FELLOWS CONFERENCE

February 23, 2013

The Stanford Court Renaissance
San Francisco Hotel
San Francisco, California

Coalition of State
Rheumatology Organizations

PROGRAM BOOK

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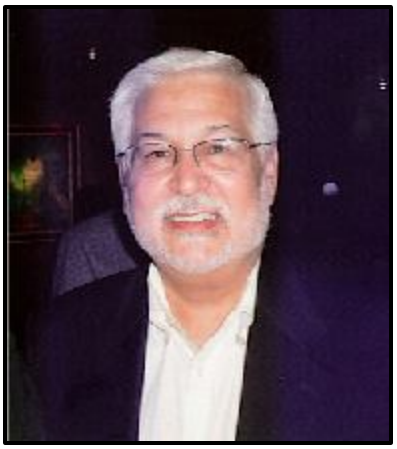
CSRO

Welcome Message



Welcome to the 2013 CSRO Fellows Conference. The CSRO developed this program to help rheumatologists who are finishing their training to better understand their entrance and participation in the world of private practice. The topics range from interviewing for your first job to evaluating an employment contract to pointers in practice management. We hope to provide you with valuable information to which you have not been previously exposed, and to better equip you to navigate the upcoming uncharted, but exciting, next phase of your professional career. We anticipate you will benefit from this opportunity not only to absorb this information, but to network with your colleagues, as well as our outstanding faculty of experienced, successful, practicing rheumatologists.

Michael Schweitz, MD
CSRO President

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Mission Statement

The Coalition of State Rheumatology Organizations is a group of state or regional professional Rheumatology Societies formed in order to advocate for excellence in Rheumatologic disease care and to insure access to the highest quality care for the management of Rheumatologic and musculoskeletal diseases.

To keep you abreast of the latest news, we send out periodic e-newsletters about current information on local and national levels.

Disclaimer Statement

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2013 CSRO Fellows Conference Agenda

CSRO

**All sessions will be located in the Stanford East Ballroom unless otherwise noted*

Saturday, February 23, 2013

7:30 a.m. - 8:00 a.m. **Registration & Breakfast**
Location: Stanford East Ballroom Foyer

8:00 a.m. - 8:15 a.m. **Welcome**
Mike Schweitz, MD
President, CSRO
Arthritis & Rheumatology Associates
West Palm Beach, Florida

8:15 a.m. - 9:00 a.m. **Washington Update**
Vicki Hart
Hart Health Strategies

9:00 a.m. - 9:45 a.m. **State of Rheumatology**
Paul H. Caldron, DO, FACP, FACR, MBA
Arizona Arthritis Rheumatology Associates
Glendale, Arizona

9:45 a.m. - 10:00 a.m. **Break**
Location: Stanford East Ballroom Foyer

10:00 a.m. - 10:45 a.m. **So You Want to Go Into Private Practice**
Herbert S. B. Baraf, MD, FACP, MACR
Arthritis & Rheumatism Associates
Wheaton, Maryland

10:45 a.m. - 11:15 a.m. **Clinical Research in Private Practice**
Joseph Huffstutter, MD
Arthritis Associates
Hixson, Tennessee

11:15 a.m. - 12:15 p.m. **Physician Employment and Contacts**
Steve McCoy, JD
Patient First Corporation
Glenn Allen, Virginia

12:15 p.m. - 1:15 p.m. **Lunch**
Location: Nob Hill

1:15 p.m. - 2:00 p.m. **New Paradigms in Gout Management**
N. Lawrence Edwards, MD, FACP, FACR
University of Florida

2:00 p.m. - 2:45 p.m. **Medical Malpractice**
Jeffrey S. Penner, MD
Atlantis Orthopaedics
Atlantis, Florida

2:45 p.m. - 3:30 p.m.	**Coding for the Practitioner** Jean Acevedo, LHRM, CPC, CHC, CENTC *Acevedo Consulting Incorporated* *Delray Beach, Florida*
3:30 p.m. - 3:45 p.m.	**Break** *Location: Stanford East Ballroom Foyer*
3:45 p.m. - 4:30 p.m.	**My First Year in Practice** Ashley D. Beall, MD, FACR *Arthritis & Rheumatism Associates* *Wheaton, Maryland*
4:30 p.m. - 5:15 p.m.	**Practice Management** Ethel Owen *Arthritis & Rheumatology Associates* *West Palm Beach, Florida*
6:30 p.m.	**Reception & Dinner** *Location: Nob Hill*

Jean Acevedo, LHRM, CPC, CHC, CENTC, has 30 years of healthcare experience. She has a particular expertise in chart audits, compliance and education relative to physician documentation and coding. Ms. Acevedo has also been an expert witness in civil litigation and an investigative consultant for the DOJ in federal fraud cases.

She is a workshop presenter for the American Academy of Professional Coders and co-author of the Academy's Compliance Toolkit, a member of the Advisory Board for Parses, Inc., an instructor at Florida Atlantic University, and a member of several Coding Institute Editorial Advisory Boards. Ms. Acevedo has been a participant in CMS' Medicare Provider Feedback Group, CMS Division of Provider Information Planning and Development since 2007 and is a member of the Jurisdiction 9 MAC's Provider Outreach and Education Advisory Group.

