



STARTING IN MEDICAL PRACTICE

Laura Palmer, FACMPE



Practice Management Services



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AUTHOR
Laura Palmer

EDITOR
Ellen Terry

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ABOUT THE AUTHOR

Laura Palmer, BS, FACMPE, is a retired practice management consultant with more than 30 years' experience. She has managed urgent care, endocrinology, occupational, family, and internal medicine practices. Her expertise includes staff recruitment, business development, and health care payment plan contracting. She has worked in the hospital setting, multispecialty large groups, diagnostic manufacturing sector, and reference laboratories. Ms. Palmer holds a bachelor of science degree in medical technology from Michigan State University and is a fellow in the American College of Medical Practice Executives as well as a certified medical practice executive through the Medical Group Management Association (MGMA).

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Course Objectives

Upon completion of this enduring material, readers should be able to:

- ◆ Use effective communication skills and problem-solving strategies;
- ◆ Determine policies needed for effective communications;
- ◆ Estimate insurance benefits for common coverage scenarios;
- ◆ Discuss techniques for collecting payments from patients;
- ◆ Apply techniques for handling difficult patient encounters; and
- ◆ Identify when and how to appropriately terminate the patient-physician relationship.

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INTRODUCTION

Not that long ago, a physician could leave residency or a group practice, pick a community, borrow money for equipment, rent an office, put up a sign, and start practicing medicine. Today, the administrative and financial challenges of starting and operating a practice have increased dramatically. The revenue cycle is quite complex, the cash outlays are much higher, and more government regulations affect medical practices.

To ensure a better chance of success, the physician needs to start with the right structure, people, and processes. From securing a loan to hiring staff to choosing software and equipment, a myriad of tasks and important decisions will impact practice operations for years to come.

Fortunately, the physician does not have to go it alone when starting a practice. TMA consultants have helped guide many Texas physicians step by step through start-up. *Starting in Medical Practice* is your guide for the journey ahead.

CHAPTER ONE

PRACTICE OPTIONS

Structure

The choice of structure and environment for a medical practice involves several factors including autonomy of decision-making; financial implications (including risk and income sharing); and professional considerations such as after-hours coverage for patients, hours of operation, and external affiliations.

Basic Practice Categories

Perhaps the most crucial decision to make is the environment where the physician wants to practice. In the past, many physicians longing for autonomy and high levels of personal satisfaction chose solo practice. They wanted to control their decisions, set their own policies, hire their own staff, and run their own business. Solo practice continues to be the choice for many physicians despite the financial risks, demands on their time, and challenges with call coverage. However, as the business of medicine has become more complex, some physicians have found it difficult to solve all the problems, pay their expenses, pay themselves a reasonable salary, and keep up with the changing health care environment. Further, the available labor pool of talented employees may be limited, making it challenging to attract and maintain good staff. It also may be difficult for solo practices to negotiate favorable payment rates in a market largely controlled by third-party payers.

Alternatively, physicians may consider group practice. Groups can vary greatly in size and structure, and the advantages and disadvantages are commensurate with both. The chief complaints about group participation are the loss of autonomy and the need to adhere to established policies. The newer physicians in the group may be scheduled to perform a disproportionate share of the work or to serve a particular patient population. These characteristics are balanced by the value of sharing financial risk and after-hours coverage, and some economies of scale. In single-specialty groups, the physicians typically have a similar philosophy and practice scope and comparable incomes and expenses. On the other hand, the group's diversity may be limited, and referrals from other practices may be reduced because of the defined specialty.

Multispecialty groups have the benefits of readily available consultations and a full range of services. A combined medical record makes patient care easier for each specialist, and a wide range of referral sources will exist within and outside the group. However, physician compensation and expense allocation are debated regularly when specialists with different expectations challenge the distribution of income and allocation of expenses.

Several physicians may decide to start a practice together either as an original group or as the result of a split from another group. Even if the new group's participants are like-minded with similar goals, establishing the division of labor and lines of responsibility and authority during early

discussions is crucial. Each shareholder may have an equal voice but bring varying interests, assets, or experience to the decision-making. Partnership agreements simplify governance and direction when they document the commitment, intent, and specific performance of each of the partners.

As groups proceed, a task-force approach may be helpful in assigning responsibilities for specific steps. By identifying key decision points, the group can determine how to work with vendors and professional advisors, and how to handle real estate and office decisions. The goal is to follow a process that is neither bureaucratic nor cumbersome. Because career and financial commitments are at stake, agreeing on how to make decisions is important.

Owner or Employee

Physicians consider the options for ownership and employment at various stages of their career. Physicians starting their career may seek:

1. Immediate practice ownership;
2. A path to ownership in an established practice; or
3. A position as an employee of an organization such as a hospital, nursing facility, hospice, or ambulatory surgical center.

Physicians in later stages of their career may prefer:

1. An exit path from ownership to retirement,
2. A transition from ownership to employment in a group, or
3. A position as an employee of an organization.

Depending on the ownership position, employment may provide varying degrees of ownership interest and control over practice finances and referrals. As an employee, the physician may have limitations on his or her workload and will have to comply with the organization's utilization guidelines and quality assurance standards.

According to a survey conducted for The Physicians Foundation by Merritt Hawkins, in 2018 Texas ranked seventh among the states in percentage of physicians who remain in independent private practice, at 39.9%. In 2015, Texas ranked second. Texas physicians are embracing new trends such as hospital employment, part-time practice, and concierge medicine, which reduce their overall hours and accessibility.

Finding an Opportunity

Physicians can find opportunities through many websites, social networking sites, their residency program, and specialty society job boards. Networking with other physicians and allied health professionals is one of the prime ways to find openings and like-minded groups.

Small groups may stress the positive characteristics of flexibility, independence, and meaningful connections with patients. Work-life balance, long-term stability, smooth operations, and updated technology can make these attractive openings. Although the first-year salary may be lower in a small group, the practice may make up the difference in later years. Productivity bonuses, relocation reimbursement, low-cost buy-ins, and the possibility of partnerships may appeal to midcareer physicians.

Organizations often work with recruiting firms when seeking physicians to fill vacancies and start new practices. Signing bonuses, income guarantees, and loan forgiveness may make these offers appealing to physicians new to practice. Hospitals, medical groups, and academic institutions pay recruiting firms to find, interview, and introduce physician candidates for consideration. Two arrangements are common: contingency and retained searches.

Contingency

This is a simple agreement between the recruiting firm and the hiring entity. The recruiting firm provides the employer the names of qualified physicians, and the employer interviews and selects the appropriate physician. The recruiting firm may represent several employers and present the same candidates to multiple entities.

Fees for contingency recruiting tend to be higher because the employer pays the firm only after filling the position. Fees typically range from 15% to 30% of the employee's first-year salary or the final offer total. Some candidates feel working with a contingency firm increases the chance of a successful match because the firm is highly motivated to fill positions and get paid.

Retained

In this agreement, the hiring entity retains the recruiting firm and pays on a monthly or contract basis. The recruiting firm is paid whether or not the candidate takes the position. Under this dedicated arrangement, the recruiting firm visits the community, meets with key contacts, obtains practice information, designs the financial package, and establishes the strength of the potential employment offer. The recruiting firm provides the physician candidate-specific information relevant to the employment opportunity. The firm also can act as a consultant in arranging site visits as well as negotiating agreements.

Because of unprofessional practices by some recruiting firms, physician candidates should require any recruiter to get permission before forwarding their curriculum vitae to a prospective employer.

A 2021 Merritt Hawkins report shows a continuing trend in physician employment over independent practice. "The 2021 Review suggests that the great majority of physicians accepting

new positions today – more than 90% – will practice as employees and not as independent practice owners/partners. By contrast, in 2001, this number was approximately 60%," the report says.¹

The top physician specialties recruiting in 2020-21 were family medicine, radiology, psychiatry, internal medicine, OB/GYN, anesthesiology, hematology/oncology, and gastroenterology.²

Top incentives for recruiting physicians

Recruitment searches offering to pay additional benefits 2020-21³

Benefit	Jobs Offering
Pay for continuing medical education	94%
Health insurance	78%
Medical professional liability insurance	76%
Relocation allowance	74%
Disability	70%
Retirement/401K	68%
Signing bonus	61%
Educational loan repayment	21%

1. 2021 Review of Physician and Advanced Practitioner Recruiting Incentives, Merritt Hawkins 2021.

2. Id.

3. Id.

Employment Agreements

Contracts for employment and partnership usually contain multiple pages of formal legal language addressing numerous business provisions. It is critical to have a clear understanding of all the obligations and terms associated with any agreement; reviewing the contract with a health care attorney is worth the expense and time.

Beyond the salary and benefits, physicians will want to fully understand terms involving termination, ownership of medical records, noncompete clauses, clinical and financial obligations and responsibilities, call coverage, leave and time off, outside income policies, partnership buy-in and buy-out, indemnification, and the length of the agreement.

Location

For practical purposes, a physician should consider selecting a location where the practice can stay for five years or longer; many commercial leases require a seven-year commitment. If the physician borrows money to build out a space or remodel an existing office, the loan payback may be five to 10 years.

Areas with clinically or geographically underserved market segments may present growth opportunities for a new practice. When choosing a practice location, physicians should consider the following criteria:

- ▶ Area demographics: Is the area's population a good match for your specialty or interests?
- ▶ Economic factors: Does the area support large industries, schools, or government offices? What is the payer mix in the area (such as Medicare or Medicaid)? What is the cost of living in the community?
- ▶ Competition: How many other primary care or specialty physicians are in the area? Where will patient referrals come from?
- ▶ Availability of space: Is medical office space available, or will the physician or practice have to lease or purchase nonmedical space?
- ▶ Proximity: Is the opportunity close to a key facility, hospital, and referral sources? Is the location near neighborhoods with potential patients? Will it be easy for patients to find?
- ▶ Build-out: Does the space have to be built out? Will the landlord contribute to the cost of remodeling the space or building out shell space?
- ▶ Parking: Will the office have sufficient parking to accommodate the anticipated patients and staff? Is the parking in a safe area, or will it require security services?
- ▶ Amenities: What common-area maintenance will be required? Does the lease include janitorial services and supplies, security, signs, and exterior maintenance?

To obtain financing for the venture, the physician's business plan must justify the planned expenses and validate the choice of location as one that will contribute to a viable business.

Leasing or Buying

Whether to lease or buy a building will depend on the stage of the physician's career, financial situation, and plans. When negotiating a lease, a physician might consider the landlord like a bank where the space is loaned, similar to a loan of money.

Rent is usually deductible as an annual business expense. Rent is calculated on square footage, the number of rooms and parking spaces, fees, and monthly costs. Leases vary; for example, a comprehensive lease will cover everything in a flat amount, whereas a triple net lease will require additional fees for utilities, insurance, and taxes. The tenant may be charged for common-area maintenance and security on top of the base rent, and repairs for plumbing or heating also may be at the tenant's expense.

Ownership deductions often are spaced over many years. However, annual mortgage interest and property taxes may be deductible. Ownership has some tax advantages and income potential if the building can be sold upon retirement or rented out. If the physician sets up a separate legal entity that owns the building, the entity can rent the space to the practice. The practice can deduct rent payments while the separate entity collects rent as taxable income and can use the depreciation to offset any profits over the operating costs.

The instability in the future of health care may encourage some potential buyers to lease. The buying risks are high, the partnership may not be stable, and the tax advantages may not work out. If the practice shrinks and the remaining partners have different financial needs, a purchase may not be a wise decision. It may be better to lock in a long-term lease at low rates if the purchase cash flow does not make sense or the buyer cannot easily qualify for the loan.

Regardless of the decision to lease or buy, the physician needs to understand the obligations of the agreement, work with a commercial real estate broker, and have an attorney review the lease or purchase agreement.

CHAPTER TWO

PROFESSIONAL AFFILIATIONS

Establishing relationships with certain professionals can help the physician set up a solid new practice. As the practice grows, these affiliations can help maintain smooth operations throughout transitions. Because of the unique characteristics of medical practice, ensuring the professionals have relevant health care experience is imperative.

Practice Management Consultant

Consultants are available to provide a variety of services to physician practices. For example, a health care consultant can handle all details of setting up a new medical practice while a physician finishes residency or continues to practice in another office or state. Practice setup services typically take between four and six months, and include support in choosing an initial space and equipping it, implementing policies and procedures, and recruiting and training staff.

Consultants also can perform assessments if the physician is joining an existing group to determine if the practice is financially sound. An operations assessment can identify operational and billing issues both for the evaluation and for initiating changes and improvements if needed. A revenue cycle assessment focuses on revenue generated through the provision of services, and may include review of coding and documentation standards. Staffing efficiency and workflows are major components of this assessment.

Checking professional references will assure the physician the practice management consultant has experience with setups, can provide reliable recommendations, and can complete the necessary steps. Be sure to ask the following:

- ▶ Is your experience health care-specific?
- ▶ How many years' experience do you have working in medical practices?
- ▶ What is your experience working with practices of similar size and scope?
- ▶ Do you have extensive knowledge of practice operations, revenue cycle, and compliance?

A practice valuation is a service typically performed by a health care accountant. This service establishes the value of an existing practice for the purpose of purchase or investment. An operations assessment and/or a practice valuation also would be useful when deciding whether to join an existing practice as an employee or partner.

Health Care Attorney

In addition to helping physicians establish the legal organization of the practice, an attorney can review and advise the physician regarding employment contracts, third-party payer contracts, and leases for real estate and equipment. It is preferable to use attorneys who are board certified in the applicable field of law, such as health care, labor and employment, real estate, estate planning, probate, or workers' compensation.

