your staff feel competent and capable.
✓ Ask questions of your staff and listen to the answers carefully. Approach staff development conversations as a learning opportunity for yourself.
✓ Rather than immediately stressing details, focus on the result. This is a solutions-oriented approach. Ask questions like “What would success looks like?”

ANNUAL PERFORMANCE REVIEWS
Annual performance reviews are a critical part of practice management and staff development. When used properly, these reviews improve morale and productivity, as well as support your practice’s budget, wage structure and organizational structure. Annual performance reviews must be done consistently and documented properly. Performance reviews should be done prior to the end of the year—perhaps in the summer—so that budgetary planning, bonus items and staffing issues can be planned in advance of end-of-year decisions. Many experts recommend semi-annual reviews. There are many types of appraisals: checklist, essay, graphic scale, group order ranking, individual ranking, and pair comparison that can be done and are defined elsewhere.

The tone of the review is important. Managers should communicate in a positive tone while clearly delineating both strengths and weaknesses, including specific examples. Job results should be discussed, and excessive criticism should be avoided. The meeting should not be rushed, and employees should be given ample time to actively participate. At the end of the meeting, ideally both employer and employee would collectively problem solve any issues and would then mutually set goals for the next review period. At the end of the review, employees should sign and date the form. Confidentiality on both sides should be stressed. The employee should be reminded that the evaluation process is continuous throughout the year and that the door is open to discuss employee performance and practice improvement.

Principles of Effective Performance Reviews
✓ Performance reviews should be done at least annually, best early in the year or summer. Many experts recommend semi-annual performance reviews.
✓ A budget should be set by your practice leadership for raises.
✓ Raises should always be tied to the performance reviews.
✓ Each employee’s performance review should include an action plan to be accomplished by the next year’s review.
✓ Performance reviews are signed by the employee, manager and physician leadership and added to the employee file.
✓ A copy of the review should be given to the employee.

RESOURCES AND SUGGESTED READING
6. See medical.gppcpa.com/enewletters/article/staff_engagement_leads_to_staff_loyality/.
7. See avvartes.com/in-every-person-there-is-a-sun/.

PRACTICAL SUGGESTIONS
✓ Do not forget that your employees are your most valuable resource. Treat them as such.
✓ Set a practice strategic plan to know where you are going and how you plan to get there.
✓ Consider an employee referral program. Your current employees will want the new employee choice to reflect well on them personally and will have the opportunity to positively affect the practice culture.
✓ Keep in touch with former employees that you would consider hiring again, particularly if they left for another job or educational opportunity and might come back with new skills.
✓ To make the best hires, prepare an excellent job description. Be a good listener and use behavioral interviewing; a systematic, analytical and objective technique to interview job applicants.
✓ If you want to increase productivity, start with a manpower review and follow with clear job descriptions.
✓ Take a proactive, personal approach to employee development. Endeavor to find ways to mentor the employees with the highest potential.
✓ Use continuous feedback in addition to annual or semi-annual performance reviews.

READ the online version of this ACG Practice Management Toolbox chapter to access a sample performance review form and a list of sample interview questions for prospective managers: bit.ly/HR-StaffDev
The revenue cycle (RC) refers to all processes involved in the collection of revenue earned through the delivery of care to the patient. The RC is not truly a cycle, but a set of interrelated events which begin prior to provider-patient contact and finish with the receipt of revenue and posting the revenue to an account. Although making a claim and sending a bill is a component of the revenue cycle, it is only a small piece.

## Components of the Revenue Cycle

The components of the revenue cycle can be divided into three main headings as to the time sequence of events:

### Prior to Patient Contact

**Why is this important?**

**FACT:** Up to 60% of claim denials are due to registration errors.

- **Pre-registration:** Collecting and verifying the insurance information and verification prior to patient arrival.
- **Registration:** Confirmation of demographics and co-pay collection.

### A/R Follow Up

### Denial Appeals

### Payment Processing

### Claim Submission

### Claim Review

### Patient Scheduling & Registration

### Insurance Verification

### Co-Pay Collection

### Patient Exam

### Coding & Charge Entry

### After Provider-Patient Contact

**Why is this important?** This is how and when you get paid!

- **Coding:** Properly coding the diagnoses (ICD-10) and services provided (CPT) so that the practitioner is fully compensated for all of his/her services.
- **Claims management:** Submitting claims of billable fees to the insurance company.
- **Payment collection:** Collecting payments after claims submission.
- **Payment failure:** When payment is NOT made.
- **Denial management**
- **Accounts receivables/Collections**

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IT IS CRITICAL THAT YOUR PRACTICE BE PAID FOR ALL THE EFFORT AND CARE THAT YOU PROVIDE FOR YOUR PATIENTS. Identifying and correcting problems in your revenue cycle management (RCM) should be a high-priority project. I developed this article for the ACG Practice Management Toolbox to guide you through the process of assessing, testing, and optimizing your revenue cycle (RC) performance.
**Systems Supporting** the Revenue Cycle

Although we can discuss the components of the Revenue Cycle, just as important are the business systems (people, process, capital equipment) that support it.