She is a frequently sought after speaker as she possesses the unique perspective of avoiding risk and liability while optimizing reimbursement in the highly regulated health care industry

Herbert S. B. Baraf, MD, FACP, MACR, is the senior member and managing partner of Arthritis and Rheumatism Associates, the largest private practice rheumatology group in the United States with 15 rheumatologists. In 1982 he founded The Center for Rheumatology and Bone Research, the research division of his practice. In that capacity he has served as principal investigator on over 300 clinical trials studying new therapeutics for more than a dozen rheumatic disorders including gout, rheumatoid arthritis, systemic lupus, Sjogren's syndrome, psoriatic arthritis and osteoarthritis.

Dr. Baraf is a clinical professor of medicine at The George Washington University School of Medicine and a clinical associate professor of medicine at the University of Maryland School of Medicine. He is a fellow in the American College of Physicians. In 2012 he was designated as a Master of the American College of Rheumatology (ACR).

As a former member of the Annual Meeting Planning Committee for the ACR, Dr. Baraf was responsible for the development of 'Practice Issues', a lecture series on topics of particular interest to practicing rheumatologists. He has served on several other committees of the College, including the Regional Advisory Council, the Finance Committee and the Professional Meetings Committee, where his efforts were instrumental in the development of freestanding musculoskeletal ultrasound courses for clinical rheumatologists.

A nationally recognized authority on issues of rheumatology practice management, Dr. Baraf has lectured at regional and national meetings throughout the United States on topics of practical importance to practicing rheumatologists. He has been invited by the ACR to present workshops and lectures on clinical practice to graduating fellows for the past several years.

As a function of his work in clinical research, Dr. Baraf has co-authored several publications concerning therapeutics in the rheumatic diseases. He has presented his work on gout, rheumatoid arthritis, osteoarthritis, ankylosing spondylitis and the safety of NSAID therapy at meetings of the ACR and EULAR. He lectures widely on the manifestations of and treatment for the rheumatic diseases.

Dr. Baraf received his BS degree at the University of Michigan in Ann Arbor and his medical degree at S.U.N.Y., College of Medicine, Downstate Medical Center, Brooklyn, NY. He completed his internal medicine training at The George Washington University Hospital, Washington, DC, and his fellowship in rheumatology at Duke University Medical Center, Durham, NC. He is Board Certified in Internal Medicine and Rheumatology.

Dr. Baraf has been recognized as an outstanding specialist in the field of rheumatology in *Washingtonian Magazine, Washington Consumers' Checkbook,* and *Best Doctors in America*.

Ashley D. Beall, MD, FACR, is a partner at Arthritis and Rheumatism Associates, PC, located in Washington, DC. ARA is one of the largest single specialty rheumatology practices in the country, currently with 15 full-time physicians. She currently serves as the physician director of infusion services at ARA. Dr. Beall joined the practice in 2008 after completing an internal medicine residency and rheumatology fellowship at the Medical University of South Carolina. Her publications have been featured in several academic journals including the *Journal of Rheumatology*. She has completed and presented clinical research on both Systemic Lupus and Systemic Sclerosis. Her areas of interest also include Rheumatoid Arthritis, Myositis and Gout.

Dr Beall is board certified in internal medicine and rheumatology. She is a fellow of the American College of Rheumatology, and is a member of the ACR 2020 Task Force, a national committee to identify future trends and issues in rheumatology. Dr Beall is also an active member of the Arthritis Foundation and the Alpha Omega Alpha Medical Society.

Paul H. Caldron, DO, FACP, FACR, MBA, received his medical degree at Oklahoma State University. He completed internal medicine residency and rheumatology fellowship at the Cleveland Clinic Foundation in Ohio. Dr. Caldron began practice in 1984 as assistant clinical professor of medicine at Northwestern University Medical School with a private office in Winnetka, Ill. In 1994 Dr. Caldron was a cofounder of Arizona Arthritis and Rheumatology Associates, PC (AARA). He is a fellow in the American College of Physicians and the American College of Rheumatology and holds a clinical assistant professorship at Midwestern University Arizona College of Osteopathic Medicine. Dr. Caldron completed an MBA in Arizona at Thunderbird School of Global Management in 2002. He has participated with various organizations providing charitable health care in developing countries and collaborates in an organization to promote the performance of clinical drug trials in Russia and the former Soviet States.

N. Lawrence Edwards, MD, FACP, FACR, is professor of medicine, Division of Rheumatology and Clinical Immunology, as well as program director and vice chairman of the Department of Medicine at the University of Florida in Gainesville. Dr. Edwards obtained his undergraduate training at the University of Notre Dame and his medical degree from the University of Miami School of Medicine. He completed his training in rheumatology at the Rackham Arthritis Research Center and the Clinical Research Center, University of Michigan in Ann Arbor, where he remained on the faculty as director of education and training in the Division of Rheumatology. In 1983 he moved to the University of Florida where he is the former chief of the Division of Rheumatology and Clinical Immunology.

Dr. Edwards is a member of many professional organizations including the American College of Rheumatology, American College of Physicians, the Association of Program Directors in Internal Medicine, and the Heberden's Society (an honorary society within the British Society of Rheumatology). He is on the Board of Directors of the Florida Chapter of ACP, the co-chair of the Special Interest Group in Gout for OMERACT and the chairman and CEO of the Gout and Uric Acid Education Society – a non-profit, patient education organization. He has authored over one hundred and fifty scientific articles, book chapters and reviews and has served on advisory/editorial boards for the *British Journal of Rheumatology* and *Rheumatology Review*.