Banker

Most physicians need a loan for start-up operations and working capital. Even with income guarantees in sponsored arrangements, the physician may be responsible for a personal office, a practice buy-in, relocation, and working capital or equipment expenses specific to his or her practice. Some banks have established departments that work with physicians and other health care entities to start a practice. Typically, for the bank to consider a loan, the physician must provide personal tax returns for at least two years and a business plan or financial pro forma.

Real Estate Broker

Whether the physician is leasing or buying, a commercial real estate broker or agent with health care experience can help determine the pros and cons of any location. The broker can provide comparable properties to compare market rates and advise the physician on local zoning requirements; the surrounding market; and accessibility of parking, hallways, and restrooms.

Health Care Accountant

Many physician practices hire a certified public accountant (CPA) for accounts payable, payroll, and quarterly/yearly tax preparation. The CPA often can develop physician compensation plans and advise the physician on the financial advantages of leasing or purchasing equipment and capital investments. The CPA also can oversee the revenue cycle and help establish internal controls to reduce the risk of embezzlement. Reviewing the accounts receivable and payable on a monthly, quarterly, and yearly basis means the practice financials are more likely to meet best practice standards of accounting. Oversight of the staff and office processes will reduce the opportunities for mismanagement and fraud.

Financial Planner

If the physician is joining a group, coming from another practice, investing in real estate, or buying an established practice, he or she may need a financial planner in addition to an accountant. Certified financial planner (CFP) professionals are a type of financial advisor, and are often investment advisor representatives. CFPs can specialize in a variety of areas, from risk management and insurance planning to retirement savings and income analysis. (Not all CFPs are strictly fee-only financial planners, so be sure to clarify what activities will accrue commissions or other fees, as these costs can eat into investment returns.) Consult with your advisor as the practice matures and retirement planning and personal asset protection become important.

CHAPTER THREE

LEGAL ORGANIZATION AND STRUCTURE

The choice of legal organization will have financial, legal, and tax ramifications. The decision of what structure to use will depend on the needs of the physician and the group. Competent legal counsel can help the physician determine which option fits best – sole proprietorship, partnership, or corporation.

This information is not a substitute for the advice of an attorney.

Sole Proprietorship

A sole proprietorship is not a separate legal entity; it is one owner (can also be a husband and wife) with an unincorporated business. Income and losses are part of the physician's personal tax return. Although the proprietorship may obtain a separate tax identification number for payroll tax purposes, no national or state filings are required to create a sole proprietorship.

This type of entity has no personal liability protection from claims against the practice. The largest risk of exposure for most physicians is medical professional liability, and no entity protects physicians from their own acts that result in medical professional liability claims.

No one else can own a part of the sole proprietorship; if the physician plans to add partners or expand in the future, this entity would not be the best choice. Health plans identify providers through the tax identification number, and changing the legal structure would require starting over with enrollment and credentialing. Sole proprietorships are not subject to Texas franchise taxes.

General Partnership

Partnerships are unincorporated businesses involving multiple owners. Although partnerships are easy to form, the more time and expense spent during formation, the less time, money, and potential litigation will be involved in dissolution. General partnerships are not subject to Texas franchise taxes, and each partner pays tax on his or her shares of the partnership income and loss whether received or not. The partnership files an "information federal income tax return" but pays no tax. The partners are allowed limited medical deductions; retirement plans also have limited deductions.

When physicians form partnerships, each general partner is fully liable for the business debts, liabilities, and torts of the partnership. For example, if one partner is sued for medical professional liability/personal injury and the claim names the partnership, all the partners' assets will be subject to seizure. General partnerships are rarely an appropriate entity for medical practices.

Limited Liability Partnership

This form of general or limited partnership registers with the state to obtain limited liability for its partners, paying \$200 per partner per year to the Texas secretary of state. A partner in a limited liability partnership (LLP) is not individually liable for obligations of the partnership, such as contracts the partnership enters into, or torts committed by another partner in the scope of employment, provided the obligations are incurred while the partnership is an LLP. An LLP partner can be held individually liable, though, where the liability is imposed by law or contract independently of the partner's status as a partner, such as if the partner personally commits a tort or personally guarantees a payment obligation of the LLP. The limitation on partner liability does not limit the liability of the partnership to pay its obligations from partnership property.⁴ Ideally, each partner should be represented by his or her own health care attorney when negotiating partnership agreements.

The LLP is subject to Texas franchise taxes. It does not pay income taxes; income and losses are passed on to the individual partners, typically based on the percentage of ownership. The LLP files a tax return to report the amounts passed through to the individual partners. In this arrangement, new owners purchase interest in the partnership from the existing owners. Each time a new partner is added to the partnership, there will be tax consequences for each partner.

Corporation/Professional Association

A professional association (PA) is a corporation formed by physicians to practice medicine. The business organization is a legal entity separate and distinct from its owners. It is fairly complex to form and dissolve, with fees due upon filing with the Texas secretary of state. Corporations and PAs are subject to Texas franchise taxes. Corporations can be structured as C or S corporations or 5.01(a) nonprofit health care corporations.

Professional associations in Texas must file an annual statement before June 30 of each year. The annual statement provides the names and addresses of the association's directors, officers, and members, and its registered agent and Texas office. Owners (shareholders) are shielded from corporate liability including the debts of others and the medical professional liability for professionals not directly supervised by that shareholder. Corporate bylaws, rather than a partnership agreement signed by the owners, govern the entity. A PA is often a good option for a solo physician who plans to expand the practice over time. It is easy to add new physicians with no tax consequences because the corporation issues new stock directly to the new owner.

C Corporation

A C corporation is required to file income tax returns at the corporate level. The corporation will seldom have a significant taxable income because salaries paid to the corporation's staff (including the physician owners) are tax-deductible expenses. For C corporations, medical expenses are fully deductible, and retirement plans have greater deductions available.

S Corporation

A corporation can be structured as an entity that elects to be taxed under Subchapter S of the Internal Revenue Code. The S corporation files an information federal income tax return but pays

4. The Office of the Texas Secretary of State.

no tax. The shareholders are taxed on their shares of the corporate income and loss, whether or not it is received. There are strict limitations on the types of shareholders; the maximum number of shareholders allowed is 100. As with partnerships and proprietorships, there is limited deductibility of medical expenses and for retirement plans.

5.01(a) Corporation

The 5.01(a) corporation was named after the original section of the Texas Medical Practice Act under which it was established. It was allowed as an exception to the Texas “corporate practice of medicine doctrine,” which ordinarily would preclude nonphysicians from owning an interest in a medical practice. Typically, one of the shareholders (members) is a hospital, and the officers and directors are physicians. While the nonphysician shareholder(s) may exercise decision-making authority over financial matters, by law, the physicians must make all medical decisions. The corporation is exempt from Texas franchise taxes and may qualify as a nonprofit organization for federal income tax purposes. If qualified, the corporation pays no federal income tax. Employees are taxed on their shares of corporate income and loss.

Professional Limited Liability Company

This hybrid entity has attributes of partnerships and corporations. A professional limited liability company (PLLC, LLC, or LC) is complex to form and dissolve, requiring filing and fees paid to the Texas secretary of state. It is subject to Texas franchise taxes and must file annual franchise tax reports. It has greater flexibility than corporations in allocating distributions, and the owners (members) are not liable for LLC liabilities, including the torts (medical professional liability/personal injuries) and debts of others. An operating agreement governs the rights and duties of the individual owners of the LLC.

If structured as a partnership for federal tax purposes, the LLC files an informational federal income tax return but pays no tax. Members are taxed on their shares of LLC income and loss whether or not they have received it. For tax purposes, this is treated as a proprietorship, and there is limited deductibility for medical expenses and retirement plans.

If structured as a corporation for federal tax purposes, the LLC pays federal income tax on the LLC income, and owners are taxed on the income and/or dividends they received. As with corporations, medical expenses are fully deductible, and greater deductions are available for retirement plans.

Solo physicians who form an LLC can expand their practice and bring in new owners. However, new members must purchase interest from existing members, which will trigger tax consequences for the existing members.

Tax Registration and Identification

Regardless of the business structure, once the physician has decided on the legal organization, the next step is to obtain a federal tax identification number (TIN) or an employer identification number (EIN). Medicare and other health plans will use the TIN/EIN to identify the physician and the organization for tax purposes. To obtain a number, the physician must file Internal Revenue Service (IRS) Form SS-4 online, by mail, or by fax. Processing by mail takes four to five weeks. If the physician uses the services of an attorney to incorporate the business, the law firm must complete the TIN/EIN on the physician's behalf.

Form SS-4 is available from a Social Security office or IRS office, on the [IRS website](#), or by calling the IRS at (800) 829-4933.

CHAPTER FOUR

PLANNING

Business Plan

Proper planning is the key to success in starting a practice. A detailed business plan and financial projections for at least five years are essential when meeting with lenders. The business plan is a tool that outlines the services to be provided, marketing, and operation of the practice. Developing a business plan is an opportunity to think through various scenarios and determine how they might be handled. For example, who is the patient base for the practice? What insurance plans are to be accepted? How will the practice be marketed? What will be the hours of operation? How will after-hours calls be handled? How will the practice be financed? What is the plan for growth over the next five years?

Practice Pro Forma

A pro forma is a statement of projected income and expenses and is a crucial part of planning for any business. The pro forma will be useful only if it is accurate, so it is important to create it using industry benchmarking information and other known data, rather than random projections. This document takes into account all fixed and variable expenses as well as anticipated charges and collections. The purpose is to accurately project cash flow per month to support the practice's ability to repay loans and other lines of credit.

Loans and Lines of Credit

Loans are typically used to finance start-up expenses such as build-out of a leased space and the purchase of medical supplies, medical equipment, computers, and furniture necessary to open the practice. In addition to loans, lines of credit may be used to cover other expenses such as medication purchases and ongoing expenses while the practice is new and cash flow is not yet sufficient to meet expenses. These figures are taken into account in the practice pro forma.

Financing a practice start-up will depend upon the level of experience and the credit worthiness of the physician owners. Many banks offer conventional loans to finance 100% of start-up expenses, often including interest-only options for the first six to 12 months of the loan. A line of credit may be offered, depending on the ability of the physician owners to repay the debt. All financing is dependent on the projected performance of the practice as illustrated in the business plan. The application process may differ depending on the type of legal formation, but most financing will require a business plan and pro forma. The process goes much more smoothly when prepared with a well-organized structure and plan.

Loan Application Checklist

Professional Association

- ✓ Certificate of association
- ✓ Articles of association and bylaws
- ✓ Assumed name certificate (if applicable)

Sole Proprietorship

- ✓ Assumed name certificate

Both of the Above

- ✓ Tax ID/Employer ID number
- ✓ Address and phone number
- ✓ Physical address (if different)
- ✓ Copy of driver's license

Financial Information

- ✓ Personal financial statement
- ✓ Personal tax returns for two or more years

Other Information

- ✓ Business plan, including monthly income/expense projections for the first year and annual projections for years two and three
- ✓ Cost budget (i.e., use of loan proceeds)
- ✓ Copy of physician's curriculum vitae
- ✓ Copy of medical license
- ✓ Life insurance (i.e., copy of policy, contact information of agent)
- ✓ Business property insurance (i.e., policy number, contact information of agent)

CHAPTER FIVE

INSURANCE

Medical Professional Liability

Although medical professional liability insurance is not required for licensure in Texas, it is required at varying amounts for hospital staff privileges and health plans. The limits of liability per occurrence and aggregate vary by specialty. Several types of insurance are available.

Occurrence

Occurrence coverage provides ongoing insurance protection even if the policy is discontinued. Claims arising from incidents that occur during the policy period are covered in the future even after the policy is canceled. It is not necessary to purchase tail coverage when an occurrence policy is canceled because the insurance still covers claims for the insurance period regardless of when they are reported.

Claims-Made

Claims-made insurance provides coverage for claims arising from incidents that occur and are reported during the time the policy is in force. Insurance policies are renewed annually. A claims-made policy that is renewed continually will have continuing coverage for any claims that arise from the original date of the initial policy, regardless of when the claim is reported.

Prior Acts Coverage

This coverage is a supplement to a claims-made policy that can be purchased from the new carrier when the physician changes insurance carriers. Prior acts coverage, also known as “nose” coverage, covers as-yet-unknown claims arising from incidents that occurred prior to the beginning of the new insurance relationship. Prior acts coverage is an alternative to a reporting period endorsement also known as “tail” coverage, which is purchased from the original carrier when a physician changes carriers, retires, moves, or the like. Companies typically require the newly insured individual to purchase either tail or nose coverage to protect against claims arising from prior acts.

Tail Coverage

Tail coverage is sometimes called a “reporting endorsement.” When a claims-made policy is discontinued, tail coverage is an option available from the former carrier to continue coverage for the dates that the claims-made coverage was in effect. Once a claims-made policy is canceled, coverage does not continue in the future for any claims that might be reported unless tail coverage or prior acts coverage is secured at the time of the policy cancellation. If neither is purchased, any future claims that might arise from services performed during the policy period will no longer be covered for professional liability.

One of the most debated issues in separations and new employment contracts is who pays for the tail policy. Contracts may fail to specify the responsible party, or the wording may state: “Upon termination of employment, the practice may in its sole discretion purchase tail coverage on the physician’s behalf.” Although tail coverage may not be a concern when a physician joins a practice, it certainly will be when the physician leaves. With average tail premiums up to twice the annual medical professional liability premium, how to handle tail coverage should be determined at the formation of the group during partnership discussions or at the time of employment. Generally, if the departing physician continues individual coverage with the same professional liability carrier, there is no need for a tail policy.