CORPORATE STRUCTURE AND LEADERSHIP: Although every corporate structure is unique, the leadership within that structure is essential to a highly effective RCM. The leadership drives the corporate vision as to the importance and necessity of RCM. The leadership needs to determine the responsibilities of each of the other three business components that support the resource cycle (RC): personnel/staff, information technology (IT) systems and external contractors. The leadership needs to develop the policies and procedures to coordinate all three of these entities.

HEALTH CARE PROVIDERS: are often the most overlooked component of RCM. However, accurate and clear documentation in the health care record are essential to adequate charge capture and coding. Inadequate or incomplete documentation may result in claim denials or down coding to a lower level of service (with less revenue). Failure to use key diagnostic terms may make it time-consuming, difficult or nearly impossible for billing personnel to convert information in the health care record into a billable claim.

SUPPORT PERSONNEL: Obviously the training and experience of multiple different personnel in multiple different positions directly impact the efficiency of the revenue cycle. Although most of the emphasis tends to be on those staff in the back office, those who work in pre-registration or registration are also important by accurately initiating the revenue cycle and thereby lessening the rate of claim denials downstream.

INFORMATION TECHNOLOGY (IT) SYSTEMS: Probably the first IT system purchased by a practice was the one to support the billing function. As time progressed electronic systems have developed for charge capture, health care record, claims submission, claims scrubbing (clerical error detection), receipt processing, etc. Seamless coordination and full integration between these oftentimes disparate and legacy systems highly impact the efficiency of the revenue cycle (and your staff).

EXTERNAL CONTRACTORS: Many practices are already dependent upon external contractors to support a few or many of the business processes of the revenue cycle. As may have happened with IT support, there may be a hodge-podge of different contractors. Some vendors (generally those associated with electronic health care record systems) provide more integrated revenue cycle management support systems.

**Analyzing & Testing** the Revenue Cycle

(Reviewing Key Performance Indicators)

In order to properly manage the revenue cycle, some testing/analysis is required. To assess your overall success in the revenue cycle, measure and monitor the four key performance indicators (KPIs).

1. **AGING REPORT: % of accounts receivable (A/R) pending after 120 days. Goal is 12% or less**
2. **MEAN DAYS IN A/R: Mean # of days between date of service and date of payment receipt. Goal is < 35**
3. **ADJUSTED COLLECTION RATE: The ratio between actual collections and the expected collections (adjusted for write offs). Goal is > 95%**
4. **DENIAL RATE: % of claims denied. Goal is < 5%**
Step 2

Identify and implement a RC improvement project: From the checklist, identify the most glaring area in need of improvement, then take steps to implement the improvement. Prioritize changes made based on financial impact.

Practice Strategies and References to Improve Your Revenue Cycle

To get the most out of this article, please explore my handpicked references and resources which illustrate practical approaches to the eight most common revenue cycle areas in need of improvement in medical practice. I provide examples ranging from the weak, absent or non-functional leadership team to practical advice on improving front-office and back-office operations, including claims, coding and collections. For each example, I have identified resources and references to guide in implementing an improvement strategy.

BUSINESS PRESSURES ARE HIGH FOR MANY IN THE INDEPENDENT PRIVATE PRACTICE OF GASTROENTEROLOGY. Major trends affecting gastroenterology groups include increased consolidation, alternative payment systems focusing on value rather than fee-for-service, risk-sharing contracts that increase the need for care coordination across specialties, and population health management. The independent practice of medicine and physician leadership in health care are under severe pressure. Many groups are partnering with hospitals and integrated health care systems, joining other groups to form larger partnerships, and even selling controlling interest to private equity (PE) platform companies or public health care companies. While your group currently may be financially successful and remaining independent may be your best strategy, it may be beneficial for your group to actively consider other strategic options that may be available before making conclusions on the best course for future success. »
Strategic planning involves an assessment of your current market environment and challenges, prioritizing the organization’s needs and goals, and then evaluating available options. Not surprisingly, there are a great many variables to consider. These include market challenges such as competition and changes in referral networks, management problems like staffing or revenue cycle performance, and partnership problems such as recruiting or senior member retirements. Capital investment may be needed for the addition of ancillary service centers or facility construction. Lifestyle choices are also always an important consideration.

Remaining fully independent remains an excellent option in many markets, and there is not one “ideal” business structure for every market. However, it is becoming increasingly necessary for medical professionals to thoroughly meet the needs of their given patient population. Gaps in service will usually invite competition and create uncertainty for the future. Even if your analysis results in changing nothing about the current structure of your practice, failing to evaluate your current business strategy and to consider strategic options could be a costly mistake. Timing may be crucial in making these decisions, as changes in the competitive marketplace continue at a fast pace, and certain current options may not be available on the same terms in the future. Many thought leaders in practice management believe that maintaining physician leadership and independence remains an important goal for the future of gastroenterology.

Some strategic options discussed in this article involve large, well-capitalized organizations that are currently investing substantial capital to strategically position themselves and their partners to be profitable as the industry undergoes transformation. Gastroenterologists should consider these options carefully and with experienced legal counsel and financial advisers.

