In today’s managed care environment, some small groups reach a point at which they can’t work any harder to maintain their incomes, says consultant Randy Bauman. “Payment rates have gotten so low that everybody’s saying we need to do something differently,” he says.

For many groups, that something means joining forces with other practices to reduce overhead, realize economies of scale, and improve payer contracts. However, these benefits may be elusive without a clear understanding of what you want to achieve and how merging may help you get there, Bauman says.

This recent trend is reminiscent of the merger and acquisition craze of the 1990s, but this time around, groups seem to be heeding the advice of consultants like Bauman and are more practical, better informed, and better equipped for longevity.

Premillenium, groups entered into deals with hospitals and physician practice management companies (PPMC) for the wrong reasons, Bauman says. The prospect of others handling their managed care contracting lured them and eased their concerns about the threat of capitation. “But neither the PPMCs nor the hospitals effectively managed the groups they acquired,” he adds. “Thus, hospitals lost millions of dollars and divested their employed practices. The PPMC industry basically disintegrated.”

The residual bad taste, combined with uncertainty over allowable group structure under the pending Stark regulations, resulted in several years of little or no merger activity. But recently, due to “natural economic evolution” and clearer rules, groups now use mergers to increase their profit margins, Bauman says.

Many of today’s mergers are on a far smaller scale than those in the 1990s—perhaps a one- or two-doctor practice joining a larger one, says consultant Judy Capko. “They merge with a group that can provide the support they need. It’s more like adding a partner than a merger,” she says.

And thinking in terms of adding a partner is a smart approach. Major problems occur when two groups with clashing cultures and values join. “Too often [groups] want to put that square peg in that round hole no matter what,” she adds.

Never entertain a merger offer on an uneven playing field. “Both groups have to feel it’s a win-win situation,” Capko says. “If someone thinks he or she is doing you a big favor, move on.”
right fit, merging can help you remain competitive in several areas, such as technology. The electronic medical record (EMR) is steadily becoming a way of life for many providers and is now even pushed by the federal government. And according to a 2003 survey conducted by the Commonwealth Fund, the predominant factor affecting use of information technology is practice size.

The survey of 1,837 U.S. physicians found that nearly 60% of physicians in large groups—50 or more physicians—use an EMR routinely or occasionally, compared to 25% of solo physicians.

Spreading the implementation cost—which could reach up to $1 million—among 20 cardiologists is more doable than among five family physicians, Bauman says.

Merging can also improve call coverage, allowing physicians more flexibility with their schedules, Capko says. Further, larger groups can better handle all staffing deficiencies and offer more attractive benefits to employees. Greater human resources, in turn, allow groups to better serve their communities, she adds.

Not a cure-all

Although merging may increase power in terms of managed care contracting, it won't automatically increase reimbursement. “It depends on the structure and the moxie of management,” Bauman says. In other words, it’s the individuals doing the negotiating with payers who really determine whether reimbursement will improve.

To increase reimbursement, you need to convince payers that you are a major player in your area—and be willing to terminate contracts with payers who won’t raise rates, he adds.

Before taking steps toward a merger, understand your goal and assess whether merging is the answer. For instance, if you consolidate five offices with three or four doctors each into one group, but you don’t consolidate location or eliminate staff, your savings are minimal, if any.

In fact, you may find yourself needing a central billing office, computer system, group administrator, and more—adding additional overhead, says Bauman.

But with more groups embracing the urge to merge, some may wonder whether small group practices will eventually become extinct. Neither Capko nor Bauman are worried, pointing to the fact they both work with many thriving small practices.

“We’re still a cottage industry,” Capko says. “A lot of patients have revolted [against] being pushed around into large practices that merge and change locations where doctors are coming and going. They are looking for a small practice where they can be part of the community,” she says.

And many physicians value their autonomy too much to give it up, Bauman says. “Physicians, by nature, are independent and there are always some who are not going to fit [in a group].”