Evidence of insurability should be part of the shareholder and partnership agreements. Failure to maintain medical professional liability insurance is often grounds for contract termination. Without coverage, a physician would be unable to contract with health plans or obtain hospital staff privileges.

Other Insurance

Other recommended insurances can further protect the physician and the business. When loaned funds are used for start-up, most banks will require life and disability insurance to protect the loan. Physicians joining groups may be offered various insurance products as part of the benefit package. The employer may pay all or part of the coverage expense.

- ▶ **Critical illness insurance:** This coverage provides a lump-sum payment to help maintain the physician’s lifestyle and financial security if he or she contracts a covered critical illness.
- ▶ **Life insurance:** Life insurance can be for a term (a set period) or permanent. It protects the physician’s family against financial difficulties in the event of the physician’s death. Lending institutions often will require term life coverage that insures the value of their loan during start-up.
- ▶ **Long-term care insurance:** Medicare or private supplements to Medicare do not cover certain long-term care expenses. This insurance can be customized based on estimates of future expenses for long-term medical care.
- ▶ **Disability insurance:** In the event of a disability that prevents a physician from earning a living, disability insurance can provide income replacement for a certain period. Short- and long-term policies are available that provide income from 90 days to retirement, depending on the policy.
- ▶ **Major medical insurance:** Comprehensive health coverage with multiple options is available from many carriers. Policy carriers include traditional indemnity, preferred provider, and health maintenance organizations with various deductibles, copays, benefits, and coinsurance levels.
- ▶ **Medical savings account:** Tax-deferred accounts can be established to pay medical expenses in conjunction with high-deductible health plans.
- ▶ **Business owners insurance:** Coverage is available to pay the overhead and expenses in the event of an accident, disability, or disaster in the practice. Business owners insurance is sometimes referred to as “key man” insurance. It is often required by lenders to secure equipment or start-up expense loans.
- ▶ **Personal accident insurance:** Additional coverage for medical and life insurance can be a low-cost way to supplement other insurance, and no medical underwriting is required.

- ▶ **Supplemental hospital indemnity:** As an addition to any existing health coverage, supplemental insurance can cover expenses not included in a basic medical plan such as deductibles, copayments, transportation to and from the hospital, private room charges, and child care.
- ▶ **Workers' compensation insurance:** State-regulated insurance programs can pay for medical bills and some lost wages for employees injured at work or who have work-related illnesses or diseases. Texas does not require employers to carry workers' compensation insurance if the business can meet state requirements for nonsubscribers. However, businesses that purchase state-regulated workers' compensation insurance enjoy liability protections from suits by their employees for negligent acts.
- ▶ **Cyberliability insurance:** This coverage protects businesses and individual users from risks such as the destruction of data, extortion, and hacking. It also protects from losses to others caused by the failure to safeguard data including breaches of protected health information.

CHAPTER SIX

LICENSES AND REGISTRATION

To practice medicine in Texas, a physician must obtain a Texas Medical Board (TMB) license. Physicians also may need to obtain a U.S. Department of Justice (DOJ) Drug Enforcement Administration (DEA) registration number.

All physicians applying for a Texas license also must be fingerprinted for background screening. The license and registrations are required for physician credentialing and contracting enrollment with health plans.

Medical License

TMB issues licenses to practice medicine. TMB requires an online application, which initiates screening and document collection. Once TMB approves the applicant and receives the physician's fee and documentation, licensing proceeds with verification. As of Oct. 6, 2022,⁵ the application fee for physician licensure in Texas was \$817.

Also upon approval of the application, TMB assigns the first registration period. These initial permit periods are between 12 and 24 months in length. First-time registration fees are prorated accordingly:

- ▶ Initial registration of 12 months: \$283.85, and
- ▶ Initial registration of 24 months: \$469.85.⁶

In 2021, Texas joined the Interstate Medical Licensure Compact. It's a voluntary, expedited pathway to licensure for qualifying physicians who wish to practice in multiple states. The application fee as of Oct. 6, 2022, is \$700 along with the cost for licensing in each state.⁷ Physicians should review all qualifications before applying.

Several years ago, the Texas Legislature mandated that TMB prioritize certain applications for physicians seeking Texas licenses. TMB expedites applications for Texas physicians who agree to treat Medicare and Medicaid patients or who are going to practice in:

- ▶ Medically underserved areas, or
- ▶ Health professional shortage areas.

Once the physician has an active license, it can be renewed online 60 to 90 days before the expiration date. Physician licenses expire at one of four times during the year: Feb. 28, May 31,

5. Texas Medical Board. [Physician Application and Registration Fees](#) (accessed Oct. 6, 2022).

6. *Id.*

7. Texas Medical Board. [Interstate Medical Licensure Compact](#) (accessed Oct. 6, 2022).

Aug. 31, or Nov. 30. These registration periods are assigned by TMB at the time of licensure. Even-numbered licenses expire in even-numbered years; odd-numbered licenses expire in odd-numbered years. As of Oct. 6, 2022, the biennial license fee is \$465.85.⁸

To maintain current status, physicians must complete 24 formal Category 1 and 24 informal Category 2 CME units every 24 months. At least two of the formal credits must be in medical ethics and/or professional responsibility education, and two in pain management and opioid prescription. Also as part of the formal credits, physicians must complete a course in human trafficking. Newly licensed physicians are exempt from the CME requirements the first time they register.⁹

Texas Medical Board

PO Box 2029, Austin, TX 78768-2029
(512) 305-7030

Drug Enforcement Agency Registration

All prescriptions for controlled substances must contain the prescribing physician's DEA registration number. As of May 2022, DEA registration application/renewal forms must be submitted online. The application fee for a three-year registration is \$888.¹⁰

Sources

- ▶ [Apply for registration](#) through the DEA Diversion Control Division using DEA Form 224.
- ▶ To order Schedule II controlled substances for office use, [request order forms](#) using DEA Form 222.
- ▶ Find the [closest DEA office](#), or call (800) 882-9539.

Texas Prescription Monitoring Program

Effective Jan. 1, 2021, Texas Health and Safety Code §481.0755 requires that prescriptions for controlled substances be issued electronically, except in limited circumstances, or unless a waiver has been granted by the appropriate agency, which for physicians is the Texas Medical Board.¹¹

The Texas State Board of Pharmacy is responsible for the oversight and processing of orders for Schedule II prescription forms. Any version of the official form issued before Sept. 1, 2018, is not valid.

Texas Prescription Monitoring Program

(512) 305-8000

CLIA Certificate

To perform even basic in-house testing such as urinalysis, hemoglobin A-1-c, or strep testing, the practice will need a Clinical Laboratory Improvement Act (CLIA) license. Federal law requires the office to obtain a certificate that corresponds to the complexity of the testing it will perform. Most solo offices perform waived testing and will need only a Certificate of Waiver. Waived tests are defined as simple lab examinations and procedures with an insignificant risk of errors.

8. Texas Medical Board. [Physician Registration/Renewal](#) (accessed Oct. 6, 2022).
9. Texas Medical Board. [Continuing Medical Education for MDs/DOs](#) (accessed June 9, 2022).
10. 21 CFR §1301.13.
11. Texas Medical Board. [Updates on Prescribing Controlled Substances](#). Accessed July 12, 2022.

The application packet, available from the Texas Health and Human Services Commission, includes a list of waived tests, a list of health facility compliance representatives with contact numbers for assistance, and additional information. It takes 30 to 90 days to obtain a CLIA certificate.

**Texas Department of State Health Services
Facility Licensing Group (MC 2835)**

PO Box 149347
Austin, TX 78714-9347
(888) 963-7111

If any of the testing is of moderate complexity and involves microscopy, the office will need a Certificate for Provider-Performed Microscopy. Higher-complexity testing requires proficiency testing and site inspections for approval. Practices should apply for their CLIA license during the start-up phase of the office because the certificate number is required for health plan credentialing applications.

View complete CLIA laboratory requirements on the [Centers for Disease Control and Prevention website](#).

CHAPTER SEVEN

VENDORS AND SUPPLIERS

Electronic Health Record and Practice Management System

The key to selecting the right electronic health record (EHR) and practice management software system for a physician practice is ensuring that the software meets the specific needs of the practice – “one size fits all” does not apply. Through research and careful planning, the physician can avoid the pitfalls of system incompatibility. Technology is a high-cost, long-term purchase, so careful attention to the current and projected needs will save time and money in the long run. Purchasing or leasing a system that does not have the expansion capabilities or modules such as are needed for incentive program reporting, a patient portal, or data analytics that the practice may need could be costly, time-consuming, and disruptive to operations. If data must be converted to a new system, the practice may have to maintain two systems for a period of parallel testing, working off the accounts receivable, or moving records.

Fully Integrated Solutions vs. Best of Breed

When researching an EHR and practice management vendor, one of the first things to consider is whether the practice should consider a fully integrated solution or a best-of-breed model.

In a fully integrated solution, the product is built from the ground up on a single platform and contains the components needed for both the practice management system and the EHR. These include clinical documentation as well as electronic prescribing, billing, scheduling, and document management. Because these systems are developed on a single platform, data flows between software functionalities seamlessly and tend to be more reliable. One developer and vendor mean a single point of accountability for any software issues.

In a best-of-breed approach, several products that excel in a specific function are joined to work as one. While this is a rare approach, it is certainly possible. A crucial point is that the disparate systems must be interfaced or linked together to minimize data entry and reconciliation between the two. These linkages can easily break when one vendor upgrades and thus requires additional maintenance. Another consideration is that there is no single point of accountability when trying to troubleshoot software issues.

Since most EHRs include the practice management system as a fully integrated solution, references to EHRs in this publication are intended to refer to both the EHR and the practice management system.

Server- or Cloud-Based Technology

EHRs can be either cloud-based (also known as an application service provider), which means all of the information is accessed via an internet browser, or client-server-based, meaning the information is contained on a server in the practice. Not all vendors offer both options, so if the practice has limitations (such as low internet bandwidth), this may be an important first question to ask a vendor.

As products are evaluated, some other important questions a practice should ask are:

Client-Server vs. Application Service Provider (ASP Models)

	Client Server	ASP
Location of Software/Data	On a server located in the physicians' office	On a remote server and commonly accessed via the internet
Security and Backup Responsibilities	Practice is responsible for maintaining a secure data center	ASP is responsible for data backup and security
Technical Staff	Practice is responsible for providing technical support for the servers and service operating systems	Vendor typically provides support and service
Cost	Higher up-front costs for hardware and installation	Lower initial fees, but there is a monthly fee payable to the vendor for access

- ▶ What functions are available?
- ▶ Does the vendor guarantee in the contract that the software will comply with all current and future federal and state regulations, incentive programs, and mandates?
- ▶ Is the product certified under the federal Health IT Certification Program? This is an important consideration – not only does using certified health IT improve care coordination and enhance patient safety, usability, privacy, and security but also certain health plans require the use of certified health IT.
- ▶ Is the software tailored for the physician's specialty? If so, how many physicians of this specialty are current users?
- ▶ Does this system work over the internet (cloud-based), or will the practice need to purchase a server?

Vendor Demonstrations

Vendor demonstrations are extremely important in the selection process. To get the most benefit from this step, practices should set up demonstrations with three to five EHR vendors. Demonstrations often last about two hours and usually are conducted virtually. To get the best demo possible, the physician should give each vendor the same clinical situation for which to

demonstrate the required documentation and coding steps. For example, the vendor could show the process for scheduling and recording a visit for a child presenting with an ear infection from the initial call to booking an appointment, recording vital signs, performing and documenting the history and exam, printing treatment instructions for the caregiver/parent, e-prescribing medication, sending a referral, adjudicating the claim or receipt of cash payment, and sending the information to the patient's portal.

Because the purchase of an EHR system involves a substantial financial commitment by the practice, all physicians who will be partners in the practice, and their practice manager, if identified, should attend these demonstrations. If the demos are scheduled within a short period back to back, comparing the options and functionality of each system will be easier. Demonstrations where the practice can “test drive” the system are more effective than a sales demo. In this way, the physicians and staff can see how many steps, clicks, and windows are needed to accomplish routine tasks they perform daily.

The demonstration should include evaluation of the reporting functions. Physicians should review with the vendor measures reporting, population health data aggregation, disease registry, and custom financial reporting to determine the feasibility of meeting regulatory requirements.

Due Diligence

Extensive information on selecting and evaluating vendors and products is available from multiple sources. However, to ensure the selected technology meets the practice requirements, contacting client references is critical to the evaluation. Making visits to the practice reference sites will allow the buyer to see the software in use. It is also advisable to completely investigate the base price for the software and hardware, training, maintenance, and upgrades over the life of the product. Determining each vendor's reliability and response to service requests, and uptime of the software will add key information to the decision process.

Physicians should bear in mind that technology, care delivery models, and electronic health records have become increasingly important in health care in recent years. Interoperability; coordination of care; and collaboration across entities, physicians, and providers is now the norm. Collaborations for the patient-centered home, clinically integrated networks, and accountable care organizations all have unique documentation, reporting, and care coordination requirements that should be considered.

Software Training

A large part of the vendor bid for implementation will be for software training. Ideally, the training should allow multiple users to become familiar not only with the mechanics and functionality of the system but also with its integration with day-to-day practice procedures. The software vendor or value-added reseller is the best source for software-specific training including system setup and customization, daily functions (from scheduling to charge entry to billing), documentation, and reports. When the practice issues a request for proposal for the EHR, the training costs should be separated from the software on the bid to better identify what the physician actually will pay for each item. It is recommended that at least one person be trained as a super-user who can then assist with other staff training. Additionally, ask the vendor if training modules are accessible online for the practice to refer to when training new staff.