The following are **FOUR STRATEGIC OPTIONS** for gastroenterology groups to consider:

**JOINING, OR BEING ACQUIRED BY, A HOSPITAL OR HOSPITAL-AFFILIATED MEDICAL GROUP**

Hospital employment has attracted many physicians in recent years. These agreements often begin with lucrative initial salary guarantees but generally do not result in any ownership equity. Although there may be some comfort in becoming part of and being managed by a large health care organization, some complaints of groups that have pursued this option include: (a) some hospitals are not good at managing physician practices; (b) hospitals generally do not pay a lot to acquire medical groups due to regulatory limitations; and (c) physician leadership in these systems is usually very limited. Hospital employment agreements usually include restrictive covenants that will restrict your mobility if the arrangement ends for various reasons.

**JOINING, OR BEING ACQUIRED BY, A MEGA-PHYSICIAN GROUP (MULTI-DISCIPLINARY OR SINGLE-SPECIALTY)**

Very large gastroenterology groups that include dozens or even hundreds of members have been forming in many areas. These groups allow for expert management, increased leverage in contracting, and investment in professional information systems management. Single-specialty groups have tended to meet the specific needs and opportunities of gastroenterologists better than multi-specialty groups, but the built-in referral networks and opportunities for risk-sharing contracts i.e., alternative payment models, of a multi-specialty group may have an advantage in some markets. Although there may be comfort in becoming part of a well-run “mega-physician group” and being managed by fellow physicians, if you are looking for significant financial “upside” (both short term and long term), this option may not fit your goals. Also, the group’s total size may not be as important as how well it meets the demands of the specific market or service area. Small independent groups may be able to meet the needs of smaller markets.

**BEING ACQUIRED BY A PE PLATFORM COMPANY FOCUSED ON GASTROENTEROLOGY AND DIGESTIVE HEALTH**

This may be a lucrative option to consider if you and your physician owners are looking for both significant short-term and long-term financial upside. The potential benefits or risks of this strategic option include:

- All physician owners of the group may reap initial financial benefit in the short term when the transaction is completed. They usually also obtain “roll-over equity” in the PE platform company going forward. The amount of this equity should be negotiated based on the time horizon of the various physicians.

- These PE companies usually plan to “exit” or sell the company to a larger national health care company in a three- to seven-year timeframe. This could create some uncertainty for physicians with a long time horizon. When the exit event occurs, the physicians who own roll-over equity stand to reap additional financial profits, sometimes at the same level or above that which they were paid in the initial transaction, when they partnered with the PE company.
• The financial rewards should be lucrative to all owners of the group, both for: (a) founder or more-senior physicians, who might otherwise receive a very minimal buyout of their ownership interest in the practice when they retire; and (b) more-junior and middle-age physicians. Younger members have often used the initial transaction to fund their retirement early. They also will not be burdened with buying out senior physicians, the risks of uncertainty in the health care market, and capital requirements that may be needed to compete effectively in the future. Further, they likely will continue to earn market-based compensation for their ongoing services.

• Physicians do not generally need to lose substantial control over their medical practices when entering into a strategic transaction with a PE-backed company. This is because PE companies do not want to take over management of medical groups but, rather, want to invest in groups that already have solid management teams. They want the current management team to remain in place and use the PE partner’s capital to expand and improve the practice (e.g., new equipment, new ancillaries, new locations, adding new groups, etc.). It is important that physician groups obtain professional valuation advice before entering these agreements, and should consider competitive bids from multiple companies. Physicians seeking to partner with a PE-backed company may take into consideration a variety of non-monetary factors as well. For more information on how PE investments in gastroenterology groups are structured and valued, as well as related legal issues, a free webinar is available at: bit.ly/PE-PPT-WEB

BEING ACQUIRED BY A NATIONAL HEALTH CARE COMPANY
There are numerous national physician services companies that are in the market seeking to partner with and invest in medical groups—some are public companies, some are private, and others are affiliated with large national payers or providers. Transactions usually are not as lucrative as PE investments (but can be), and usually do not involve roll-over equity (although there may be some exceptions to the foregoing). Investments by these national health care companies are usually much more long term focused and strategic, as opposed to investments by PE-backed companies, which invariably will seek a financially lucrative exit in medium-term horizon.

CONCLUSION
In summary, gastroenterology group practices should, at a minimum, be exploring potential strategic options for their future success and for the financial well-being of their physician owners. Independent physicians should consider pursuing group structures and strategies that meet as many of their goals and objectives as possible. Several strategies that preserve physician leadership and practice independence remain viable. The best structure will take into consideration your group’s unique set of professional challenges and personal goals.

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When Performing Experimental Treatments

By Ann M. Bittinger, Esq., a health care attorney with physician group clients across the country.

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There are few things more vexing from a medical-administrative standpoint than performing cutting-edge treatments to help patients only to have insurers deny claims on the basis that those services are “investigational.” Equally frustrating is the payer second-guessing the treatment you prescribe, saying the patient should be on one drug prior to another drug—commonly called step therapy.