With more groups embracing the urge to merge, some may wonder whether small group practices will eventually become extinct.
Take an organized approach to EMR implementation

Devote ample time to preparation, communication for best results

Third in a three-part series.

Last month, we provided you with the tools you need to write and analyze your request for proposal (RFP)—one of the final steps in selecting an electronic medical record (EMR) vendor. Here we discuss how to transition your processes and culture to make the most of your new investment.

EMR implementation success depends on solid preparation—both in terms of training physicians and staff to use the tools and preparing them emotionally for change.

Lay the groundwork for success

Give users plenty of time to practice using the system before going live, says consultant Jeffery Daigrepont. He has asked every client who has implemented EMR the same question: If you had to do one thing over again, what would it be? And 100% said they would have committed more time to training and learning the system.

“IT’s kind of like learning to play the piano,” says Linda Jesberg, RN, BSN, CPC, an EMR senior clinical coordinator for St. John’s Mercy Medical Group in St. Louis. “You don’t just walk into Carnegie Hall and start playing Beethoven,” she says. Jesberg recommends giving physicians at least four months of lead time to learn the system. This may seem impossible to do without disrupting the flow of the practice, but Jesberg has a solution: Provide physicians with security tokens so they can access the system from home and become familiar with it.

Well before EMR becomes a way of life at your practice, Jesberg advises you also give everyone in the practice a chance to voice his or her fears about converting to EMR. Plan an afternoon to gather all your physicians and staff together and invite them to share their concerns. Anticipate some of what you might hear and prepare responses.

For example, someone may say she’s afraid of losing her job, Jesberg says. Reassure her that by learning the new skills necessary to use the EMR, she will actually become a more valued employee. “We try to teach them that as long as they’re willing to have their job duties change a little bit, they will be fine,” she says. At Mercy Medical, Jesberg has even seen jobs upgraded following EMR implementation (e.g., file clerks who don’t just file but also scan, index, and more).

Among physicians, the number-one fear is a drop in productivity, Daigrepont says. “That’s a direct hit on their pocketbooks. If you cause them to lose three to four patients a day as a result of slowing them down, that could be thousands of dollars.”

Jesberg has found that giving physicians ample time to get accustomed to the applications, templates, etc., minimizes the affect on physician productivity.

Daigrepont suggests physicians begin by using the EMR for every third patient and using paper immediately.

1 Daigrepont is a manager with the Coker Group in Roswell, GA. Contact him at 300/345-5829 or via e-mail at jdaigrepont@cokergroup.com for an outline of specific EMR implementation project management requirements.

2 Jesberg has coordinated EMR implementation among 165 physicians at 65 Mercy Medical Group practice sites. Contact her at 314/364-3779 or via e-mail at jesbln@stlomercy.net.

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Before closing the deal with an electronic medical records (EMR) vendor, consultant Jeffery Daigrepont recommends contractually addressing the following items:

- **Access.** Request that the vendor seek prior approval before accessing your server or workstations.
- **Additional support fees.** Agree to a rate for services outside of the scope of the main agreement (e.g., customization).
- **Application service provider (ASP) services.** Decide whether you may become a software ASP or data center to other healthcare providers in the area and under what conditions.
- **Assignment.** Determine the conditions by which the vendor will allow assignment to a parent or subsidiary (e.g., merger, acquisition, buy-out, name change, corporate reorganization).
- **Audit.** Request that the vendor notify you a certain number of days (e.g., 60) before an audit and that it provide the reason for the audit.
- **Change in number of users.** Determine the cost adjustment if the practice increases or reduces the number of people using the system.
- **Clinical content and data mining.** Agree on how your data may be accessed and used and by whom.
- **Confidentiality.** Establish whether the vendor will allow you to provide outside consultants or legal counsel access to confidential information.
- **Copyright infringement.** Determine vendor responsibility against copyright infringements.
- **Customization.** Because customization needs will be greatest immediately following installation, request 50 hours of specialized support at no charge and a reduced rate for the first year following installation.
- **Discontinuation of maintenance.** Address the terms by which you may elect to discontinue regular maintenance services (e.g., 90 days notice, after which the vendor will charge a maximum of $125 an hour for requested support).
- **Dispute resolution.** Determine jurisdiction of governing laws (e.g., under the law of the state of the practice).
- **Documentation.** Discuss ownership of the documentation you create using the EMR.
- **Entity relationship diagrams (ERD).** ERDs are data-modeling tools. They help organize data into projects and entities and define the relationships among entities. A data entity is anything real or abstract about which you want to store data. Entity types fall into five classes: roles, events, locations, tangibles, or concepts.
- **Escrow.** It is industry standard for the vendor to pay the cost of setting up an escrow account to hold the source code in the event of bankruptcy, liquidation, or sale.
- **Future upgrades, new releases, version changes, mandated modifications.** Determine how the vendor will address installation, support, and costs.
- **Good-customer discount.** Negotiate a discount off the annual maintenance cost once your support utilization levels off.
- **Hardware acceptance period.** Set a period (e.g., 90 days) after software installation to double-check that the performance of all hardware meets your expectations. Specify how the vendor will correct any problems.
- **Health Insurance Portability and Accountability Act of 1996 compliance.** Address vendor’s responsibility to ensure the security of all protected health information.
- **Implementation assistance.** Request that implementation trainers have a minimum of two years of employment in their current role with the vendor.
- **Increases to support fees.** Agree on a limit to the percentage that fees may increase (e.g., 1% less than consumer price index) within one year.
- **Interfaces.** Specify vendor’s responsibility regarding interface performance.
- **Noncovered services.** Mutually agree on a maximum rate for services outside the main agreement.
- **Reinforcement/Ongoing training.** Address availability and cost of additional training.
- **Relocation agreement.** Establish whether and how often you may relocate servers if necessary.
- **Showroom/Site visits.** Set terms under which you will host site visits on behalf of the vendor.

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1 Daigrepont is a manager with the Coker Group in Roswell, GA. Contact him at 800/345-5829 or via e-mail at jdaigrepont@cokergroup.com.
Offer flexibility and fun

Whatever strategy you adopt, let physicians ease into the transition. “If a doctor has a bad experience with EMR the first two or three days, [he or she will] dig in and just won’t come back out,” Daigrepont says. To prevent resistance early on, give physicians flexibility, he adds.

When approaching what can be a stressful transition, secure buy-in by increasing morale. Jesberg suggests making implementation fun. For example, tap into physicians’ competitive nature by offering prizes for the most charts entered electronically. Consider rewarding their efforts with a go-live luncheon including more activities to create a fun atmosphere, she says.

Tip: Books about change management, such as Who Moved My Cheese? by Spencer Johnson, MD, make rewarding prizes.

When getting users up to speed, try an incremental approach. Daigrepont recommends having physicians begin with tasks that don’t require significant behavior modification.

For example, a doctor who uses e-mail should quickly get the hang of an EMR messaging system. From there, move to automating incoming faxes, prescription writing, looking up labs, and ultimately achieving point-of-care documentation. These simple tasks build confidence among the group as everyone gradually becomes more comfortable.

If you have multiple locations, automate one clinic at a time, Daigrepont says. However, do not create needless chaos by converting only one or two physicians within a single office. Two coexisting systems running simultaneously may overburden staff managing tasks related to both paper and electronic charts.

Encourage teamwork

All users, not just information technology personnel, must take ownership of the project, Daigrepont says. Throughout your implementation process, continually provide a forum to exchange feedback with physicians and staff.

Jesberg’s groups have a monthly meeting that includes the medical director and members of the implementation committee (generally the same task force as your vendor selection committee). During the meeting, they review all ideas for improvement submitted during the past month and decide whether to implement changes. Before adopting any modification to the system, the committee assesses whether the change will benefit the group as a whole.

To encourage feedback, make sure everyone knows they are heard and reward good ideas. Pay special attention to key users, such as office managers, who have the power to sabotage the project by resisting change, Jesberg says.