Depending on the system selected, ongoing maintenance costs may include additional training, or this training may have to be purchased separately. It is advisable to plan and budget for additional training several months after installation. Once the physician and staff become familiar with the routine functions of the system, another round of training will improve the efficiency of the users and provide information on advanced features. Some systems also have local or regional user group meetings and electronic mailing lists or online communities for networking with other practices to maximize system efficiencies.

Cost

When a practice acquires an EHR, it is actually acquiring a license to use that software. The most common metric for pricing is the number of licensed professionals in the practice whose services can be billed. Those professionals include not only physicians but also any advanced practice nurses, physician assistants, and physical therapists the practice employs. With some vendors, the number of users determines the licensing fee. This will raise the cost of the software because each staff member who has a terminal, including the health care professionals, will be counted as a user.

There are several pertinent questions to ask when researching EHR system costs:

- ▶ Will the practice require interfaces with labs or radiology? If there is a fee, is it a one-time fee or ongoing?
- ▶ What are the ongoing price considerations such as annual fees, upgrades, maintenance, or technical support?
- ▶ Does the software already include specialty-specific templates (e.g., well-child visits, obstetrics), or will these be customized at additional charge?
- ▶ Are there charges for additional features such as reporting tools, voice recognition, scanning software, or the patient portal?
- ▶ If applicable, what are the costs associated with having current records converted into the new system?
- ▶ What are the hardware needs?

Physicians should be aware that some expected costs are merely estimates. Health information technology is a highly competitive industry, and in some cases, vendors may attempt to close sales by using estimates that are unrealistically low. Implementation costs have been reported to be 5%, 10%, and sometimes 50% more than vendor estimates. The physician should confirm the actual cost and check the vendor's reputation with other practices before signing a contract. An attorney should review the contract to protect the physician from unexpected terms and unfavorable clauses.

TMA members are eligible to receive a free technology contract review from Coker Group. See www.texmed.org/Coker for details.

Incentives for Using Technology

Public and private payers alike encourage the use of technology to improve quality through reporting programs. An example of this includes the Medicare Merit-Based Incentives Payments System (MIPS). Physicians should see what programs are offered by the various payers and weigh

the cost of participation versus the potential incentive. Some programs have very detailed reporting requirements that may be updated annually. Alternatively, some programs, such as MIPS, may penalize physicians for nonparticipation.

For more information on federal incentive programs, visit the TMA website at www.texmed.org/PI.

To further assist with evaluation of EHR products, the following resources are available on the TMA site at www.texmed.org/EHR:

- ▶ TMA EHR Comparison Tool (compares most-used EHRs in Texas);
- ▶ How to do an RFP for an EHR;
- ▶ Questions for EHR Vendors; and
- ▶ Questions for EHR Vendor References.

Interoperability and Information Exchange

Certified EHRs are required to be interoperable, which may require costly interface fees when connecting to a health information exchange (HIE). HIEs allow bidirectional electronic access to information across organizations including other practices, hospitals, and government agencies. Being able to exchange information – whether via a regional exchange, a national network, or secure messaging – is vital as physicians must comply with information-blocking regulations of the 21st Century Cures Act. Unless an information-blocking exception applies, physicians are required to promptly share electronic health information with patients and other treating physicians and providers upon request. Participating in an HIE and using interoperable software should:

- ▶ Aid in compliance with federal regulations;
- ▶ Improve health care quality and outcomes;
- ▶ Allow quicker access to information for treatment purposes;
- ▶ Reduce health disparities, errors, and duplicate services;
- ▶ Enhance care coordination and stakeholder satisfaction among physicians and providers;
- ▶ Provide risk management and contingency options for emergencies; and
- ▶ Promote greater efficiencies.

Telephone System

Telephone systems have evolved from the black box on the desk with multiple buttons to a sophisticated multipurpose device. With voice over internet protocol (VoIP), T-1 lines, Bluetooth headsets, mobile phones, and hosted phone systems, the possibilities and expectations for service and pricing are limitless. Many vendors can provide data services that combine cable, VoIP, and phone services in one bill at a reduced, bundled price.

Before purchasing telephone hardware and software, the physician should identify the anticipated needs of the practice, such as:

- ▶ Number of voice and data lines;
- ▶ Number and type of telephone sets (i.e., display, nondisplay, cordless);
- ▶ Voicemail availability, with or without outgoing messaging;

- ▶ Message or music on-hold capabilities; and
- ▶ Remote programming for call forwarding.

Depending on the setup in a solo practice, the office typically can expect to use a minimum of five lines. The main number is the official, published number. Incoming calls can roll over to two back lines when the main number is busy. The fourth line is often the private physician line, and the last number is a data line that can handle the fax, credit card, and any other data that need a dedicated line. A dedicated billing line is a usual addition.

Because the needs of a practice change, the phone system should have expansion capabilities in terms of the number of sets, the number of voice and data lines, and system features. Maintenance agreements from the manufacturer or vendor typically are available beyond the original purchase. The physician should compare these with local service plans for price and response time by checking online rating services and other user referrals.

To establish permanent phone and fax numbers for the practice, a remote call forward (or telebranch) can be arranged with the local phone carrier prior to opening. As soon as the physical location is determined, numbers can be assigned for use in publicity, credentialing, website development, and office paperwork. Before the office is open, the published phone and fax can be forwarded electronically to a voice mailbox, electronic fax, or another phone (cell or home office) for message retrieval and response. As soon as the office is occupied, the telebranch can be disconnected, and the lines will ring into the office. The phone vendor will program the system to accept incoming calls, faxes, and voicemail.

Medical Equipment and Supplies

Medical equipment and supplies are available from sales representatives, distributors, mail order catalogs, or internet sites. Prices are very competitive; frequent monitoring will reward the bulk user with bargains once the consumption patterns are established. If the office has sufficient storage space, the practice can take advantage of sales and discounts. If available, group purchasing organizations (GPOs) can reduce the cost of medical supplies and drugs through volume discounts.

Although a supplier may offer an exclusive purchasing agreement, practices should be aware that association with a single supplier can be either a hindrance or an advantage. If the medical supplier doesn't think the purchaser has received better pricing offers or payment terms (such as shelf-life dating for dated products, or delayed payment without accruing interest or financial charges), the practice may end up paying higher-than-market rates for equipment, supplies, and biologicals.

When figuring costs, the physician should include the time spent negotiating prices in addition to the actual costs of the supplies and normal inventory levels. Paying careful attention to changes in the cost of drugs and supplies will ensure the office fee schedule covers these increased costs.

Vaccines and injectables are particularly costly items to purchase and stock. Developing an effective inventory control process is advisable for keeping track of expensive vaccines and drugs. The practice should ensure the office refrigerators have recording thermometers to confirm products are stored at the correct temperature. Offices with large stocks of refrigerated supplies may warrant monitoring systems with alarms to prevent inventory losses. The office insurance should be increased to cover the cost of replacement in case of power outages or natural disasters that might impact supplies or drug inventories.

Office Equipment and Supplies

Office equipment and supplies often can be purchased through a group purchasing organization in the same manner as medical equipment and supplies. Major office supply retailers participate with GPOs and may offer same-day delivery at no cost and provide discounts to frequent buyers. The practice may purchase some office supplies, like paper products and janitorial and laundry supplies, in bulk from discount retail outlets to keep costs low.

Office furniture may be purchased from a variety of outlets, such as furniture stores, discount retail outlets, or even large office supply retailers. Another, often overlooked, source is other medical practices that are closing or remodeling and selling lightly used furniture for lower-than-retail prices.

Answering Service

Using a good answering service will help provide a positive impression of the practice and can be helpful to patients after hours. Calls answered by uninformed or rude personnel can discourage callers or drive them away altogether. By carefully selecting, monitoring the performance of, and randomly testing the answering service, physicians can ensure it is following their instructions and serving patients and referring physicians well. For physicians moving into a new area, getting recommendations from local colleagues is a good way to find a competent answering service. Unless the service is specifically contracted for medical triage, clinical calls should be referred to the physician or health care professional on call.

Mail

Even with fax-com solutions, email, and electronic funds transfer, the practice will handle packages, statements, and correspondence. Initially, purchasing stamps and sending packages from the post office will work. When the volume of mail warrants, both the U.S. Postal Service and independent carriers allow postage to be printed from personal computers. Postage meters are available from multiple vendors to dispatch mail directly from the office. For competitive rates on packages, compare independent carriers, such as FedEx and United Parcel Service, with the post office, and compare with GPO contract rates.

Biohazardous Waste Removal

In some medical professional buildings, biohazardous waste pick-up is included in the lease and maintenance contracts. Practices also may be able to contract with the hospital. In most communities, service is contracted through independent waste removal companies that also may pick up routine garbage. You can consult the [Texas Commission on Environmental Quality database](#) to find a registered transporter of medical waste and sharps in the community.

Laundry Service

Laundry services are typically offered by local companies. Even if the practice uses paper drapes and gowns, lab coats, and surgical tray liners, it may need to use a laundry service. Often colleagues or other building residents can provide references for reputable companies that provide pickup and delivery services at a reasonable cost.

Janitorial Service

Janitorial services may be included in the cost of the lease. Physicians should review their lease to determine if they are already paying for janitorial services in the agreement or if they need to contract with an outside vendor. It will be helpful to determine what services and routine maintenance will be included and what the practice will need to pay for separately (for example, cleaning carpets, furniture, windows, or baseboards). The contract should state the frequency (daily, weekly, monthly), the timing if provided after the office is closed, and whether or not supplies are included in the price of the service. Maintenance employees should be bonded in case anything in the office is broken or stolen, and contract workers with any access to protected health information should sign business associate agreements for privacy protection.

Security System

Once again, other building tenants may have recommendations for service companies. When comparing bids for services, the physician should review each contract to determine whether the service is monitored and how the office is notified of security breaches. Some services provide monitoring for fire and security and also can advise when temperature variations occur in the office, which helps protect medical supplies and vaccines. It may be necessary to have security in parking areas during and after business hours depending on the location of the office.

Payroll Service

Depending on the number of staff members and the manager's expertise, it may be advantageous to contract with a vendor to process payroll records, manage accruals, pay taxes, and prepare checks. Depending on the services needed, payroll vendors also can manage insurance programs and premium payments, administrative leave, continuation of insurance following departures (through: the Consolidated Omnibus Budget Reconciliation Act, or COBRA), and other employee benefits. Payroll vendors are particularly helpful when the practice is starting up and later when the volume of employees makes it worthwhile to outsource one of the management functions to reduce the administrator's workload.

CHAPTER EIGHT

PERSONNEL MANAGEMENT

Personnel management is critical to the success of a medical practice. However, finding qualified staff can be challenging at times because of market saturation, low unemployment rates, and other factors. To increase the chances for success in hiring, it is helpful to have accurate job descriptions and to determine what qualifications are needed for each position. Following the legal regulations for interviewing, hiring, and dismissing staff is good risk management.

In the absence of a written employment agreement, Texas is considered to be an employment-at-will state. Employees may leave the practice voluntarily or be terminated for any reason or no reason. Employees serve at the will of the practice. Any provision, written or implied, regarding a disciplinary process should follow procedure.

Refer to Appendix B for federal laws that affect employment practices.

Advertising

Although many physicians rely on word of mouth to recruit staff, there are more reliable ways to fill staff positions. Physicians can place job postings in the [TMA Career Center](#); county medical society job banks; and employment sites such as Indeed, ZipRecruiter, or LinkedIn.

A written ad should be based on the current job description and personal characteristics the candidate should possess. The ad should be as detailed as possible and include the job title and an overview of the responsibilities and specific skills required. It should direct the candidate to mail a resume with salary history or email it to a free email address (e.g., a Gmail, Outlook, or Yahoo! address) set up for recruiting. Using the physician's personal email address is not recommended.

Even if candidates appear at the new office, hand deliver a resume, or are recommended to the physician by a colleague, they should be encouraged to follow the same process as any other candidate being considered for the position. To avoid any discrimination complaints during hiring, the selection procedure should be consistent for each candidate and designed to only ask questions about each applicant's qualifications. The intent of interviewing is to determine the applicant's knowledge, skills, experience, and ability to perform the essential functions of the job.

Job Descriptions

The health care industry often overlooks the need for job descriptions. Job descriptions give structure and objectivity to hiring and evaluation, and provide a foundation and documentation for agreed-upon duties and responsibilities. Job descriptions should be included in the office policies and procedures manual and readily available to each employee.

Job descriptions should be based upon the duties of the position in relation to the current needs of the practice and allow for changes as the practice grows. The job description will provide a basis for future evaluations, compensation decisions, and probation or termination decisions.

Physicians should consider legal issues when constructing the job description and ensure the job is in compliance with the Americans With Disabilities Act, Title VII Civil Rights Act, and Fair Labor Standards Act (classifying employees as exempt or nonexempt).

The job description should include the following:

- ▶ Job title;
- ▶ General summary of duties;
- ▶ Supervisor;
- ▶ Employees the person supervises (if any);
- ▶ Essential functions;
- ▶ Education;
- ▶ Experience;
- ▶ Requirements such as licensure;
- ▶ Skills;
- ▶ Environmental working conditions; and
- ▶ Physical and mental demands.

Both professionals and support staff should have computer knowledge. The job description should include any expectations of technology knowledge, such as website development, practice management system support, and documentation in an electronic health record.

Screening Candidates

In a solo practice, the physician will make the decision regarding the hiring of a practice manager and support staff. In a larger group, the process is not as clear-cut, and physicians must agree upon the hiring procedure. If the practice is very large, it would be helpful to form a search committee to screen candidates and report its results to the full board, who can interview the candidates and make the final selection.