Vicki Hart is the founder and president of Hart Health Strategies and provides a breadth and depth of knowledge and experience in healthcare policy, politics and process. Ms. Hart has counseled policy makers, business leaders and association executives for more than twenty years. Ms. Hart is a Registered Nurse and has a Masters in Epidemiology and Public Health.

Prior to establishing the Firm in 2002, Vicki Hart served as a senior lobbyist and policy advisor and headed the health policy practice for the law firm of Verner Liipfert. Her expertise includes knowledge of healthcare reform, Medicare and Medicaid reimbursement, quality, health information technology, and other health-related issues. She has successfully built coalitions to advance healthcare priorities, including the establishment of the Alliance of Specialty Medicine.

Before moving to the private sector, Ms. Hart was a presidential fellow and worked for nearly a decade as a senior health policy advisor for two Senate Majority Leaders. In this high-level position, Ms. Hart provided technical and strategic advice to the Senate Majority Leader, members of the United States Senate and their staff.

Ms. Hart holds BA (English) and BS (Nursing) degrees from Fairfield University and a Masters in Epidemiology and Public Health from the Yale School of Medicine.

Steve McCoy, JD, graduated from the University of Virginia in 1993 and from the University of Virginia School of Law in 1997. He spent 11 years in private practice as a partner in the health law section of Williams Mullen, in Richmond Virginia, where he represented physicians, hospitals and other healthcare providers. For the past five years he has served as general counsel to Patient First Corporation, a provider of primary and urgent care services that employs over 350 physicians and extenders at 43 locations in Virginia, Maryland and Pennsylvania and treats patients during more than 1.8 million visits annually. Mr. McCoy is the past chair of the Health Law Section of the Virginia State Bar and is currently a member of the Board of Governors of the Virginia Bar Association's Health Law Council.

Jeffrey S. Penner, MD, is certified by the American Board of Orthopedic Surgeons and is a fellow in the American Academy of Orthopedic Surgeons (AAOS) and a fellow in the American College of Surgeons (FACS). Dr Penner has been practicing in Palm Beach County since 1977. He is the senior physician and the founder of Atlantis Orthopaedics, which has grown to be a group of fellowship-trained orthopedic surgeons in various disciplines of orthopedics.

Dr. Penner received his medical degree from University College of Medicine and Dentistry, New Jersey Medical School. He served his surgical internship at Emory University in Atlanta, and completed his orthopedic residency at the Hospital for Joint Diseases in New York City. Dr. Penner has focused his surgical practice on total knee and hip replacements.

Dr. Penner was one of the first orthopedic surgeons to provide free medical care to local indigent patients and was recognized by the Palm Beach County Legal Aid Society for his efforts by being awarded the ProBono Legal Aid Society Award.

Since coming to Palm Beach County, he's been recognized as an authority in Compulsory Medical Examinations (CMEs), and Second Opinions, and has been given lectures through south Florida and the nation regarding these intricate evaluations. He has been certified by the American Board of Independent Medical Evaluators and has been a member of ProBono Panel of physicians working for the State of Florida. He is also a past member of Palm Beach County Bar Grievance Committee. He is a certified Healthcare Risk Manager and performs consulting services in that field.

He has been involved with a number of community service boards, has worked for the Palm Beach County Medical Society, has been the chairman of a number of orthopedic departments at local hospitals and a member of various hospital committees. Dr. Penner is on staff at JFK Medical Center and West Palm Hospital (formally Columbia Hospital).

Dr. Penner is married with three grown sons. He is also an accomplished musician and can be seen and heard in Palm Beach County playing at a number of different venues and charity events.

Mike Schweitz, MD, completed a seven year undergraduate and medical school program at the George Washington University in Washington, DC, in 1972. He completed his internal medicine training at GW and his rheumatology fellowship at Georgetown University in 1977. He then entered private practice in West Palm Beach, Florida.

Dr. Schweitz is a partner in Arthritis and Rheumatology Associates of Palm Beach, a seven physician single specialty practice in Palm Beach County. He is Fellow of the American College of Physicians and the American College of Rheumatology. He served as a member of the Committee on Rheumatologic Care. He is a past president of the Florida Society of Rheumatology and continues to sit on its Executive Committee. He is an active member of the American Society of Clinical Rheumatology.

He has served on the Board of Directors of the Arthritis Foundation at both state and local levels for many years and for the past thirty-three years has donated his time in helping to staff a free arthritis clinic for medically indigent patients in Palm Beach County.

Currently, he is president of the Coalition of State Rheumatology Organizations (CSRO), an advocacy group comprised of state and regional rheumatology societies, which he helped form in 2003. In this capacity, he has been an active proponent of advocacy for rheumatic diseases in the nation's capital. He is also a frequent lecturer on topics related to rheumatology and practice management.

Dr. Schweitz has been recognized in "Best Doctors of South Florida" and "America's Top Physicians". His personal interests include wine collecting and wine education, as well as collecting first edition crime fiction.

8:15 a.m. – 9:00 a.m.

Washington Update
Vicki Hart

9:00 a.m. – 9:45 a.m.