Your GI colleagues experience denials for the following, among other items:

- Capsule endoscopies;
- Various drugs, particularly inflammatory bowel disease biologics and direct-acting antivirals; and
- Motility studies (viewed as experimental).

Take these steps to prevent medical-based denials.

**PAYER RELATIONSHIPS**

As big insurance companies get bigger, it may be more difficult for gastroenterologists and practice administrators to develop mutually beneficial relationships with payer representatives, yet these relationships are more important than ever. Successful GI groups meet at least quarterly with major private payers in their markets. They talk strategically, educating each other on issues and working on solutions.

Cultivate a relationship with the payers’ medical directors in charge of GI and endoscopy. Volunteer to serve where physicians can help (focus groups, guidance drafting, speaking services, etc.)

Gastroenterologists can fight denials by putting themselves in the payers’ positions and proactively making their cases to payers before services are rendered. A payer’s main objective is to pay for services at the lowest-reasonable cost to their insured. Embrace that objective. Explain that while a therapy may be more expensive in the first six months, if it works it avoids later treatments that are more expensive. In other words, when negotiating with payers, the argument that emphasizes that your plan of care is, indeed, the most cost-effective one (in the long term or big picture, considering other diagnostic tests, specialists visits, drugs and other procedures) is an argument with which payers will most likely agree.

Pay attention to the different payer service lines and which one each payer favors. Some payers may be more lenient in allowing experimental treatment for health maintenance organization (HMO) contracts, over which they have more control of specialists. Be sure your contract does not have “all products” language, meaning your group has to participate in all types of contracts the insurer has to provide to patients.

**CONTRACT**

The key to legal enforcement of payer payment obligations is the GI group-payer contract.

**Contract Terms**

The definitions sections of these contracts are typically most important in clarifying what the payer will and will not pay. Negotiating on the front end will make payment more likely and improve chances of winning legal disputes. Key terms to negotiate include:
Medical Necessity
This term is the holy grail of payment enforcement disputes. The payer has to pay for services that are “medically necessary.” How that term is defined is crucial. Who decides what is medically necessary? If you see a phrase like “in Payer’s sole discretion,” you will likely never win a dispute on the medically necessary basis. The broader the language, the more likely you can win a dispute.

- **Experts**: Benign definitions of medically necessary like “services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms,” require a physician expert to decide if something is medically necessary. This involves an expert witness or the use of peer-reviewed journal articles to establish medical necessity. You can add that if there’s a question on medical necessity, the dispute will be decided as follows:
  - **Each party chooses one expert**, board certified in gastroenterology, who has no financial relationship with either party, and those two experts choose a third. The panel of three experts reviews the cases of each side and determines if the procedure is, indeed, medically necessary. This process allows for a focused, prompt resolution by individuals with medical (not business administration) backgrounds. A provision that allows the payer’s medical director to decide what is medically necessary is usually a Trojan Horse and should be avoided.

- **It is also important to use guidance** issued by the payers. Payers often publish guidelines similar to Medicare’s local and national coverage determinations. Often that guidance contains citations to peer-reviewed journals. If the payer used an article or study in support of its position on one procedure, use it and its rationale to support the procedure they are questioning, as applicable. Don’t reinvent the wheel by finding sources they have never cited as credible. Use their sources, and the associated authors and investigators, as your experts—to support your position.

- **Third-party sources** like the InterQual Guidelines may also be helpful.

Experimental
Often the definition includes exceptions like “services…that meet accepted standards of medicine” or “except for services that are experimental in nature.” Consider citing ACG clinical guidelines and studies to help demonstrate that the service or procedure is considered the “standard of care.” Use the definitions to cut off denials of arguably experimental treatments. Use language to establish how things are determined to meet “accepted standards” of medicine. The challenge lies in that there may be no bright line as to evolving procedural effectiveness.

Many payers include a process by which they will judge if something experimental warrants reimbursement. Learn these processes. Often that process includes testing the new procedure against three to five other established procedures to determine effectiveness. The fewer existing procedures the experimental procedure must beat, the better.

The best way for gastroenterologists to prove experimental processes are working is to participate in studies and publish findings. This establishes a reference base that can be used to promote reimbursement. It’s not enough to show results in your own practice; you need to show that the specialty is finding results. Network with colleagues, develop protocols about new procedures, test them, and publish results. Those publications are the roots for establishing the reimbursement requirements for those procedures.

Fighting the Fight
Most payer agreements allow for informal internal appeals processes. Another option is to file a complaint with the appropriate state agency. I encourage practices, however, to consider filing for arbitration. Most payer contracts have arbitration provisions, meaning disputes are handled privately (and usually less formally and less expensively) by an arbitrator. If you cannot work your relationships with payers, as described above, or if you are stuck with contract definitions, evaluate your arguments, experts and peer-reviewed data and make a case for arbitration. Oftentimes, invoking arbitration is as easy as sending a letter to the payer and paying a filing fee with an arbitration service. You will need an experienced health care attorney to prepare the claim.