Filling multiple positions requires time and patience. If the first round of candidates does not result in filling all the positions, a second round of screening may be necessary. Starting the screening four to six weeks prior to opening is advised. If software training and orientation are scheduled prior to opening, the physician may want to start the hiring sooner to have staff working before the office is open and ready to see patients. It may take longer than a month to screen and interview candidates, check references, and allow the selected candidate to give notice to his or her current employer. Rushing the process may create a short-term solution that causes long-term problems.

Initial screening of candidates involves a review of resumes. The review should address the following questions:

- ▶ Does the candidate have education and training that fit the job description? The appropriate candidate should have personal goals that fit the practice's goals.

- ▶ Does the candidate have experience working in a practice setting? Hospital or facility experience may be insufficient to prepare candidates for ambulatory care offices. If the physician is new to private practice, it will be helpful to have employees with experience in that environment or specialty.
- ▶ Is the size of the candidate's current employer similar to that of the hiring practice? A person accustomed to managing a large office with multiple locations may be bored with a small practice or not have the hands-on experience needed for the small office.
- ▶ What medical specialties does the candidate have experience with? This is important in billing, collections, and coding. It also may be important in understanding the practice's marketing activities and referral relationships.
- ▶ Is the person currently employed? Some individuals may take a position that fails to meet their long-term professional goals because they are seeking any position or specific employment benefits. The individual may work only temporarily for this practice while seeking other employment.
- ▶ How many candidates will be interviewed? All of the top candidates should be interviewed. Ideally, the physician will have three to four candidates to interview for each open position.

Interviewing

Interviews can be a valuable source of job-related information about applicants, giving the interviewer a chance to fill any gaps on the application form, gauge the applicant's job-related knowledge and abilities, and describe particular features of the job and practice. Like other components of employee selection, interviews are subject to scrutiny under federal and state equal-employment-opportunity rules.

The safest way to interview is to identify the basic requirements of the job and develop a standard set of questions designed to reveal each applicant's ability to perform those specific requirements. For example, when hiring a medical assistant for a pediatric practice, the physician wants to be sure the new employee knows how to draw blood from an infant. During the interview, rather than asking the candidate if she knows how to draw blood, the applicant could be asked to describe how she would go about drawing a blood sample from a baby. The physician could ask her the steps she would use to prepare the child and what she would do and say to reassure the child and caregiver or parent. A billing candidate could be asked to describe how he would go about filing an appeal to a claim denied for payment. The physician could ask an applicant for the front office receptionist position what she might say to a caller when the schedule for the day was already full. By asking open-ended questions that relate to the job requirements, the physician will be better able to determine the best candidate for an opening.

Phone or Video Interviews

When reviewing the resumes, the physician should rank the applicants according to their match to the position requirements. Before investing time and effort to meet personally with each applicant, screening should start with a call to the top candidates at the contact number they provided. Three to five key questions will give the physician more information with which to proceed.

Some recommended questions are:

- ▶ Why are you looking for a position? (Is he moving? Did he lose his current job?)
- ▶ What attracted you to this posted position? (Does she want to work in your location, need different hours, have child care issues?)
- ▶ When are you available to start work? (If the applicant is out of work now, he may not be able to wait for your position to start.)
- ▶ The physician could restate any job requirements. For example: “This position requires you be able to work until 7 pm on Tuesday and Thursday, or every other Saturday from 9 am-noon. Would that be a problem for you?” This will better ensure the applicant understands the offered position will require working after 5 pm or on the weekend.

The physician can conclude the brief phone or video interview by thanking the applicant and advising him or her of the next step. If the physician is unsure the candidate will be asked for a personal interview, he or she can tell the candidate the practice will be reviewing the resumes to determine who will be called back for an interview. If the physician wants to further the conversation, a personal interview can be arranged with the applicant at this time.

Personal Interviews

After concluding the phone or video interviews, the physician should formulate a series of face-to-face interview questions. In most cases, interviews last about 30 minutes for entry-level staff and up to an hour for key personnel such as managers or nonphysician practitioners. Scheduling 15 minutes between interviews will leave time to record thoughts and responses and allow for a mental break.

An applicant may not know anything about the physician or the practice if he or she is new to the area. However, some job seekers may come to the interview prepared. One of the best questions a physician can ask applicants if the practice or physician has already been in the area is “What can you tell me about this practice?” Applicants who can describe the physician, the previous practice, or what they have heard in the community or from colleagues may deserve special consideration because they show they are conscientious and attentive to detail.

The interviewer should:

- ▶ Begin the interview with an introduction of all the individuals present. Give a brief overview of the position, the timing of the opening, the size and makeup of the practice, and any personal philosophies that describe the practice. This should take less than three minutes.
- ▶ Ask the candidate to briefly discuss his or her background as it relates to the position.
- ▶ Conduct the interview dialogue through specific questions. “Are you good with computers?” may be too vague a question, while “Tell me about your experience with vendor selection or a software conversion” will elicit a response that demonstrates a candidate’s strength or weakness in this area.
- ▶ Focus questions on the role the person will be filling. An office manager’s interview questions should focus on billing and collections, supervision, and daily operations experience. A medical assistant should be questioned about clinical skills and experience assisting a physician.
- ▶ Observe the candidate’s dress; it will reveal a great deal about how he or she will represent the practice. The right candidate must convey a professional attitude and appearance in the community.

- ▶ Listen carefully to the questions the candidate asks. Is he more interested in the practice, or does he focus on salary and benefits? Does he demonstrate good communication skills? Does he have an understanding of the local competition and health care payment environment?
- ▶ Ask the candidate about overcoming challenges. Ask her to describe the situation and steps taken to handle a patient complaint or a challenge (for example, drawing blood from a difficult patient or combative child).
- ▶ Ask about strengths and weaknesses. Phrasing the question as, “What would your (current or former) supervisor say are your strengths/weaknesses?” often will provide more information than asking the candidate to describe him or herself.
- ▶ At the end of the interview, thank the candidate for his or her time and describe the next steps of the process (such as timing and decision points).

Refer to Appendix B for guideline questions to ask during an interview.

Top 10 Tools for Hiring Success

1. Create an accurate job description.
2. Advertise wisely.
3. Develop a consistent interview process.
4. Conduct reference/background checks.
5. Hire the right person, even if it takes time.
6. Orient the new hire.
7. Train, train, train.
8. Provide feedback.
9. Develop retention strategies.
10. Conduct exit interviews.

Top 10 Mistakes to Avoid

1. Believing job descriptions aren't necessary
2. Hiring too quickly
3. Not equally emphasizing skills, behaviors, and cultural “fit”
4. Doing most of the talking in an interview
5. Waiting until review time to assess performance
6. Basing performance appraisal on opinion not documented facts
7. Performing one-way appraisals
8. Believing turnover is a fact of life
9. Not involving physicians and staff in the retention program
10. Failing to recognize the power of praise and recognition

Selecting the Top Candidate(s)

Even if the candidate has provided a resume, each candidate should fill out an application-for-employment form at the time of the personal interview. Application forms require signatures attesting to the accuracy of the provided information. Practices that lack a standard form may obtain copies from TMA,¹² the web, or an office supply store.

After the practice has conducted all the interviews, the top candidate may be evident, or more than one top candidate may emerge. In the latter case, more interviews with the chosen candidates may be appropriate. If a candidate has gaps in employment, the physician should ask for more explanation during the interview. The applicant may have one of several reasons for not working, including education, maternity or medical leave, caring for dependent children or other family members, rehabilitation from drug or alcohol problems, or others. Employment lapses do not mean the candidate should not be hired; it only gives the physician more information with which to make a decision on the best fit for the practice. Background checks also will give more insight into the candidate's employment history.

Making the Offer

Once the practice decides on a candidate, the physician should extend that person an offer. The offer should be made conditional upon satisfactorily completing the employment process. Calling the candidate adds a personal touch, but the practice also should document the offer in writing and obtain the acceptance in writing, or by email, from the applicant.

Upon mutual agreement on salary, start date, and job conditions, the practice should send a written offer letter via mail or email with a time frame for acceptance stated. The letter should identify the monthly or hourly compensation, the start date, the job title, and any job requirements such as dress code/uniforms. The offer should be dated, on practice letterhead, and signed by the physician owner. After acceptance by the candidate, the practice should perform reference and background checks.

Professional References

Candidates should supply at least three business references. Practices may also request references from colleagues who shared a nonsupervisory relationship with candidates. These individuals can share a wealth of information about work habits, personality, and expertise in the field. The candidate's current employer should not be contacted in any manner until the candidate has completed the employment process and given notice of resignation.

Background Checks

Performing background checks on potential employees is essential to ensuring a quality candidate. To follow federal and state hiring guidelines, the check should be performed after the candidate has received an offer conditional on passing the background check. The practice will ask the candidate to sign a release and provide additional information if needed. The candidate can be asked for prior addresses, other names used for work history, Social Security number, driver's license number, a photo ID, and birth date to verify identity. Employee screening companies can perform the following individual background checks:

12. TMA members can request a copy from TMA Practice Consulting at practice.consulting@texmed.org, or (800) 523-8776.

- ▶ Statewide criminal background search – a search of the official state repository for crimes that may include felony, misdemeanor, and traffic offenses for the past seven years;
- ▶ National criminal offender profile summary – a nationwide search of state and county criminal record databases that may cover 10 to 15 years;
- ▶ County criminal search – a criminal records search in any U.S. county and some Canadian provinces of felony and misdemeanor offenses for the past seven years;
- ▶ Government health care program eligibility – for practices that intend to accept patients enrolled in Medicare, Medicaid, or other government health programs, a check in the U.S. Health and Human Services Office of Inspector General [searchable database](#) of individuals excluded from participating in or working for a physician who seeks payment from any of these programs (this check should be repeated periodically for existing employees);
- ▶ Social Security validation – a background check that validates a Social Security number; provides information on past addresses and movement patterns; and verifies the candidate’s full name, date of birth, and phone numbers;
- ▶ Credit checks – a check of credit history to determine the credit rating and financial standing of the candidate for positions that require bonding or insurance for handling office funds;
- ▶ Education and employment verification – a service that verifies the highest educational level attained by the candidate and information regarding employment history; and
- ▶ Motor vehicle report – a report of motor vehicle violations, suspensions, and revocations as well as the type of driver’s license the candidate holds and any restrictions on its use if the employee will be driving for the practice. Note that in some Texas counties, convictions for driving under the influence of alcohol and drugs may not appear in county criminal records but will appear on this report (if applicable).

NOTE: Check for local “ban-the-box” ordinances that limit when an employer may permissibly ask about an individual’s criminal history during the interview process.

Orientation and Training

New employee orientation helps ensure the working relationship starts out “on the right foot.” Welcoming new staff members and allocating time to orient the employee to existing staff will help build the patient care team. Most employees report they learned on the job from other employees, and there are rarely any written instructions.

Training and orienting staff from a start-up checklist will ensure that each employee has the same understanding of the physician’s expectations and performs consistently. Providing training and encouraging staff participation in workshops and seminars is an excellent staff development and retention technique that benefits both the staff member and the practice.

Initiative in this area should be included as performance criteria for consideration when evaluating employees for potential merit raises and/or advancement.

Performance Appraisals

Performance appraisals will be one of the main tools for making salary and promotion decisions in the practice. They also help improve employee performance and morale, identify training and development needs, promote better communication between supervisors and staff, and reduce absenteeism and turnover. Typically, new hires receive an appraisal after the initial 90 days of employment and annually thereafter. A well-designed appraisal system can provide solid documentation of performance, accomplishments, or problems that the physician and practice can use to justify a wide range of personnel actions or decisions.

CHAPTER NINE

POLICIES AND PROCEDURES

Developing personnel policies and office procedures for the practice will help streamline operations and improve efficiency. The policies and procedures manual can serve as a training and orientation guide, an ongoing reference and training resource for staff, and a risk management tool. It is important to keep the manual current and share it with new staff members at orientation.

The policies and procedures manual should include job descriptions for each position in the practice as well as detailed procedures for all job functions. Along with general processes for office procedures, it should include scripts for appointment scheduling, scheduling protocols, instructions for balancing the day's receipts, and clinical triage and drug management processes. The policy manual should include examples of the office confidentiality statement and an internet security policy. Having these will help ensure employees ask the right questions and give correct information when taking telephone appointments, following up on lab tests, refilling prescriptions, and managing cash.

Key elements of a policies and procedures manual are:

- ▶ Human resources – dress code, vacation and holidays, hiring, payday and record keeping, performance evaluations, and job descriptions;
- ▶ Front desk – scheduling and telephone protocols;
- ▶ Business office – billing and collections, payment plan requirements, and claim forms;
- ▶ Management responsibilities – facility maintenance, accounts payable and receivable, and supply inventory control;
- ▶ Clinical – education distribution, patient consent and education, and protocols and standing orders;
- ▶ Medical records – retention, release, maintenance, and security;
- ▶ Safety – exposure control, personal protective equipment, patient/staff injuries, and emergency evacuation plan;
- ▶ Compliance – patient rights and responsibilities, safety, and compliance officer;
- ▶ Health Insurance Portability and Accountability Act (HIPAA) and corresponding state law – patient privacy and security training, confidentiality, business associate agreements, documentation of training, and privacy officer (note that Texas laws are more restrictive than HIPAA); and
- ▶ Anti-discrimination, anti-harassment, and anti-retaliation policies.

The manual also should include a fraud and abuse compliance plan. Medicaid, Medicare, and Medicare Advantage-contracted physicians' practices are required to have compliance plans. In addition, the manual should contain Occupational Safety and Health Administration (OSHA) and HIPAA policies and procedures. Written processes help eliminate the “word of mouth” training that often perpetuates an incorrect way of doing things.