State of Rheumatology
Paul H. Caldron, DO, FACP, FACR, MBA

THE STATE OF RHEUMATOLOGY

Paul H. Calabrese, DO, FACP, FACR, MBA
Coalition of State Rheumatology Organizations
Fellows Conference

February 23, 2013
San Francisco, California USA

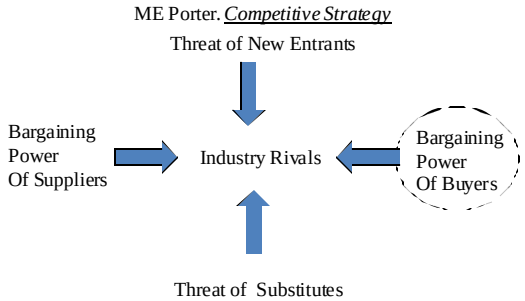
The State of Rheumatology

An Industry Analysis
the Bigger View

- What is the Industry?
- History of the Industry and its guilds
- Socio-financial and technological influences
- The market - large and expanding
- Who are the players
  - Why the successful?
- Supply and Demand
  - Physician Shortage
- Market Dynamics
  - Payers – Government, Managed Care, Consumer / Prescriptive
  - Provider laws, Pharmaco-economic Data
  - Lack of business and communication skills in the rheumatologist
  - An Environmental Audit

Forces Governing An Industry

ME Porter. *Competitive Strategy*



Why Do We Love Rheumatology?

Intellectual Stimulation

Considered Intellectual (Respect of Colleagues)

Prestige

Lifestyle (Call not bad)

< Opportunity Cost

Long-term Relationships With Patients (the therapeutic response "hit")

Exciting new therapies

Income

Strategies for Addressing the Shortage of Rheumatologists

See Only Immunological Disease

Design More Efficient Practices

Advanced Practice Clinicians (NP/PAs)

Attract New Blood

Who's Responsible For What?

(Where's the leadership?)

Rheumatology Academic Mandate

- Basic Research into Disease Mechanisms
- Bench Research into Therapeutic Options
- Education of Students and House staff, and the Public
- **Validate / Support Economic Efforts of Private Rheumatologists if only as Supply Chain Management**

Rheumatology Private Practice Mandate

- Mandate for Superior Rheumatic Disease Care
- **Clinical Research in therapeutics**
- Institutional Mandate of the Profession
  - Sound Business Practice to Maintain the Legacy of the Profession

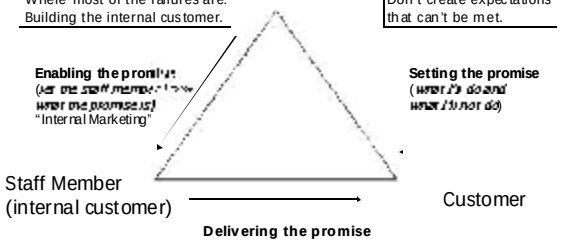
The State of Rheumatology

Characteristics of Service Offerings

- Intangibles - deeds, actions, performances, experiences
- Perishable - non-storable, momentary, spontaneous
- Encounter - based--only as good as your last encounter
- Heterogeneous experience - different time/person/activity
- Based on operational process
- Requires stable people - grooming for consistency

Operational Considerations

Services Marketing Triangle



Operational Considerations

Managing the External Environment

- Evaluation and Management—Contracts
- Vertical and Horizontal Integration—Adding Services
- Functional Relationships with the Exchange Network
- Cooperating with Colleagues for Strength

Vertical and Horizontal Integration

Managing the External Environment

Laboratory
X-ray
Densitometry
MRI
Diagnostic / Interventional US
Orthotics, Supportive devices
Non Pharmacy Dispensing Site

Infusion Services
Clinical research
Physical / Occupational Therapy
Electrodiagnostic Studies
CORRONA Database Entry
Theralogix
Complementary Therapies

Bargaining Power Of Suppliers

Industry Rivals

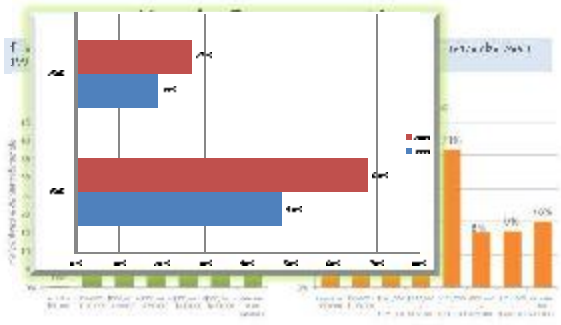
Bargaining Power Of Buyers

*Group Purchasing Organization

*Employer based Community

Functional Relationships with Exchange Network

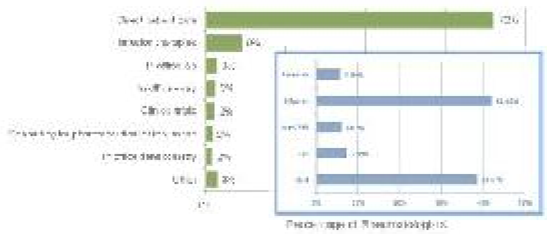
- No longer the hospital
- Infusion product producers
- Hemocare (Prosorba)
- MRI Radiologists
- Managed Care (individual to collective)
- CORRONA
- Theralogix
- Clinical trials sponsors
- Employer companies
- Government – only as a collective
- ACR, CSRO, State and Local organizations
- Arthritis Foundations, other Advocacy and NGOs



Q20/Q34. What is the range of your yearly compensation?