Some people may not accept a major change in how they’ve worked or practiced for years. If you can’t persuade them to change their minds, decide whether to remove them from the practice, Daigrepont says. “It’s not worth blowing up a $100,000 EMR project over one or two people’s lack of objectivity.”

Every practice’s EMR implementation will be unique, Daigrepont says. Your vendor will also assign someone to assist your practice with implementation, but beware of a generic approach. “That’s where a lot of implementations go wrong. The vendor will take a standardized, canned approach to it based on the way the software works but not how the practice works,” he says. Take advantage of the vendor’s help, but also make sure to assess your practice’s workflow, work styles, and culture and make it a team effort to optimize your EMR’s benefits.

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**EMR implementation**

For the other two.

- **Software acceptance period.** Determine a period (e.g., 90 days) after the go-live date of each module to ensure proper software installation. Specify vendor’s corrective responsibilities.
- **Solicitation.** Request that the vendor not attempt to solicit employees from the practice without permission.
- **Support fees.** Require that the vendor charge for support commensurate with what it actually installs and determine when support fees begin (e.g., 90 days after go-live).
- **Support.** Develop a support agreement defining the turnaround time required for various requests.
- **Termination.** Specify contract termination rules for vendor and practice.
- **Third-party software.** Determine vendor’s role regarding third parties’ software that it may recommend to supplement its products.
- **Travel.** Address travel expenses and scheduling.
- **Warranties.** Specify how the vendor will respond to errors, malfunctions, or performance defects in its software.

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Correct reimbursement and compliance depends on accurate coding. The following five common coding problems can be costly and frustrating. Coding consultant Joette P. Derricks, CMPE, CPC, CHC, offers suggestions about how to avoid them at your practice:

1. **Unbundling**

   Some procedure codes are bundled, meaning one code represents a group of services performed together. For example, the code and fee for a surgical procedure includes the dressing change. Unbundling occurs if you charge for the dressing change separately when it is already included in the surgery code.

   Sometimes unbundling results from not keeping up with annual changes to current procedural terminology (CPT) codes (rather than intentional attempts at deceiving the government to receive more money). Until now, providers had a 90-day grace period to implement changes. However, in 2005 that grace period was eliminated, and the deadline for this already daunting task was January 1.

   “This year there was no grace period for the coding update and I’m finding a lot of practices are [still] behind the gun in understanding what has changed and what they can and can’t do,” Derricks says.

   For example, a 2005 change catching many practices unaware is a new list (found in Appendix G of the 2005 CPT book) of services and procedures that now include conscious sedation, Derricks says. Several anesthesia and gastroenterology practices are still discovering that they are not being paid for conscious sedation when it is improperly unbundled, she adds.

   Further, many practices don’t use the current version of the Medicare’s National Correct Coding Initiative (NCCI) edits, which flag inappropriate coding combinations. The Centers for Medicare & Medicaid Services’ (CMS) Web site ([www.cms.hhs.gov/physicians/cciedits](http://www.cms.hhs.gov/physicians/cciedits)) offers the updated NCCI edits for free and breaks them down by specialty.

   “The correct coding edits have been available for years, but so few practices are pulling that information and incorporating it into their coding and billing procedures,” Derricks says.

2. **Misuse of modifiers**

   Too often, coders resort to unjustifiably adding modifiers to codes simply to get claims paid. Two of the most misused are modifiers -59 (distinct procedural service) and -25 (significant separately identifiable evaluation and management [E/M] service by the same physician on the same day of a procedure or other service).

   “It gets back to having a good understanding of coding procedures and not just saying, ‘We’ll try this to see whether they pay it,’ and adding a modifier -59,” Derricks says. Although modifier -59 indicates two separate sessions or procedures performed on two separate body parts, it is considered fraud to report a modifier just to get the claim paid. And this is the case with other modifiers as well.

   In fact, misuse of modifier -25 is something the Office of Inspector General (OIG) will target this year, according to its 2005 Work Plan. With modifier -25, the problem isn’t usually inappropriate use, Derricks says, but insufficient documentation to show that the physician performed a separately identifiable service.