Invoking arbitration gets your argument out of the payer’s claims administration department and into the hands of the plan’s lawyers—typically in-house counsel who are not paid by the hour. Discovery is streamlined in arbitration as opposed to litigation.

To arbitrate, claims must already have been denied. It’s not possible to ask an arbitrator to require payment prospectively. Be mindful of attorney’s fees provisions. You may have to pay for the payer’s attorney’s fees if you lose; if you win, the payer may have to reimburse you for yours.

These cases generally settle, with an agreement about how the procedure will be performed (or not) going forward. Arbitration can be a last resort to educate the payer about the science behind new procedures. Invoking arbitration can be a way to have the aforementioned dialogue with the payer.

A good health care attorney will not, however, take your case unless you have done your homework. The gastroenterologist is typically in a better position than an attorney to scour medical literature to find and evaluate journal articles that support the group’s position. The gastroenterologist may be the best person to identify experts to retain and to explain the nuances of why current payer guidance is outdated or inaccurate.
WARNINGS THAT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES will do away with fee-for-service reimbursement to physicians has been a bit like the boy who cried wolf. Although much has been said and written on forecasted reforms to the Medicare Physician Fee Schedule—to pay package rates per episodes of care or to expand global fees—gastroenterologists have not seen those ideas implemented nationally. The warnings that “If your practice doesn’t restructure itself to provide services other than fee-for-service, it will become bankrupt” haven’t materialized. That being said, many physicians and private payers heeded the warnings. They did not wait for Medicare to dismantle the Fee Schedule. The change is happening faster in the private sector in some markets than with Medicare. Innovative payers and physician groups are collaborating to creatively address payment regardless of when the Medicare-mandated changes may occur. Just as politics makes strange bedfellows, otherwise-non-aligned payers are meeting physician groups at the drawing board to develop ways to align payment with quality of care.

How can a GI practice execute this type of negotiation?

INVESTIGATE THE PAYER AND ITS INNOVATION LEADERS

First, do your research about the payer. Identify the right person handling gastroenterology global or bundled reimbursement modeling. Most payers have departments in charge of physician group “innovation.” These are people whom the payer has given the task of thinking outside the box on physician reimbursement structures. You probably do not want to be talking with the people you have always worked with on contracting, as they are tasked with maintenance of contracts and relationships. Similarly, you do not want to be talking with someone on the hospital side of payer operations or innovations if you are a physician group. Depending on the payer size, you may find someone in charge of gastroenterology innovation in specific, but in my experience, the payers break down the roles by hospital payment and physician payment innovations.

Research what this payer’s physician innovations department is doing. Follow key personnel on LinkedIn. See if they have written papers or made presentations. Reach out to colleagues in your specialty to see whether they have been approached by—or themselves have approached—the payer with an innovative payment plan.

PICK THE TEAM AND STRUCTURE A GAME PLAN

Next, identify your area of focus in your practice. Are you looking to collaborate with a hospital, surgery
center and other specialists to coordinate one price for everyone's participation in an episode of care—a bundled payment? Or are you looking only at payments for services within your practice—a global fee? The former is, of course, more difficult to achieve outside of a sophisticated system, multi-specialty practice, loosely-aligned clinically integrated network (CIN), or accountable care organization (ACO). One baby step toward developing a more-formal CIN or ACO is to try a bundled payment model first. The gastroenterology practice, the facility and related specialists agree contractually (not via the more-permanent merger or development of a CIN or ACO) to approach a payer with a proposal to work together on certain services by way of protocols, standards and measures. If the measures are reached, then each of the separate companies gets a bonus payment from the payer. Many payers are focusing on bundled payments involving multiple providers. For example, a gastroenterology practice that controls its own surgery center may be able to negotiate one fee for all aspects of colonoscopy—evaluation, the procedure, anesthesia, surgery center facility fee and follow-up. Another bundled payment type across providers could be a bundled payment for gastrointestinal hemorrhage. Others may include gastrointestinal cancer, inflammatory bowel disease or gastroesophageal reflux disease.

**FOCUS ON CODES**

Once you have identified an episode of care, start by identifying exactly which CPT codes should be bundled. You will be speaking in the same language as the payer if you talk in terms of CPT codes and their scope. They know the codes. And more importantly, understand the reimbursement rates for those codes by Medicare and the payer with which you are collaborating. This ACG-provided list provided is a helpful place to start: bit.ly/18MPFSSRates. Also analyze associated surgery center codes (bit.ly/ASCPayment) and anesthesia (bit.ly/CMS-Anesthesia).

**APPEAL TO THE PAYER’S NEEDS**

To get to “yes” with the payer, the alternative payment model (APM) has to be about more than just the payer paying the physician more. Keep the reimbursement rates in mind, but focus on more than just the numbers. Be prepared to answer these questions:

- Why would bundling these services benefit the payer other than simply saving the payer money?
- How will you keep costs down?
- How will you measure your actions for quality?
- What protocols will you implement and why?
- Will post-procedure admissions or repeat procedures drop due to the collaboration model with the other associated providers or facilities?
- Will detection and screening improve due to the collaboration with pathology, for example?