Personal Sources of Compensation

Rheumatologists practicing in private practice indicate nearly three-fourths of all personal sources of compensation come from direct patient care.



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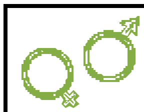
Q35. What are your personal sources of compensation from the practice of rheumatology? Indicate the percentage of income you receive from each of the following.

Adult Rheumatology Programs

Academic Year	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009
ACGME Accredited Programs	105	107	108	108	106	109
Total Positions Available*	363	378	385	396	415	434
Total Positions Filled^	333	333	365	388	406	423
1st year Positions Available*	179	177	184	189	199	209
1st year Positions Filled^	165	149	163	176	192	198
Number Completing Program**	145	161	149	173	186	188
Percent of IMGs^	29%	33%	34%	33%	38%	37%

[illegible]

Gender and Generation



- 2011: Practicing Members 66% Male 33% Female
  Fellows in Training 34% Male 66% Female
- Baby Boomer Retirement over the next 10 years
- Generation X & Y: XX and XY want the same work life balance
- Movement towards outpatient based [illegible]
- [illegible]

10:00 a.m. - 10:45 a.m.

So You Want to Go Into Private Practice
Herbert S. B. Baraf, MD, FACP, MACR

So You Want to Go Into Private Practice?

Confessions of a Managing Partner

[illegible]

Herbert S. B. Baraf, M.D., FACP, MACR
Clinical Professor of Medicine
George Washington University
Managing Partner
Arthritis and Rheumatism Associates
Washington, D. C. Wheaton, MD.

The Medical Student's Dilemma Getting Even

>86% of 2011 Graduating Seniors Had Debt

Average Debt	$161,300
$100,000 or more	78%
$150,000 or more	59%
$200,000 or more	33%
$250,000 or more	15%
>$300,000	5%

http://aamc.org/programs/firstdebtfactcard.pdf

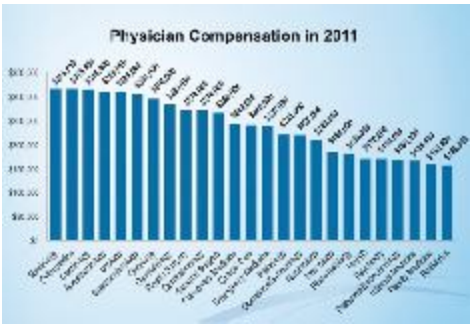
So You Want to Go Into Private Practice?

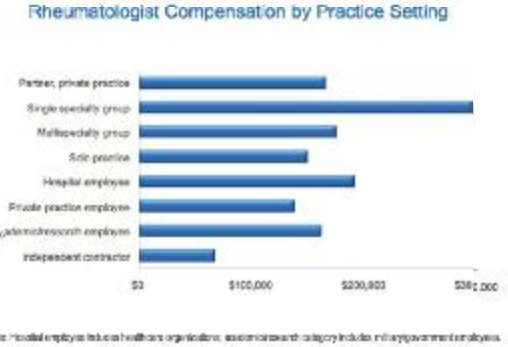
- Practice Setting
- The Interview
- The Contract
- Building Your Practice
- Business of Practice

I

Practice Setting

- Academic
- Institutional
- Government Industry
- Private Practice
  - Solo or group
    - single specialty
    - multi-specialty
  - Large or small
  - Rural, urban or suburban





Solo Practitioner

Pros

- Decision Autonomy
- Complete oversight of business operations
- Total control over strategic planning and practice future
- Consistent relationships with patients
- Opportunity to determine practice revenue

Cons

- Reduced practice coverage for time off
- Loss of cost sharing
  - labor, rent and supplies
- Financial insecurity if time off is required - illness, maternity, etc.
- Less $$ suppport for expansion
- More vulnerable to competition

ACP

Starting A Practice

BUY NOW

Staff Management

Starting A Practice

A Handbook to Marketing Your Practice

ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

Single Specialty Group

- Pros
  - Potential for improved office efficiencies
  - Stable coverage for time off
  - Potential for cost sharing
  - Work/Life balance
  - Increased negotiating power with payers and others
- Cons
  - Reduced input into business decisions
  - Complex division of revenues and costs
  - Politics in the group varies with practice size
  - For large practices:
    - Is there an ideal size?
    - Duplication of expense with multiple offices

ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

Multi-Specialty Group

Pros

- Flexibility to respond to market forces
- Marketing and name recognition
- Negotiating power with insurance carriers and vendors

- Cons
  - Reduced input of individual physicians into decision making
  - Subjugation of individuals needs to those of the group
  - Higher overhead costs
  - Need to cover areas of medicine outside of your expertise
  - Complex revenue division
    - crediting downstream revenue
    - uneven investing in new technologies

ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

Employed Practitioner

Pros

- Financial security
- Work/Life balance
- Reduced involvement in administrative business operations
- Streamlined administrative activities
- More time to focus on patient care, research and teaching

Cons

- Less or little involvement in practice decision making
  - Staffing levels
  - Policies and procedures
  - Billing operations
  - Retirement planning
- Larger organizations are more bureaucratic

Looking for Opportunities

- Focus on where you want to live
- Classifieds
- Local medical society
- Program director
- Networking
- Headhunter
- Cold calling

Timing is Everything!