A customizable policies and procedures manual is available from TMA and other professional organizations. Purchasing a manual specific to Texas that addresses more than just human resources policies is the best option to meet the practice needs and reduce risk.

TMA's *Policies and Procedures: A Guide for Medical Practices* is available through the TMA Education Center at www.texmed.org/Education or the TMA Knowledge Center at (800) 880-7955. Also available is *Fraud and Abuse Prevention Simplified*, by Amanda B. Hill, JD. This TMA book looks in depth at fraud and abuse and how to comply with the applicable laws.

Acknowledgment

All employees should review the manual at orientation and sign an acknowledgment statement indicating they read, understood, and agreed to the office policies and procedures. Providing access to this manual through a shared office document allows employees to review the information as needed during their employment and makes it is easy to update as needed. When any changes to policies and procedures are made, employees should be notified and asked to review and acknowledge the changes.

When employees acknowledge and review the policies and procedures annually, they serve as a performance standard and a reference if corrective action or disciplinary steps are required. It is imperative that the practice actually implement and enforce all policies and procedures consistently.

Annual Training

Annual policies and procedures review and training will reduce the chance of inappropriate actions by employees and hold staff accountable for behavior that does not meet practice guidelines. HIPAA and OSHA training is required as part of routine staff education. In practices contracted with Medicaid, Medicare, or Medicare Advantage plans, annual compliance training also is required.

CHAPTER TEN

HIPAA

Privacy Standards

The HIPAA Privacy Rule provides legal protections for personal health information held by covered entities and gives patients a collection of rights with respect to that information. Every medical practice, regardless of size, that transmits health information electronically is considered a covered entity. Using electronic technology, such as email or faxes, does not mean a practice is a covered entity; the transmission must be in connection with a standard transaction. These transactions include but are not limited to claims, benefit eligibility inquiries, and referral authorization requests.

The HIPAA Privacy Rule, along with the Texas Medical Privacy Act, covers practices that electronically transmit transactions directly or use a billing service. HIPAA also imposes a number of duties regarding the use and disclosure of patient information, including:

- ▶ Adopting appropriate physical, technical, and administrative safeguards to protect health information;
- ▶ Having written confidentiality policies for the practice to follow;
- ▶ Designating a physician or staff member in the practice to be accountable for implementing and enforcing those policies;
- ▶ Posting a notice of those policies in a public area where patients can read them;
- ▶ Training employees within 90 days of employment and within one year of the duties of an employee becoming affected by a material change in state or federal law concerning protected health information, documented with a signed attendance statement; and
- ▶ Making a good-faith attempt to get patients' acknowledgment they have received the notice of privacy practices.

For more information, go to the [U.S. Department of Health and Human Services Office for Civil Rights website](#). In addition, TMA's publication, *Managing Your Medical Records*, gives an in-depth look at patients' rights and protections regarding their protected health information and medical records. It is available through the TMA Education Center at www.texmed.org/Education or the TMA Knowledge Center at (800) 880-7955.

Transactions Standards

HIPAA regulations cover a large range of topics. First among the act's purposes is an assurance for Americans that their insurance will be "portable." A person may change employers without fear that the new employer's health plan will not contain exclusions for preexisting conditions.

HIPAA also contains penalties for embezzling funds meant for health care, strengthens federal fraud and abuse laws, and introduces administrative simplification. The latter is the federal government's effort to eliminate the hundreds of variations of electronic claim forms required by insurers and health maintenance organizations. The government has replaced differing formats with a single standard electronic claim form that the U.S. Department of Health and Human Services adopted for financial transactions related to health care delivery. The regulations require physicians to submit transactions in the federally mandated standard format or be subject to sanctions.

Of course, most of this is invisible to the physician who relies upon vendors to ensure that claims sent to carriers are in the standard format. Most physicians send claims either through a clearinghouse or through software purchased from a vendor who, according to contract, will send HIPAA-compliant claims on the physician's behalf.

Security Standards

HIPAA security standards are a subset of the HIPAA privacy standards. These regulations lay out the physical, technical, and administrative safeguards a practice should have in place to protect the confidentiality of medical information it transmits or stores electronically. While the privacy standards apply to all medical information, the security standards apply only to electronic medical information. Within the U.S. Department of Health and Human Services, the Office for Civil Rights has the responsibility for enforcing the Privacy and Security rules through voluntary compliance activities and civil monetary penalties.

A major goal of the Security Rule is to protect the privacy of patients while allowing physicians and health care providers to adopt new technologies to improve the quality and efficiency of patient care. The Security Rule is designed to be flexible and scalable so that physicians can implement policies, procedures, and technologies appropriate for the practice's size and structure. Rather than lay out exact actions physicians must take in regard to electronic privacy, the regulations require physicians to engage in a risk assessment of their practice. Based on the risks identified, the physician must act as their judgment dictates. The regulations focus more on this assessment than actual methods of protecting information.

Access and Administrative Requirements

The Texas Medical Privacy Act has stricter requirements than HIPAA or the subsequent federal Health Information Technology for Economic and Clinical Health (HITECH) Act regarding patient access to records. The technical security service requirements specify enhanced unique user identification, emergency access procedures, automatic log-off, encryption and decryption, audit controls, and authentication. Physicians are advised to review available materials and verify compliance with current administrative requirements. Vendors and affiliated partners also must comply.

The requirements include evaluation of and policies for:

- ▶ Security management – risk analysis and management, sanction policy, information system activity review, and assigned security responsibility;
- ▶ Workforce security – authorization and supervision, workforce clearance, and termination procedures;

- ▶ Information access management – isolating clearinghouse functions, and access authorization;
- ▶ Security awareness and training – security reminders, protection from malicious software, log-in monitoring, and password management; and
- ▶ Security incident and contingency plan – response and reporting, data backup plan, disaster recovery plan, testing and revision procedure, and applications analysis.

Business Associate Agreement

Physicians as covered entities are required to have business associate agreements (BAAs) in place to contractually bind associates to HIPAA requirements. Examples of business associates include clearinghouses for claims transmittal, billing companies, independent transcriptionists, and collection agencies. BAAs also will include a CPA firm if accounting services involve access to protected health information, an attorney whose legal services involve access to protected health information, or a consultant who performs utilization reviews. Under the HITECH Act, business associates are directly subject to HIPAA privacy rules as well, and they are subject to the same disclosure requirements and civil and criminal penalties as covered entities. Penalties apply for breaches of unsecured protected health information.

CHAPTER ELEVEN

THIRD-PARTY PAYER CONTRACTS AND CREDENTIALING

Participation in third-party payer contracts requires credentialing, a process that includes verifying the physician's education, licensure status, medical professional liability insurance status (including the physician's claims history), and hospital privileges. Credentials usually will be renewed biannually to make updates and verify that all licenses and registrations are current. Initial credentialing typically takes 180 days to a year.

Types of Payers

Third-party payers contract with physicians to provide health services under an arranged fee schedule for a defined patient population. Physician and provider contract types include the following:

- ▶ HMOs offer comprehensive health coverage for both hospital and physician services. They may contract for either capitated or fee-for-service payments. Typically, HMO patients have restricted access to out-of-network services. To manage the cost of care, HMOs usually require primary care physicians to act as gatekeepers of medically necessary care. Patient visits to specialists often require a referral from the primary care or treating physician. Physicians paid under capitated arrangements may receive a set amount per member per month for managing the care of a member. Patients will pay a copayment for most services.
- ▶ PPOs are created by purchasers of care (e.g., employers, insurance companies) and physicians and providers who offer patients incentives such as lower deductibles and copays to use in-network providers. Physician payment is usually in the form of a fee-for-service agreement and also may have restrictive utilization review guidelines. Patients who wish to access physicians outside the network usually may do so at a higher out-of-pocket expense or be subject to higher deductibles. Patients will pay a copay for most services and may have a deductible.
- ▶ Medicare and Medicaid have traditional delivery systems and Medicare Advantage Plans in some areas. Physician and provider information for traditional fee-for-service Medicare and Medicaid programs is public information on the [CMS website](#). Medicare and Medicaid plans contracted through Medicare Advantage plans require additional contracts, and the physician/provider enrollment and credentialing guidelines may differ.
- ▶ More recent contracting vehicles include groups such as independent practice associations (IPAs), physician hospital organizations (PHOs), accountable care organization (ACOs), and other clinically integrated networks, some of which are aggregated by technology vendors or private equity firms. Plans are evolving to include value-based payment models that are linked more closely to quality outcomes, patient satisfaction, better care coordination, and cost reduction.

Physicians should pay careful attention not only to the fees third-party payers offer but also to the administrative time and staffing needed to meet guidelines, additional risks, and workflow changes the practice will incur as a result of contracting choices. A competent health care attorney can provide insight into the legal language of the contract and help define the risks of participation. Once the concerns are defined, they can become points upon which to negotiate. If the physician chooses to accept an insurance plan with which the practice is not contracted as a way to rapidly build a patient base, the practice should establish policies that address out-of-network issues. Further, some value-based care contracts mandate that a physician practice accept new patients from a particular payer to participate in the program. Others mandate that the physician must participate in all contracts offered by the IPA, PHO, or ACO or risk expulsion from the contract.

Essential Elements for Credentialing

After obtaining a medical license, a physician needs to acquire a few basics to begin the credentialing process: address, phone number, fax number, National Provider Identifier (NPI), and medical professional liability coverage. The physician can obtain phone and fax numbers through a telebranch and an office address through a letter of intent to occupy at a future date prior to moving into a new office. He or she also can obtain medical professional liability coverage with an effective date in the future. Residents must have a certificate of completion from their program before applying for an NPI.

What Is an NPI?

The National Provider Identifier is the standard unique identifier for physicians and health care providers adopted by the U.S. Health and Human Services secretary in accordance with HIPAA. Any physician or health care provider (individual or organization) who sends electronic health care claims to a health plan(s) is a covered entity and must obtain an NPI. Those who are not covered entities may elect to apply for an NPI but are not required to do so. The NPI follows the physician from one practice location to another throughout his or her career, and the NPI is public information.

A sole proprietor/sole proprietorship is an individual, not an organization, and thus eligible for a single NPI. The sole proprietor must apply for the NPI using his or her own Social Security number, not an employer identification number even if the proprietor has one. As an individual, a sole proprietor/sole proprietorship cannot be a subpart and cannot designate subparts.

Sole proprietors can [apply for an NPI](#) online. For assistance, contact the NPI enumerator at (800) 465-3203.

For the latest information regarding NPIs, visit the [CMS website](#).

CHAPTER TWELVE

FINANCIAL MANAGEMENT

Financing is among the top business concerns in the practice beginning with the start-up and continuing as the practice operates, expands, and possibly recruits new partners or changes locations. From the beginning, the physician should be prepared to play an active role in the financial management of the practice and to stand behind the practice's established policies. Financial policies should address monthly and yearly reports, inventory control, billing and collections, payroll oversight, and embezzlement prevention.

Using Money Wisely

Bidding out purchases, vendors, and services can save substantial money even in the early phases of the practice start-up. The cost of supplies needed to open an office can be a surprise, and it makes sense to arrange for a discount on any initial order and ongoing consumables. In addition, practices can save money by doing the following:

- ▶ Using an outside printer rather than the laser printer: Toner ink is too expensive to make large quantities of standard forms such as new patient paperwork or patient education handouts for exercises, advice, or presurgery instructions. It is cheaper to distribute this information via a secure patient portal. If you must print, email the master to a printer or a copy service. Papers can be collated, stapled, and predrilled if needed at a much lower cost than paper, toner, and manpower in the practice. Forms can be printed on two sides to save money and space.
- ▶ Eliminating paper forms: By using secure patient portals and on-site kiosks or tablets, practices can avoid using paper for most patient forms. Personnel and other business forms also can be electronic. If you need to create a paper form, look online for samples, and check out tools and forms TMA or medical specialty societies may offer for members.
- ▶ Finding free prescription pads: Physicians who still use paper prescription pads and don't object to looking at ads can get them free from several vendors who want to advertise their products between the blank script pads.
- ▶ Shopping for competitive rates: No matter what the service or product, it does not hurt to ask if a better rate is available. For credit card fees, merchant services, monthly bank fees, electronic transactions, overnight courier service, phone service, medical professional liability insurance, and temporary staffing, rates are competitive. Physicians should ask for discounts for cash or early payments. Asking the question "Is this your best deal?" often can result in discounts that would not have been offered if not asked.
- ▶ Using independent contractors or temporary staff: If the practice needs short-term assistance, using independent contractors or temporary agency staff with good references for records management, scanning charts into an electronic health record, and other short-term staffing is a good option. The contractors are responsible for paying their own taxes and benefits.

- ▶ Monitoring billing company performance: Most billing companies charge a percentage of collections for their fee. A practice may be able to negotiate a lower rate if the office performs more of the billing steps. If the vendor is not meeting benchmarks, the physician and manager should meet monthly with the billing company until the performance improves or a vendor change is warranted.

Reports

Good business planning requires ongoing, overall financial evaluation of the practice, including regular audits of key financial reports. At a minimum, the practice should generate and review the following reports on a monthly and annual basis:

- ▶ Accounts receivable aging for patient and insurance accounts;
- ▶ Procedure frequency analysis;
- ▶ Charges, payments, and adjustments summary;
- ▶ Collections analysis;
- ▶ Unpaid insurance claims; and
- ▶ Credit balances and write-offs.