If you propose to be paid more under the bundled approach, there has to be something else in it for the payer. This U.S. Department of Health and Human Services source may be helpful in identifying benefits to all parties: bit.ly/HHSASPE.

The payer is not simply going to raise the rate under an APM over the fee-for-service price. To be successful in the negotiation, the provider has to convince the payer that the model will produce overall, long-term cost savings for the payer for a certain population of insureds.

Payers and providers may reach agreement on models in concept but, to seal the deal, the parties have to develop standards and measures to prove the payer that they achieved the agreed-upon goals. How will outcomes be measured? GIQuIC and ACG clinical guidelines offer excellent starting points for standards and metrics to use with payers.

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**CONTINUE READING**

this installment of LAW MIND on the ACG BLOG for several more negotiating tips, including advice on outside experts who can help: bit.ly/LawMind818

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**AGC IS WORKING ON STARK LAW REFORM: WE NEED YOUR HELP**

CMS stepped up its emphasis on value-based reimbursement in June when it issued a formal request to the health care community for information about new alternative payment systems. With an August 24 response deadline, CMS wants recommendations to lift regulatory walls that block implementation of care coordination and arrangements to incent improvements in outcomes and cost reductions.

Learn More about how you can help: bit.ly/ACGStark
PHYSICIANS MUST IMPLEMENT A LONG-TERM, STRATEGIC APPROACH TO NEGOTIATING CONTRACTS WITH PAYERS. Gone are the days of trying to get a few dollars more per CPT code or a few numbers higher as a percentage of Medicare. Today, it’s about more than the rate. Successful physician groups are building strategic alignment with payers to provide quality care for reasonable prices.

Analyze Your Group

As in any successful negotiation, first you need to know what you bring to the table. I’m surprised how many clients can’t tell me how much their top three payers pay them for a colonoscopy, or how much those payers are supposed to pay them per their contract. Often those two numbers are not the same. First, get your house in order. Understand what the contracts say versus what the payers are paying you. If you’ve been underpaid for a while, that lemon can be turned into lemonade by using that fact as justification that the insurer should pay you more going forward.

How long does it take payers to pay claims? Which payers dispute claims or haggle about medical necessity, pre-authorizations and the like? A good practice chief executive officer will interview billing staff to learn the nuances of each payer before going to the negotiating table with the payer. This is important because often payers will not give an across-the-board increase but will carve out a few CPT codes and grant an increase on those, while leaving others the same or lowering them.

Also, what’s your payer mix? What is your private pay versus Medicare percentages of patients? Within the private payers, what payers represent what percentages? Within government payers, what percent are Medicare versus a Medicare managed care plan?

When you analyze this information, you will see trends. Once you lay the contracted charges and payments analysis on top of the payer mix percentages, you will identify which payer will give you the most bang for your buck, so to speak, to target for negotiations. This process can take anywhere from one to six months.

In addition, analyze procedures versus E&M coding for office visits versus diagnostics (and another subset of services you may provide). Would you be willing to sacrifice a lower rate for imaging, for example, to get a higher rate on procedures? Would the net outcome be an increase?
Expect the payers to offer a change like this in response to an offer by you for an increase: in other words, a “Yes, we agree to an increase on some but we are lowering something else.”

Clients often want to focus on costs of running the practice. While this is good from a practice management standpoint, my experience is that payers are not swayed by costs. Their first response is typically: “Well your biggest cost is physician payroll, so pay your physicians less.” Additionally, sharing physician salary information without the information being subject to a non-disclosure agreement is not a sound decision. Generally, the negotiations include confidential information, trade secrets or other information about the practice—which is not uncommon in some payer-physician arrangements—so you want the payer to sign a nondisclosure agreement.

Other than charges, collections and payer mix data, I suggest that clients analyze their groups in additional ways prior to the negotiations. What makes your group a better partner with the payer than the other groups? Do you submit claims cleaner and faster than your competitors? Do you have good relationships with the payer? Are the geographic locations of your clinics appealing to the payers’ patient mixes? Is there something about your endoscopy center that sets your group apart from other centers or hospitals? Identify and accentuate a value proposition.

Once you’ve done this analysis and are ready for presentation to the payer, set your sights on a reasonable goal, but don’t make the first offer and don’t draw a line in the sand during the negotiations. The payer-physician dynamic is changing. Groups need to be ready to think creatively about how to structure payments.

Keep in mind that the payer may know more about your practice than you do. Most major payers have sophisticated systems to analyze physician data. In the meetings I discuss in part II of this article, which is available now on the ACG Blog, it may be helpful to listen to the payer’s representative talk about what they see in the data that they have about your group, and compare that with what your data reveals.
NEW LAWS IN NEW ENGLAND HAVE MANY WONDERING if a national trend is emerging to illegalize physician non-compete agreements, leaving practice owners searching for ways to protect their practices. Physicians have dueling interests in non-competes. As to their personal professional freedom, they oppose non-competes. However, as physician group owners, non-competes—or reasonable tools like them, as this article explains in greater detail below—are necessary to maintain a thriving group practice.