Interviewing
The Process

- Initial Interview/Contact
  - Write a thank you note!
- Second look
  - Meet all the physicians
  - Meet staff
  - See the facilities
  - Write a follow-up note!

What Are You Looking For?

- Fulfillment?
- Good personality fit?
- Highest possible income?
- A challenge?
- Part time or full time?
- A good practice?*

What Are You Looking For?

- Clinical research
- Teaching opportunity
- Ultrasound
- Interventional rheumatology
- Chance to innovate or build something new?
- A job?

Clues to a Good Practice*

- Friendly greeting/staff
- Nice surroundings
- Good Karma
- Location
- Community reputation
- Tradition of service
  - Community
  - Prof. Organizations
- Forward-thinking
- Acquisitive or defensive
- HMO penetration
- Ancillary services
- Respectful of one another
- Prior history with new physicians
- Strong management

Other Considerations

- Is staffing adequate?
- Does the office layout work well?
- Is there space for you?
- Are the physicians open to new ideas?
- How competitive is the market place?
- Will you be incentivized?
- How quickly will you be busy?
- Is your spouse on board?

What Are They Looking For?

- An employee?
  - Another body to do the work (a schlepper)
- A chance for a buyout?
- A special skill or demographic?
- A partner?
- Someone to participate in practice building?
  - New location
  - Share overhead
  - Share responsibility
  - Market strength

The Contract

- How long until partnership
- Restrictive covenant
- Incentives
- Perks
  - Malpractice, health, life and disability
  - Gas, auto expenses
  - Meetings, dues, subscriptions, vacation
  - Moving expenses
- Call Schedule
- Leaving a practice
- Going to part time
- Covering your 'tail'

The Contract

- Partnership
  - When does it begin?
  - Do you get to parity?
    - Are some partners more 'equal'?
  - How is income divided?
  - What is the buy-in arrangement?
- Buying a practice

The Contract

- Everything is negotiable
- Some things are more negotiable than others
  - The second to join
  - The eighth to join
- All parties in a negotiation have to 'win'

The Contract

- Get an attorney
- Discuss with your peers
- Fairness comes in many forms

Once You Have Accepted

- Start working immediately on
  - State license application
  - Hospital privileges
  - Insurance credentialing
- Bad things happen to those who don't!

Paradigm shift: Busy is Good!

Practice Building 101

- Humility
- Eagerness
- Visibility
- Accessibility
- Make yourself known

Practice Building 101

- Be a consultant
  - Call on all consults but get off phone quickly
  - Get letters out; attractive and readable
    - Make impressions and advice accessible
  - Take great care of your patients
    - Show interest in them
    - Being kind and concerned is just as important as being right

Practice Building 101

- Put some talks together and give them
  - Grand rounds
  - Departmental meeting of internal medicine, FP, ortho
  - Patient groups
- Community service
  - Arthritis Foundation/Lupus Foundation/Scleroderma Federation
  - Religious, ethnic, service organizations

ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

Insurance Company

- A business designed to be a clearing house for funds used to finance health care
- Collection of premiums - payout of benefits = profit
- Such companies do not provide health care
- They pay for health care
- Profit is derived by paying....
  - Less for services
  - For fewer services
- Their goal: earn a profit for investors
- The "Golden Rule"

ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

Business Concepts

- What are receivables?
- What are payables?
- Payer mix?
- What's a PPO, HMO, POS, Indemnity plan?
- What's a co-pay?
- What does it mean to participate...
  - with Medicare?
  - with the Blues, a PPO, or an HMO?

ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

"I'm from the Government... and I'm Here to Help You"

- HIPAA
- Stark
- OSHA
- CLIA
- E & M coding compliance
- Medicare Modernization Act
- P4P/Quality/PQRI
- e-Prescribing and Meaningful Use
- Price controls and the SGR
- ACA
- ACO's

HIPAA

Health Industry Paying All Attorneys

Highly Intricate Paperwork in Abundant Amounts

Health Insurance Pain in the Ass Act

High Income Potential for Aggressive Attorneys

Having Impact Past All Assumptions

Huge Increase in Paperwork and Aggravation Act

10:45 a.m. – 11:15 a.m.

Clinical Research in Private Practice
Joseph Huffstutter, MD

Research in an Office Based Setting

J. E. Huffstutter M.D.
Clinical Asst. Prof. of Medicine
Univ. of TN at Chattanooga
Partner, Arthritis Associates PLLC

Gladwell's Five Steps to Success

- 1. Find meaning and inspiration in your work.
- 2. Work hard.
- 3. Discover the relationship between work and reward.
- 4. Seek out complex work to avoid boredom and repetition.
- 5. Be autonomous and control your own destiny as much as possible.