The practice should pay careful attention to the following areas:

- ▶ Production: Monitor individual physician production for overall consistency. Once the practice is full, productivity should not vary greatly from month to month unless a physician has been out of the practice for an extended period such as vacation. A drop in production may signal failure to bill on a timely basis or a decline in patient or service volume.
- ▶ Charges, adjustments, write-offs: The practice should track charges, payments, contractual adjustments, and bad debt write-offs. The components should be compared from year to year to identify any significant changes. Careful attention should be paid to any increases in contractual adjustments, which may indicate a shift in payer mix. Should this occur, the practice may need to develop a strategy to shift to a more profitable payer mix. Computer programs are available to help track payments and to monitor contract compliance.
- ▶ Amount of payments or medical revenue: A drop in payments from one year to the next could indicate a change in payment patterns, such as a decrease in office visits, delayed payments, increased payer adjustments, or a problem with billing and collections.
- ▶ Rate of collections: Review the collection percentages to determine whether these are reasonable. Dividing the payments by the practice gross charges will give the collection ratio. By tracking this data for a year-to-year comparison, the physician can investigate the cause of any significant changes.
- ▶ Contractual adjustments: Review contractual adjustments by payer to determine whether any particular payer makes up the majority of practice revenues. Heavy reliance on a particular payer could put the practice at financial risk if the plan were to pull out of the market or terminate the contract with the practice. To decrease the contractual adjustments, the practice will need to renegotiate plan contracts and/or shift the practice payer mix. Accepting fewer patients from a particular carrier or terminating the contract for carriers whose adjustments are higher in comparison with other contracts will shift the patient mix over time.

- ▶ Accounts receivable: The physician and manager should track accounts with balances older than 90 days and compare the total outstanding amount or percentage for the same period in a previous year. The practice should watch for gradual increases in accounts receivable aging (bracket creep), which could signify a problem with collection procedures.
- ▶ Fee schedule: The practice should conduct a regular spot audit of the practice fee schedule against HMO and PPO explanations of benefits. Staff can load the practice's contract amounts into the practice management system, which will alert them any time the the practice receives a payment that doesn't match the contracted rate. If the billed charge is equal to or lower than the amount received from the payer, this could indicate that the practice's fee schedule for this particular code warrants adjustment.

Billing and Collections

The goal of any medical practice is to provide quality care to patients; however, the practice of medicine is also a business that involves billing and collecting money for medical services. Establishing and enforcing billing and collections policies that are equitable for all patients is critical to financial success.

The practice financial policies and procedures should include:

- ▶ Data collection accuracy: Well-designed forms and templates make gathering financial data easier. At times, the accuracy of the data depends on the skill of the staff member entering the information into the practice management system; the manager should conduct spot audits to check the accuracy of data input. Many practice management systems track each staff member's activity. This feature also can serve as a training tool and a measure for performance evaluations.
- ▶ Benefit verification: It is recommended that a practice verify benefits and eligibility for all patients prior to each patient's appointment. A valid referral is no guarantee the patient is eligible at the time services are delivered. Verification of benefits should help the office determine the patient's financial responsibility for copays, deductibles, and coinsurance and allow for financial counseling and collection at the time of service. Most software programs can perform automated verification of benefits and eligibility from the appointment schedule without staff intervention or calls.
- ▶ Claims filing: Many practices use vendors such as Availity, Gateway EDI, Waystar, Change Healthcare, or NaviNet to file their claims electronically so claims are processed daily and payments generated more rapidly. Inaccurate data input can cause claims to be rejected or returned for further information. Claim scrubbing software increases the acceptance rate and can correct errors detected on transmission to the payer.
- ▶ Account follow-up: Maintaining and reviewing a detailed accounts receivable aging report is an essential part of revenue cycle management. A systematic approach, based on age and dollar amount criteria, includes following up on unpaid claims and outstanding patient balances. A chronic problem for many practices is a carrier saying it has no record of the claim. By starting inquiries at 14-30 days after submission, the practice will find out as soon as possible whether the carrier received the electronic claim and entered it into the system for adjudication and payment review. If not received, the practice can refile or correct claims quickly enough to meet filing deadlines. The sooner staff start follow-up, the more quickly the claims will be paid. The goal should be to obtain carrier payment within 30 to 45 days. If checking all carriers with

unpaid claims at 30 days is not feasible, then staff should set specific dollar amount criteria and pursue these carriers first. Payers such as Medicare and Medicaid often process and pay electronic claims within 14 days.

- ▶ Patient collections: Implementing a patient collection procedure will help ensure more payment collection at the time of service. Collecting patient-due portions for self-pay, copays, coinsurance, noncovered services, and remaining deductible should be standard procedure for each patient at the time of the visit and prior to any nonemergency procedure, surgery, or delivery. Assigned staff should handle past-due accounts on a monthly basis, using a combination of telephone calls and collection letters. The practice should keep a record, in either a manual log or documented in the practice management system, of all patient contacts and responses, with the status of the account and when a payment can be expected. Accounts that cannot be collected in house can be turned over to an outside collection agency and/or written off. Accounts are commonly turned over to collections when they exceed 90 days and the practice is unable to reach an agreement for payment terms.

Internal or Outsourced Billing

The decision to perform billing and collections with internal staff or outsource to a vendor can depend on many variables. Although the practice may have better data and improved performance and collections with in-house staff dedicated to the practice, it may not be able to find or justify a full-time employee dedicated to billing.

It is natural to be reluctant to perform billing and collections in house when the physician is unfamiliar with billing. Cash flow delays, expenses, and increased administrative burdens are reasonable concerns in low-profit-margin practices. Lack of knowledge and experience combined with the difficulty in understanding the total revenue cycle can increase the fear of failure and the potential for internal errors. Using an outside vendor may be more practical if the availability of qualified personnel and technology is limited locally. However, there is no guarantee that collections will increase using outsourced billing.

When deciding whether to hire internal billing staff instead of an outside vendor, the physician might consider the following opportunities with internal billing. The practice can:

- ▶ Develop and use efficient charge capture tools (forms, devices, tablets, laptops);
- ▶ Dedicate appropriate staff levels to maximize workflow and revenue cycle efficiency;
- ▶ Educate dedicated staff on specialty-specific coding requirements;
- ▶ Integrate new technologies and codes easily;
- ▶ Identify problems earlier in the billing process;
- ▶ Improve information, demographics, and documentation of services;
- ▶ Provide immediate feedback on the payment status for new codes; and
- ▶ Increase the manager's role in preserving and growing profits.

With the increased oversight for billing and collections, the practice might be able to:

- ▶ Increase collections for time-of-service and patient-due balances (the receptionist can be rewarded for achieving collection targets);
- ▶ Manage denials and appeals by investigating delayed payments and challenging underpayments;

- ▶ Use a flexible monthly billing schedule for statements (called “cycle billing”) to improve cash flow and minimize call volume;
- ▶ Prioritize account follow-up by dollar value and aging;
- ▶ Generate custom reports to investigate payments and denials by CPT code by plan; and
- ▶ Review adjustment reports for trends and patterns.

Internal billing does increase the workload for some staff and the physicians. There will be more staff to manage, insure, pay, and schedule, and the long-term cost of turnover and continuing education will be difficult to predict. Billing company contracts can be written with clauses to minimize the impact on the practice of vendor staff turnover, training, and education.

If the disadvantages of internal billing seem too great or the availability of seasoned billing staff is limited, it will be essential to develop performance requirements for an outside company.

The following standards should be expected of billing staff, whether in-house or outsourced:

- ▶ Claims submitted daily;
- ▶ Statements generated weekly;
- ▶ Payments posted within 24-48 hours;
- ▶ Denials reviewed and resolved within two working days;
- ▶ Delinquent patient balances followed up on after 45 days;
- ▶ Delinquent insurance balances followed up on after 30-45 days;
- ▶ Customer inquiries addressed within the same working day; and
- ▶ Reports generated by the first working day after the period close.

Degradation of services can occur over time with internal or external billing. The practice must set criteria to maintain a maximum level of payment, make sound business decisions, justify staffing, and demonstrate value to the practice.

Embezzlement

Effective use of cash is essential to the operation of any practice. Internal controls can promote efficiency and reduce the risk of errors and fraudulent activities. Professionals, whether they be physicians, dentists, or attorneys, are focused on their professional responsibilities to their patients and clients and therefore can be easy targets for embezzlement. Policies for the following areas can help:

- ▶ Cash transactions: No one employee should have complete control over the entire sequence of cash transactions. Standard procedure should be to separate between employees the data entry of charges and of payments, or use automated payment posting and have another staff member make the bank deposit.
- ▶ Account access: Only key employees should have access to cash and bank accounts. The practice software can be set up for audit trails to monitor write-offs and adjustments.
- ▶ All financial transactions: These should be segregated so that employees who keep practice accounting records do not handle receipts or perform cash disbursements. If this division of labor is impractical, the physician can arrange for a review of all work at least quarterly by an outside accountant or bookkeeper.

- ▶ Bonding: The physician should consider requiring that business office employees be bonded under the practice business insurance.
- ▶ Outside audits: Hiring an outside accounting agency or consultant to perform periodic financial audits can help ensure the integrity of financial transactions.
- ▶ Signatures: Staff should not be allowed to sign checks on behalf of the practice or use signature stamps. Electronic funds transactions help minimize the number of live checks issued in the practice.
- ▶ Salaries: Only the physician partners should approve salary increases, and replacement or extra salary checks, or approve the addition of new personnel or system administrators to the payroll system.

Other Forms of Employee Theft

The practice has many noncash assets and resources that may be vulnerable to employee theft, such as postage, office and medical supplies, medications, and time. Good internal controls can prevent abuse of overtime, personal time used while on the clock, and fraudulent billing practices. Some abusive practices may seem inconsequential, but they are still theft, such as personal use of credit card reward points or frequent flyer miles. Employees may use the company credit card for all purchases and payments possible so they can gain the rewards, but rebates and rewards belong to the practice.

Identity theft has become a major issue across the board. Few businesses gather as much personal information as medical practices, so it is particularly important to protect patient information. Social Security numbers are no longer necessary for filing insurance or collections, so be sure to remove them from patient forms. Ensure that electronic systems provide sufficient safeguards to protect information stored, but above all, do your due diligence when hiring and exercise strong internal controls. Always run background checks for new employees, and listen to your instincts and take action if suspicious activity is discovered.

CHAPTER THIRTEEN

CODING AND DOCUMENTATION

Coding is the physician's responsibility. The government and other payers hold the physician accountable for incorrect, noncompliant coding. While a staff member may help with coding, the physician must review the codes for accuracy prior to submitting them for billing.

Because of the fear of overcoding, undercoding is prevalent. Undercoding means lost revenue that is rightfully due to the practice. Learning to code to the correct level offers a significant opportunity for revenue enhancement for many practices. The American Medical Association has reported that physicians on average lose 10% to 30% of potential revenue by incorrectly coding the services provided. This equates to \$25,000-\$75,000 for a physician earning \$250,000 annually.

An annual audit of a physician's coding and documentation is recommended to ensure accuracy and appropriateness based on the most current evaluation and coding guidelines adopted by the Centers for Medicare & Medicaid Services. Practice management consultants can perform coding and documentation reviews and provide recommendations for improvement as well as train the practice staff to conduct internal audits on a regular basis.

According to the [CMS 2022 Evaluation and Management Services Guide](#), the following are general principles of medical record documentation:

- ▶ The medical record should be complete and legible.
- ▶ The documentation of each patient encounter should include a reason for the encounter and relevant history, physical examination findings, prior diagnostic test results, assessment, clinical impression or diagnosis, plan for care, and date and legible identity of the observer.
- ▶ If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- ▶ Past and present diagnoses should be accessible to the treating and/or consulting physician.
- ▶ Appropriate health risk factors should be identified.
- ▶ The patient's progress and response to treatment, changes in treatment, and any revision of diagnosis should be documented.
- ▶ The CPT and diagnosis codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

What May Trigger an Audit?

- ▶ Within a group setting, inconsistent coding patterns among partners.
- ▶ Excessive use of one code.
- ▶ Coding level 5 services instead of preventive medicine codes for annual physicals.
- ▶ Upcoding on stable chronic conditions.
- ▶ Cloned documentation when using an electronic medical record.
- ▶ Missing physician signatures for lab and test requests and results ordered by a physician assistant, nurse practitioner, or physician.
- ▶ Using words such as “maybe,” “perhaps,” “probably,” or “rule out” in the medical record instead of recording signs and symptoms.
- ▶ Using symbols or shorthand without referencing a standardized list. The practice should have a list stored in its policies and procedures manual or software library of what the symbols or shorthand means in the practice. Negative symbols without elaboration are not considered sufficient documentation.
- ▶ Lack of specificity about what is being reviewed. Stating the review of systems is “unremarkable” is insufficient to support that a review was completed.

Coding Resources

Specialty-specific coding assistance is available from TMA and specialty professional societies. Software and coding tools and training can be helpful in submitting claims in the correct format, and reviewing payer denials for potential appeal. Because codes are added, deleted, and amended quarterly, practices should budget for training and annual coding books or online subscriptions to ensure they are using the most up-to-date resources available. Attending annual training on Medicare updates in the fall will help staff and physicians anticipate major changes in coding for the following year.

CHAPTER FOURTEEN

MARKETING

Successful marketing plans are long-term investments supported by a sufficient budget and a commitment to continue the plan, even though results may not be immediate. To market effectively to the target population, the physician must understand its characteristics. Area hospitals, real estate agents, and the local chamber of commerce may be able to provide demographic information about the area's population and employment trends, including changes that have occurred over the past few years. In addition, recognizing the practice's competition and identifying the physician and patient referral base are key to developing effective marketing messages.

It is also helpful to know which insurance companies have the largest market share in the area. Determining the insurer for the school system, the hospitals, and the major area employers will be useful when evaluating and negotiating health plan payer contracts. Offering to be a speaker for social and church groups, employers, and schools may be a way to introduce the physician to new patients and the community.