WHAT IS A NON-COMPETE?
A non-compete agreement, also referred to as a covenant against competition, is a contract between a physician and his or her employer. In exchange for the benefits that accompany employment, the physician agrees that for a period after the employment ends, he or she will not practice medicine in certain areas for a certain time.

In most states, a court will enforce reasonable non-compete terms in a signed employment agreement. In my practice in Florida, almost all physician employment agreements I draft or review contain non-competes. Non-competes consist of three components: geography, time and prohibited type of work.

Geography
The physician may be prohibited from working a certain mileage radius from a location(s) at which the physician worked or from the employer-operated locations. Delineations by county name or zip code are common.

Time Period
The physician may be prohibited from working a certain amount of time after termination of the relationship in the geographic area. Generally, we see periods range from six months to two years. In Florida, for example, statute mandates that judges presume non-competes are illegal if they are more than two years long. The fact of the matter is that if the patient-physician relationship is cut off for more than six months in most specialties, physicians lose those patients forever, so a length longer than six months may not matter.

Prohibited Type of Work
It is important to scrutinize what type of work is prohibited. It may be the practice of medicine entirely. It may be a specialty. It may be described more generally as “any act that is competitive with the Employer.” Hospital-owned groups often allow physicians to leave and compete on their own but prohibit them from working in association with or for a competing hospital system. The rationale for this last approach is that if the physicians leave and go out on their own, they will still do cases at and refer patients to the hospital, but if they become an employee of a competing hospital system the referrals will go to that competing system.

IS SOLICITATION THE SAME AS COMPETITION?
Usually prohibitions against solicitation of patients accompany the prohibitions against competition. They are two
More state legislatures are making it difficult for physician groups to restrict employed physicians from competing after they leave the group to start their own practice or work for a competitor.

Employers should strategize options other than non-competes to restrict post-employment competition, such as exclusive relationships with facilities and insurers and “clean sweep” and non-solicitation provisions in employment agreements.

Regardless of state law, entrepreneurial physicians should be aware of practical barriers blocking their opportunities to start their own practices, such as tail insurance costs, medical records costs, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and medical staff issues.

NEW LAWS
This background on the three components helps in understanding the new laws.

Rhode Island
The Rhode Island governor signed a law in July that restricts non-competes unless related to a practice sale. There are few nuances to the law. It makes illegal any contractual agreement restricting a physician’s right to practice medicine in any geography area for any period of time. The law maintains a physician’s right to provide treatment, advise, consult with or establish a physician/patient relationship with any current patient of the employer. Furthermore, it makes illegal any acts to solicit or to seek to establish a physician/patient relationship with the former employer’s patients.

Massachusetts
Non-competes have been illegal in Massachusetts for many years.

Connecticut
Less restrictive is a new law in Connecticut, which took effect this summer. It is much more nuanced and subject to loopholes than the prohibitions in Rhode Island or Massachusetts, including:

• They cannot be more than one year.
• They cannot be more than 15 miles, and that 15 miles can extend only from the location where the physician generated most of his or her revenue. In other words, prohibitions of “x” miles from any location at which the employer has an office or any location at which the physician worked—both of which are common provisions in Florida and many states—are illegal in Connecticut.
• The provision can be enforced only if made in anticipation of a partnership or ownership agreement. This is interesting for non-physician-owned employers, which are gaining market share in the health care industry.

The Future
It will be interesting to see if physician employers have an easier time recruiting physicians to their practices in Connecticut, Rhode Island and Massachusetts as compared with other states, as the fact of no non-compete may be appealing to recruits. Where do these changes leave physician groups in these states? How can groups in other states act to protect their practices in anticipation of similar changes in their states? And what are entrepreneurial physicians’ options after they sign non-competes in states that allow the prohibitions?

Exclusive Arrangements
If a physician is prohibited by something other than an employment agreement’s non-compete provision from working at a facility then that physician cannot, in effect, compete. For example, a hospitalist group that has an agreement with a hospital to be the exclusive provider of hospitalist services does not really need a non-compete agreement with the employed hospitalist. The effect of the covenant against competition arises from the fact of the physician-group exclusive agreement.

Medical Staff Bylaws
It is important to remember that the relationship between employer and employee is a separate and distinct legal relationship from the relationship between...
medical staff member and a hospital or surgery center by way of the medical staff bylaws. For many specialties, there is protection against competition if the physician loses his or her privileges at the hospital in the event employment terminates. These often take the form of exclusive arrangements described above. They also take the form of “clean sweep” provisions. These provisions—crafted into employment agreements to prevent a coup by a subset of physicians in the group to end a current group-hospital relationship—say that a physician automatically loses his or her privileges or will resign from the medical staff at a hospital upon termination of the employment relationship. This may be a loophole around the new laws. The employment agreement could say that upon termination of employment, the surgeon will resign from the medical staff of the hospital and the physician signs a power of attorney at the time of executing the employment agreement that allows the employer to send a resignation letter to the hospital medical staff director on the employed physician’s behalf.