   Derricks recommends that physicians document two separate notes in these circumstances—one for the visit and one for the procedure. Although two notes are not required to support the use of modifier -25, regularly noting the visit and procedure independently ensures that each is documented appropriately. Further, it makes it easy for anyone who reviews the record to clearly see that the physician performed two separate services on
the same patient on the same day, she says.

We often think of improper modifier usage in terms of reporting a modifier when it’s not warranted or reporting the wrong modifier; however, not reporting a necessary modifier can also cause problems. For example, failure to report modifier -26 (professional component) when the physician performs only the professional component of a service is an OIG concern in 2005.

If an independent diagnostic testing lab or another facility performs the technical piece and the physician only performs the professional piece—the physician’s interpretation—report modifier -26, Derricks says. “You have no right to be paid for the technical piece if the physician’s practice did not physically perform the test with its own equipment, employees, etc., or purchase the technical component.”

5 Upcoding and downcoding

Upcoding means coding for a more intensive, expensive service than the one actually performed. Although E/M coding gets the most attention regarding billing an inappropriate level of service, any code that is part of a series (e.g., 97597–97606 for wound care) is subject to upcoding. Payers and the OIG may become suspicious if all your claims consistently fall in the highest payment range.

This is not news to physicians, and it causes many to refrain from using higher-level codes, even when warranted. Speaking from over 30 years’ experience, Derricks estimates physicians downcode three times more often than they upcode.

Solid documentation can solve this problem. Derricks relates a recent case she reviewed. Based on the level of medical decision-making—the intensity of the work done—the higher-level code was appropriate, but the documentation didn’t support the higher level.

“Sometimes I feel bad for the physicians when I have to say, ‘Sorry, this should have been a level four visit based on what the presenting problem is, but you just didn’t write down everything you did,’” she says. “That’s kind of sad.”

But the fact remains that coders cannot infer the level of service based on information that isn’t documented. Refer to CMS’ 1995 and 1997 E/M documentation guidelines for more information (www.cms.hhs.gov).

4 Clustering and ‘one coding’

Clustering refers to physicians tailoring their coding to meet a predetermined formula rather than basing the coding on the level of service rendered. For example, a practice may aim to bill 50% of its visits at 99212 (minimal office visit for an established patient) and 50% at 99214 (detailed office visit for an established patient) and assume that the payment will equal about the same as if it coded each case individually.

“There’s no relationship between what they’re billing and the reality of what they’re doing,” Derricks says. This practice can lead to overcharging certain individuals and undercharging others and is wrong regardless of the overall payment the practice receives.

There’s nothing wrong with tracking the percentage of low- and high-level visits at your practice for benchmarking purposes, but do not use such data as a coding shortcut.

“One coding” is similar to clustering and refers to a doctor “falling in love with a code” and always using the same code to reflect a level of service. Even if a physician thinks he or she is performing a level four consultation 99% of the time, the physician must document each case and code each one based on its own merits, not out of habit.

5 Default coding

Default coding refers to the practice of programming your system to give the “right” answer, Derricks says. She often sees default coding with ICD-9 coding to support medical necessity. For example, if diagnosis code A represents a medically necessary code for a procedure performed, but the documentation reflects the diagnosis was code B, it is inappropriate to default the system to code A. “Sometimes people default or select the diagnosis code not based on the documentation but based on what would get paid,” she says.

Coders and billers should not choose from a canned master list of 20 diagnosis codes known to be paid with services a doctor typically performs. The same goes for test ordering. You can’t just have a sheet where you check off the test in one column and one of 10 diagnosis codes in the other, Derricks says. “You have to let the physician tell you, ‘This is the condition of the patient; this is why I want the test,’ and go from there.”