Spending on Clinical Research

- Funding on biomedical research jumped from $37.1 billion in 1994 to $94.3 billion in 2003 (a doubling of support when adjusted for inflation)
- Industry sponsorship of clinical trials increased from $4 to $14.2 billion while federal support remained unchanged (NIH $26.4 billion)
- Industry funding from pharmaceutical biotechnology and medical device firms increased 102% from 1994 ($26.8 billion) to 2003 ($54.1 billion)

Reasons to do Clinical Research

- Prestige
- Information
- Networking
- Monetary
- Patient Factors
- Altruism

Reasons NOT to do Clinical Research

- Time Consuming
- Difficult
  - More space requirements
  - More personnel
  - Requires different skills
- Malpractice Risks

Types of Research

- Pharmaceutical Sponsored Trials
- Investigator Initiated Trials
- Registries (i.e. CORONA)
- Grants
  - Advocacy Groups (Arthritis Foundation, Scleroderma Foundation, etc.)
  - Government (NIH, schools, etc.)
  - Private Foundations

Types of Pharma Trials

- I Very early work looking to document safety in normal controls and patients
- II Small pilot studies/medium size trials to document proof of concept and dose ranging
- III Larger trials to document efficacy, safety in larger numbers, usually with the intent of FDA approval
- IV Post Marketing

Personnel

- Principle Investigator
- Sub-Investigator
- Study Coordinator
- Site Personnel
- Study Monitor

Terms to Know

- 1572
- Regulatory Documents- CV.s, financial disclosure forms, etc.
- Source Documents
- CRF's
- DCF's
- Electronic Data Capture

Training

- Good Clinical Practice
- Belmont Report
- CITI Course
- Sponsor Specific Learning

Getting Started

- Decide your interests and goals
- Review research feasibility
  - Space
  - Personnel
  - Legal issues
- Make appropriate contacts
  - Pharma
  - Research companies

Examples of Research Management Companies

- PPD www.ppdi.com
- Quintiles www.quintiles.com
- ICON www.iconclinical.com

Things to Avoid

- Site Management Organizations
- Local IRB's
- Projects for which you have no interest
- Underfunded studies
- Projects you need excessive equipment

Timeline for a Project

- Initiate contact
- Sign financial/confidentiality agreements
- Site visit
- Regulatory document submission
- Investigator meeting
- Initiation visit
- Patient data collected
- Study monitoring
- Study close-out visit
- Maintain records

Conclusions Regarding Clinical Research

- Feasible
- Rewarding
- Not for everyone

Tips To Get Started

- Determine your interests
  - -ACR
  - -Patient needs
- Make contacts
  - -Pharma scientists
  - -Web-sites (www.centerwatch.com or www.Clinicaltrials.gov)
- Adjust office setting

11:15 a.m. – 12:15 p.m.

Physician Employment and Contacts
Steve McCoy, JD

Employment Contracts and Related Issues: Guidance for Physicians

Rheumatology Fellows Conference
February 23, 2013

Stephen C. McCoy

Outline: What We Will Cover Today

- **3 Critical Areas of Physician Employment Agreements**
- **Due Diligence Investigation of Medical Practices**
- **Land Mines in Hospital Employment**
- **Trends in Health Care**

Employment Agreements: 3 Critical Areas

- Think of your employment relationship in three phases and review your contract with these in mind:
  1. How do my employer and I work together?
  2. How does our relationship end?
  3. What happens after my employment ends?

Phase 1: Working Together

- **The easy(ish) parts:**
  - **Term: How long does your contract last?**
  - **Description of your obligations: Read and understand. How much discretion does your employer have to change your duties (focus on this in hospital contracts)?**
  - **Record-keeping / billing / coding requirements: Avoid indemnities.**
  - **Representations and Warranties: Make sure these are accurate. Correct inaccuracies before signing.**

Phase 1 (cont.): Compensation

Compensation:

a. Salary
b. Salary plus bonus (production-based or fixed)
c. "Pure" production models
- The physician is paid based on productivity (charges or collected revenues less allocated expenses)
- Your production will be negative for at least the first 90 days of practice and you are likely to be "net" negative for the first 12-18 months of practice
- Avoid pure production models during first 2-3 years of practice.
- Especially problematic in hospital-owned practices

Phase 1 (cont.): Benefits

Understand your benefits:

(1) Salary and Bonus;
- Understand how these work. Ask for models.
(2) Health and disability insurance (employee and dependents);
(3) Professional dues, licenses and insurance;
(4) CME Allowances;
(5) Recruitment Incentives (we will discuss salary guarantees later);
(6) Vacation / Sick Leave.

Phase 1 (cont.): Professional Liability Insurance

The Basics:

- **Employer should pay for coverage**
- **Usually written with "Per Incident" and "Annual Aggregate" limits**
- **Know the Cap in your State (if applicable)**
- **Get and Keep a Copy of the Policy**
- **Know and follow your employer's procedure when an incident occurs**

Liability Insurance (cont.)

Two Types of Professional Liability Coverage:

(1) Occurrence-based Coverage
- **Coverage is Period-Based**
- **More Expensive, Uncommon Outside of Hospital Settings**

(2) Claims-Made Policies
- **Coverage is Claim-Based**
- **Prior Occurrences Binder ("Nose")**

Working Together (cont.)

Indemnities

An indemnity is an agreement that you will pay any costs or expenses that arise as a result of your actions or failures to act (usually these are specified in the indemnity but the description may be as general as "physician's acts or omissions")

Your employer should insure against such losses and should not look to you personally to make the employer whole

Avoid or limit indemnities wherever possible

Working Together (cont.)

Here is a sample indemnity provision. Avoid the language in yellow (particularly) and negotiate for the underlined text if you can't avoid the indemnity altogether:

If any claim should be asserted against Employer for Physician's activities occurring during the term of Physician's employment and arising out of alleged malpractice, *third party payor (e.g. Medicare, Medicaid, or private insurance) reimbursement or claim submission,* or tax deficiencies relating to disallowed business expenses incurred by Physician, Physician (or Physician's estate) shall bear the financial responsibility therefor *to the extent any such claim would not otherwise be covered by insurance required to be maintained hereunder*.