**Controlled Settings**

Surgeons can utilize this type of loophole by focusing all or most of their surgeries at surgery centers that they control. Similarly, in controlling the endoscopy center market, gastroenterologists make it more difficult for a physician to leave the group and start his or her own practice, because the center is essential to the specialty and is expensive to build on one’s own. These sorts of specialty-specific controls of practice settings have the strategic and practice effect of stifling the entrepreneurial efforts of a physician employee to compete.

**OPERATIONAL ISSUES**

It is very difficult for a physician to start a practice from scratch. If the physician is cut off from communication with patients, it is hard to let patients know of a new, competing practice. Groups and departing physicians can focus on the following as ways to make it easier or more difficult to leave and compete:

**Phone Numbers**

The ability of a physician to leave a group and take his practice phone number with him is a great tool for the departing physician to maintain contact with his or her patients. If a physician leaves a group, does he or she have the ability to take the practice phone number? Can the physician cut off the number, or is it controlled by the group? Although risky and perhaps burdensome for other reasons, if the patient has the physician’s cell phone number, it will be easy for the patient to find the physician after he or she leaves the practice. A group may consider banning physicians from patient contact via cell phone.

**Website**

The best advice I can give a departing physician with regard to non-competes is to spend good money on a website and search engine optimization. If a physician is setting up shop legally, just outside the geographic area, immediately following termination, the patients need to be able to find the physician. An excellent website that allows patients to find the physician’s phone number with a simple google search is crucial to the departing physician.

**Letters**

Groups should be agile enough to be able to generate letters or emails through their patient portal to notify their patients that even though the physician is departing, another physician at the group will still see the patient. Dedicated an employee to contact all patients who have appointments with the physician and reassign the patients and reschedule them is worth the investment. On the other hand, if a physician can negotiate the right to contact patients with letters that say his or her new location, that would alleviate the concerns about theft of trade secrets in using patient lists. Physicians may be able to negotiate this during the off-boarding period in exchange for staying employed at the group for longer than the physician has to or in exchange for some other benefit to the group.

**Social Media**

I often have physicians ask me if they can contact patients via Facebook or otherwise advertise their new practice on social media. This depends on the solicitation provisions of the contract and the methodology of the relationship under the social media platform. A departing physician whose new information is easily available on Facebook to the public will have an easier time transitioning his or her practice. Having patients as Facebook friends may pose other difficulties as to solicitation.

**Appointment Scheduler**

The appointment scheduler is possibly the most important person involved in steering patients once a physician leaves a practice. Groups should give the scheduler a script of what to say when patients call to schedule with the departing doctor. The departed doctor should try to see if the group would allow the scheduler to give out the physician’s new contact information to patients.

**Payers**

Although this may change with the new presidential administration, the Affordable Care Act (ACA) has had the effect of creating new types of health maintenance organization-like relationships between physician groups and insurance companies. Insurers are also narrowing networks of physicians within specialties, meaning that insurers are lowering the number of physicians allowed to see their insureds as patients. If a physician leaves a group to start his own practice and cannot get a contract with one of the major insurance companies, that physician’s new practice will not survive. Physician groups facing laws against non-competes may want to work with payers to be the exclusive provider of services.
within their specialty for different products that the insurer provides. For example, perhaps in exchange for certain fees for services or certain collaboration to promote ACA-related models (like accountable care organizations or medical homes), the insurer would agree that all of its insureds would be sent to the group (and all other providers would be non-participating or non-networked providers). We are already seeing deals like these being done between insurers and physician groups, regardless of the trend against non-competes.

**Tail Insurance**
In many states for many specialties, tail insurance costs tens of thousands of dollars. Tail insurance is the insurance that must be purchased to cover a physician for claims that arise after the physician leaves the employer for acts that occurred while the physician was employed under a claims-made policy. An employment agreement provision that mandates that when the physician leaves, the physician must buy tail insurance has a stifling effect on physicians leaving and competing. It adds tens of thousands of dollars to their start-up costs.

**Records Ownership**
If a physician can negotiate into his or her employment agreement the right to free copies of all patients’ medical records upon termination of employment, that makes it easy to stay in touch with patients and avoids the argument that the physician stole a trade secret in the form of a patient list or records. It also eases the transition into seeing new patients, as there is a huge risk management issue in continuing to see a patient without having the prior medical records. HIPAA allows a practice up to 60 days to send records pursuant to a patient's authorization to a newly departed and now-competing physician. I have seen practices deliberately delay sending patients’ records to the newly competing physician to stifle the patient’s ability to receive follow-up care from the new competitor.

Statutes and case law interpretations of non-competes are very state-specific. This article is a general overview of components of typical non-compete provisions and practical steps to take, which may or may not be enforceable in certain states in certain settings. Seeking out the expertise of an attorney experienced not in employment law but in physician business transactions is crucial to developing a strategic plan to reasonably protect the practice from competition. Physicians desiring to leave their employers and establish their own practice should consult with a physician business attorney to strategize the departure process risks.