This process is difficult for practices because it often involves issuing patients advanced beneficiary notices, Derricks says. “They don’t want to tell the patient there might be a liability because Medicare beneficiaries in particular think everything they have done should be covered by Medicare,” she says. “But that’s not the case. Rather than educate the beneficiaries, some practices merely select a payable diagnosis.”
Consultant’s perspective

Incorporate goodwill into partner buy-out

Combine it with A/R and pay it as deferred compensation

By Leif C. Beck, JD, CHBC

When structuring payout for partners who leave your group, consider two types of income assets: straightforward accounts receivable (A/R) and the intangible, often debated, goodwill value. I call goodwill an income asset because its value, if any, depends on expectations of future earnings, and therefore relates to income.

Once you agree on a method of valuing the A/R, combine it with a method of valuing goodwill, thus creating a single income payout figure. Arriving at an acceptable goodwill valuation approach, however, is often the most difficult task partners face when deciding on their buy-out arrangements.

Practice advisors often can’t agree whether goodwill value even exists, much less on its amount. Although the only resource available, The Goodwill Registry, claims to report on goodwill values across the nation, it lacks depth and timeliness, so you shouldn’t solely rely on it. Instead, take into account practice traits such as location, that may positively or negatively influence value, and the revenue-based calculations described below.

Great variation

Some practices are extremely valuable. Take, for example, a six-doctor general surgery group to which referrals come constantly and whose partners take home several hundred thousand more dollars per member than what surgeons typically earn. Or consider a pediatric practice whose partners earn $200,000 annually while average pediatricians earn perhaps $130,000 annually.

However, some practices—although admirable providers of quality care—don’t have any goodwill value. For example, their incomes may just meet or fall below national averages, they may be located in areas where it is difficult for new groups to establish themselves, or they may be in service areas where the insurance picture—both in terms of third-party payers’ bargaining power and malpractice carriers’ rate structure—are troublesome. Such practices cannot afford to pay much to a departing partner and still have enough earnings to obtain a quality replacement.

Casual rule of thumb

Most practices’ goodwill values are modest, if not zero. A partner is invariably better off financially staying in practice another year—maybe even on a reduced-work basis—than retiring. To estimate many specialties’ value, I often use a simple rule of thumb: 25%–35% of a year’s gross revenues.

On that basis, a three-partner practice with $1,500,000 of collections may have a goodwill worth of perhaps $450,000 (some $150,000 per coowner). But even that group needs to carefully consider whether it can pay that figure and keep the remaining group alive.

Seek reasonable fairness

Whatever the combined value of your group’s A/R and goodwill, pay out the departing partner’s share as income, not as capital gains. It’s hard enough for the ongoing group to accept paying a former member, but not being able to tax-deduct the payments makes it worse. Thus, treat the payout as “deferred compensation” to a valued physician-employee.

To do so, determine the combined values so the resulting figure will approximate some sort of income-based measure. Because A/R and goodwill are not easily quantifiable, reasonable fairness—not exactness—should be your goal.

Following is an example of a typical payout: a four-doctor urology group whose A/R typically runs at three months of gross income (25% of a year’s revenue) and whose agreed goodwill value is 35% of a year’s gross. The two income items thus combine to a total of 60% of annual practice revenue. The four partners’ W-2 compensation totals 50% of gross (meaning their practice has about a 50% overhead ratio). In effect, by paying each partner 120% (60% divided by 50%) of one year’s salary spread out over perhaps 60 months, you pay out the income assets’ value, hopefully without breaking the bank.

Therefore, you can include in employment agreements that upon a member’s retirement, death, or other departure, he or she (or his or her estate) shall be entitled to deferred compensation equal to 120% of his or her most recent year’s salary in monthly payments over five years. Younger partners may object that this will impose a terrible burden on the practice, but next month I’ll conclude this series by suggesting a number of protective limitations to make it work.

1 Beck advises on top-level group practice matters. Contact him at Leif C. Beck Consulting at 610/355-0797 or via e-mail at leifbeck@comcast.net.

2 The Goodwill Registry is a national database of healthcare practice transactions published by the Health Care Group. Go to www.healthcaregroup.com for more information.