Marketing the practice begins the minute a patient calls the office, hears about the physician, views the practice website, reads an online review, or walks in the door. The office decor and signage, the behavior of the staff and the physician, and the policies of the practice must create a friendly and professional impression on patients and referring physicians – the first time and every time they interact with the practice.

Practice Websites

Websites are essential marketing and patient education tools for medical practices. The practice site can include the basic office policies, information about the physician and staff, the care philosophy, patient education material prepared by medical specialty societies, the latest medical news, and a secure system by which the office can communicate with patients over the internet. Patient portals can be set up to communicate lab results, send appointment requests and confirmations, remind patients of appointments, provide visit summaries, follow up on abnormal and maintenance procedures, and provide online payment options.

Information should include the office hours, phone number, address with map, availability and types of appointments, after-hours instructions, billing and payment options, insurance plans, referral policies, and how to obtain medical records and prescription refills. Short biographies with pictures of the physician and staff can help patients recognize and become familiar with them before they arrive for the first appointment. New patient forms can be downloaded prior to the visit or completed online.

Brochures

Patient brochures are another excellent way of communicating basic office policies and other information to patients. Handouts about special procedures, nonphysician practitioners, and immunization recommendations can provide patients take-home information for later consideration. They also can reduce the time needed to repeat patient information in the office. Brochures about specific health subjects can become a routine part of patient education as well as the marketing strategy.

Medical Staff Networking

Local physicians who will be referral sources and hospital medical staff where the physician has privileges should be told the practice is accepting patients. Announcements should provide the physician's name, specialty, practice address, and phone number. This will start word-of-mouth advertising that will help the practice grow. To develop an ongoing relationship with other physicians in the area, the physician can send thank-you notes for referrals, send holiday cards, and make donations to charitable and community events on behalf of the referring physicians. Providing consultation reports for referred patients within 24 hours of their visit will help ensure repeat referrals.

Prior to the opening of the office and during the first few weeks when the appointment schedule is not full, it would be helpful to make brief introductory visits to potential referring physicians' offices. Leaving behind information such as practice business cards and maps for referred patients will make it easier for the other physician to refer patients to the new practice. The chance of the referral increases when the new physician also brings his or her office manager or receptionist to meet the referring physician and staff. Giving the new office's private number to the referring office will encourage the referring staff to share patient information and speed up the referral process for both offices.

Attending local presentations on clinical topics other than the physician's own specialty will provide an opportunity to meet different specialists. Attending social events and meetings of the county medical society and mingling at the hospital physician dining room are other ways to meet local physicians.

Patient Satisfaction Survey

Patients given an opportunity to share their views about the practice through patient satisfaction surveys often feel a stronger commitment in the patient-physician relationship. By asking for and receiving patient input about the practice, the practice can establish a "we care what you think" relationship. Measuring patient satisfaction and meeting patient expectations are part of the new quality requirements for future value-based payments. Patients are more likely to recommend the practice to others who are looking for a similar type of relationship with a physician. Responding quickly to any patient complaints is also critical to repairing a damaged relationship and often will lead to a stronger bond when handled appropriately.

Open Houses

When a physician opens in a new location, an open house can draw in potential patients and referring physicians. It can be used to educate the surrounding community or neighborhood on a particular topic or procedure and introduce the physician to patients who might benefit from knowing this physician. If the practice has invested in state-of-the-art equipment or the facility, local residents, retail owners, and people who drive by daily on the way to work may be curious and want to see it.

The success will depend on attracting as many people as possible. The practice can promote the open house by invitation postcards, posters, emails, the practice website, and ads in the local newspaper and neighborhood newsletter. If the physician has existing patients, he or she can send postcards to them, as well as to any nearby medical practices a few weeks before the event. Staff can make a follow-up phone call to key attendees. Electronic invitations to “save the date” with follow-up reminders sent a day or two ahead of the event can be effective. A typical response is about 25% to 30% of the invited list. A banner or sign on the practice front will spread the word in another format.

Once the office has been open a few weeks and all the furniture, equipment, decor, and staff are in place, the best days to host open houses are Tuesday, Wednesday, or Thursday. Late afternoon into evening (4-8 pm) is the best time of day because patients and staff are available to attend before they head home for the evening. All of the office staff including the physicians should attend the open house and be prepared to introduce themselves, give tours of the office, and introduce guests to the physicians.

Social Media

Some physicians see benefit to getting their name or their practice on as many platforms as possible. Twitter, Facebook, and Instagram can serve as an extension of their website presence and as effective marketing tools. Besides the cautions for privacy issues associated with public forum posting, Twitter’s 280-character format limits communication. The potential for negative publicity and reviews is also a major concern for some physicians.

When using social media, it is important to keep the content fresh and current; outdated information can reverse the positive aspects of the posting.

The responsibility for responding to and daily monitoring media sites should be assigned to a staff member to ensure prompt attention and feedback to the physician and the participants. In addition, clear, HIPAA-compliant guidelines and policies are essential for preparing content. Practices should remember that simply acknowledging publicly that someone is a patient breaches confidentiality and can violate HIPAA and state privacy laws.

CONCLUSION

Setting up a medical practice can be rewarding and challenging. Even in dynamic economic times, a physician can accomplish the complex process of starting a practice with hard work, research, and the advice of experts. By being informed, planning, governing smartly, and managing wisely, a physician can be successful in solo and group settings.

APPENDIX A

WEBSITES TO BOOKMARK

Professional Affiliations

- ▶ TMA Practice Consulting
- ▶ Texas Medical Board (licenses and registration)
- ▶ U.S. Drug Enforcement Administration, Diversion Control Program
- ▶ Texas Prescription Monitoring Program

Promoting Interoperability Programs

- ▶ Centers for Medicare & Medicaid Services
- ▶ Quality Payment Program

Personnel Management

- ▶ Civil Rights Act of 1964 (covers sexual harassment and religious discrimination)
- ▶ Americans With Disabilities Act
- ▶ Age Discrimination in Employment Act of 1967
- ▶ Equal Pay Act of 1963
- ▶ Occupational Health and Safety Administration
- ▶ Employee Retirement Income Security Act of 1974 (ERISA)
- ▶ Consolidated Omnibus Budget Reconciliation Act (COBRA)
- ▶ Family Medical Leave Act

HIPAA Privacy/Security Standards

- ▶ Texas Medical Association
- ▶ U.S. Department of Health and Human Services Office for Civil Rights

APPENDIX B

A REVIEW OF FEDERAL LAWS THAT AFFECT EMPLOYMENT PRACTICES

Name	Purpose
Title VII of the Civil Rights Act of 1964	Employers cannot discriminate on the basis of race, color, religion, sex (includes sexual orientation, gender identity, and transgender status), or national origin.
Americans With Disabilities Act	Employers cannot discriminate against qualified disabled individuals. Applies to employers with 15 or more employees.
Age Discrimination in Employment Act of 1967 as amended (ADEA)	Employers cannot discriminate on the basis of age against any individual 40 years of age or older. Applies to employers with 20 or more employees.
Sexual harassment under Title VII	Employers must promulgate a comprehensive policy to ensure that sexual harassment complaints are promptly and thoroughly investigated, complaints are held in confidence and disclosed only to those authorized, and no retaliation is permitted against employees filing bona fide complaints. Appropriate disciplinary action must be taken against the offender.
Religious discrimination provisions of Title VII and E.O. 11246	Prohibits religious discrimination. Employers must reasonably accommodate religious beliefs of their employees and ensure that employment decisions are made without regard to religion.
Equal Pay Act of 1963	Forbids compensation discrimination on the basis of an employee's sex.
Pregnancy Discrimination Act of 1978	Amendment to Title VI prohibits discrimination in all areas of employment on the basis of pregnant and pregnancy-related conditions. Employers must not discriminate against a qualified pregnant employee.
Uniformed Services Employment and Reemployment Rights Act	Prohibits discrimination against persons based on their service in any uniformed service.
U.S. Bankruptcy Code	Prohibits private employers from terminating employment or otherwise discriminating against any individual who is or has been a debtor or has filed bankruptcy.

APPENDIX B
A Review of Federal Laws That Affect Employment Practices

Name	Purpose
Consumer Credit Protection Act	Employers are prohibited from discharging an employee because his or her earnings have been subjected to garnishment for any one indebtedness.
Fair Credit Reporting Act	If an applicant is denied employment either in whole or partly based on information in a credit report, the report's user must advise the applicant and supply the name and address of the consumer reporting agency.
Drug Free Workplace Act of 1988	Employers must take specific steps to maintain a drug-free workplace. Applicable to all employers receiving federal grants and those entering into federal contracts of \$25,000 or more to be performed in the United States.
Occupational Safety and Health Act	Mandates strict record-keeping and reporting requirements regarding occupational injuries and illnesses.
Employee Polygraph Protection Act	With limited exceptions such as professions involved in national defense or security, the use of polygraphs (lie detectors) is prohibited for employment purposes.
Employment Retirement Income Security Act of 1974 (ERISA)	Governs all employee pension, health, and welfare benefit plans. Plan administrators must provide employees summaries of their benefit plans, updates of major changes, and reports on financing certain plans.
Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)	Employees and eligible dependents must receive a temporary extension of health insurance at group rates in certain cases in which coverage otherwise would end. Applies to employers with 20 or more employees.
Fair Labor Standards Act of 1938 (FLSA)	Establishes the minimum wage, maximum hours, and overtime pay provisions employers must provide for covered employees.
Immigration Reform and Control Act (IRCA)	Prohibits employment of aliens and nonimmigrants not legally authorized to work in the United States.
Jury System Improvement Act	Employers cannot discharge, threaten discharge, intimidate, or coerce an employee because of jury service.
Family and Medical Leave Act of 1993 (FMLA)	Employers must provide qualified employees leave of absence for the birth or adoption of a child, the care of a seriously ill family member, or an employee's own serious health condition. Applies to employers with 50 or more employees

APPENDIX C

GUIDELINE QUESTIONS TO ASK DURING AN INTERVIEW

Subject	Don't Ask	Do Ask
Name	Have you ever legally changed your name? What was your original name?	Do I need additional information about use of an assumed name or nickname to check previous employment?
Age	What is your date of birth? What is your age?	If hired, can you provide proof that you are 18 years of age?
Birthplace	Where were you born? Where were your parents born?	Will you be able to provide a birth certificate, resident alien card, or other proof of employment eligibility upon being hired?
Residence	Do you own or rent your residence? What are the names and relationships of persons residing with you?	What is your present address, and how long have you resided there? What is your former address, and how long did you reside there?
Race/Color	What is your race? What color is your hair, eyes, or skin?	None.
Religion	What is your religious affiliation? What church do you belong to? What's the name of your pastor, minister, or rabbi? What religious holidays do you observe?	None.
Sex	Are you male or female?	None.
Photographs	Submit a photograph with your application form or after the interview.	A photograph may be required after hire for an ID card or other identification purposes.
Education	List the dates you attended or graduated from high school or college.	List your academic, vocational, or professional education and the public and private schools attended.

APPENDIX C
Guideline Questions to Ask During an Interview

Subject	Don't Ask	Do Ask
Citizenship	Of what country are you a citizen? Are you or other members of your family naturalized citizens? If so, when did you or they become citizens? Do you intend to become a U.S. citizen?	Are you a citizen of the United States? If not, are you prevented from becoming legally employed because of visa or immigration status?
National origin	What is your lineage, ancestry, national origin, descent, parentage, or nationality? What is your native language? What are the nationalities of your parents/spouse?	What languages do you read, speak, or write fluently (only if another language is necessary to perform the job)?
Height/Weight	What is your height and weight?	None, unless employer proves that a bona fide occupational qualification is involved.
Arrests	Have you ever been arrested? Have you ever been charged with any crime?	Have you been convicted of any crime?
Family status	What is your marital status? What was your maiden name? How many children do you have? Are you pregnant or do you plan to have children? Do you have any day care provisions for your children?	None.
Military record	What type of military discharge did you receive? Were you ever disciplined while in the service?	Are you a veteran of the armed forces? If yes, what type of training or education did you receive while in the military?
Groups	List all organizations, clubs, societies, and lodges to which you belong.	List any professional, trade, or service organizations of which you are a member or have been a member.
References	What is the name of your pastor, minister, or rabbi?	Who referred you for a position here? List the names of persons willing to provide professional or character references for you.
Handicaps	Are you handicapped?	Are you capable of performing the necessary assignments of this position in a safe manner? [Define any special requirements, such as lifting 50 pounds or reaching 6 feet.]

APPENDIX D

PATIENT SATISFACTION SURVEY SAMPLE

We would appreciate your comments on your experiences in our center. When you have completed the survey, please mail it in the postage-paid envelope provided. Thank you!

General Information

1. What time of day did you visit our center? Morning Afternoon Evening
2. Do we participate in your insurance? Yes No
3. Was this the first time you were a patient at our center? Yes No
4. Do you consider this practice's physician to be your regular doctor? Yes No
5. Did you have an appointment for this visit? Yes No
6. Was the date and time you were able to get an appointment reasonable to you? Yes No

Reception/Registration Area

Scale definition: P - Poor ; F - Fair ; G - Good ; VG - Very Good ; E - Excellent

- | | P | F | G | VG | E |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 7. The courtesy of the registration staff? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. The comfort of the reception area? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. The cleanliness of the reception area? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. Length of your wait in the reception area? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Comment (describe good or bad experience): _____

Clinical Staff (nursing staff, x-ray technicians, medical assistants)

- | | P | F | G | VG | E |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 11. The courtesy of the clinical staff? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. The concern the clinical staff showed for your problem? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. Explanation of your testing and/or treatment? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Comment (describe good or bad experience): _____



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