Working Together: Buy-In Provisions (non-hospital practices only)

What You Need:

(1) Decision time-line included in the contract

(2) Price or methodology included in the contract
- **Discuss tax-advantaged methods**

(3) Other requirements specified in the contract

(4) Right to buy-in to ancillary businesses and terms for buy-in

(5) The right to leave with limited consequences if you are not offered the opportunity to buy in

Phase 2: It's Not Me, It's You (Ending the Employment Relationship)

Employment agreements terminate in 3 ways:

1. **Expiration (this is rare);**
2. **Termination with cause (more common);**
3. **Termination without cause (most common).**

Phase 2 (cont.): Termination

- **Without Cause:** ***This Agreement may be terminated by either party without Cause upon ninety (90) days' written notice to the other party.***

  Standard contract provisions - not cause for alarm.

  Ask for reciprocal notice periods.

  Focus on other contract provisions that are triggered by termination.

Phase 2 (cont.): Termination

Termination with "Cause":

(1) Material breach / failure to comply with policies of Employer;**
(2) Failure to maintain license / privileges / Right to Participate with Medicare and/or *Medicaid;*
(3) Felony or "moral turpitude;"
(4) Loss of insurance (vs. insurability);
(5) Disability / Substance Abuse;
(6) Inaccuracy of warranties / representations.

****Contract should give you the right to cure.**

Phase 3: It's Over, but It's Not Over Restrictive Covenants

The Employer's Purpose: To prevent you from building a patient base, then leaving and taking your patients with you to a second employer or to your own practice.

General Prohibition: the physician may not practice medicine

- **in competition with his/her employer**
- **within a defined area**
- **during or after employment**
- **(if after) for a set period of time**

Non-Competes (cont.)

Contrary to widespread belief, physician non-competition agreements are enforceable in most states.

How is a covenant not to compete enforced?

- **Injunctive 'Relief' (the court orders you to stop)**
- **Money Damages**
- **"Later of" Clauses**
- **Awards of Attorneys Fees and Costs**
- **Loss of Tail Coverage and other post-termination benefits**
- **Chilling Effect on Prospective Employers**
- **Expense and Uncertainty**

Non-Competes: What are your options?

Before you sign:

- **Review with counsel and understand the restriction**
- **If possible, negotiate a mutually exercisable buy-out**
  - **One year of compensation is typical measure**
- **Negotiate other limitations**
  - **e.g., Not applicable if group terminates without cause or fails to offer equity ownership**
  - **Hospitals may agree to restriction on employment by other health systems / large physician groups**

Non-Compete Options (cont.)

After you sign:

- **Don't leap before you look!**
- **Consult with counsel before terminating employment**
- **Always keep a copy of your contract**

Two physician households should pay particular attention to these provisions (and may have better luck negotiating exceptions).

Phase 3 (cont.): Tail Coverage

Extended Reporting Endorsements

- a.k.a. "tail coverage"
- provides coverage of prior acts following termination of claims-made insurance
- Negotiate for cost-sharing or for permission to maintain continuing claims-made coverage without purchasing tail coverage (generally only possible if you move within the state)

Phase 3: Other Post-termination Items

- Observe any notice periods
- Watch for other contract provisions with post-termination effects:
  - Confidentiality provisions
  - Repayment obligations

Due Diligence: Kicking the Tires

Ask questions about practice organization:

- How is the practice organized? Hospital owned, health plan-affiliated, or private?
- How old are the partners / shareholders?
- Who last made partner? On what terms?
- How is call shared? How is holiday coverage apportioned?
- How (and how much) are partners compensated? What are regional averages in your specialty?
- Are the younger physicians happy? How many have left? When? Why?
- Do the practice physicians own ancillary businesses or property used by the practice?

Due Diligence (cont.)

Ask questions about the practice's planning:

- Does the practice have a long-range plan? What is it?
- Is the local health system purchasing physician practices?
- Is the practice in a Medicare ACO or commercial ACO(s)? Is it participating in other coordinated care initiatives? Are those being considered? Do they exist in the market?
- Does the practice have an electronic medical record (EMR)?
- If not, where is it in the transition to EMR? How does the practice plan to pay for EMR? What is the projected effect on physician compensation?
- Does the practice prescribe electronically? If not, why not?

Hospital Employment of Physicians

Critical Issues:

1. Compensation
   - Negotiate to 75th percentile of MGMA compensation (available online and through your attorney)
   - Negotiate for signing bonuses / moving allowances
   - Watch for changes in compensation structure in later years of contract
2. Description of services and limits on hours / Call-sharing
   - Negotiate for hard ceiling versus "equal treatment"
3. Restrictive Covenants (understand)
4. Recoupment of payments (avoid)

Hospital Recruitment Assistance and Salary Guarantees

1. Watch provisions triggering repayment obligation
   - For recruitment assistance, repayment is typically required if you leave the hospital's service area during the subsidy period or the 2-3 year period following the end of the subsidy
   - Repayment should be a practice obligation unless you breach
2. The practice should not restrict your ability to remain in the hospital service area following termination
3. Consider the tax impact of signing a note

Hospital Recruitment Assistance (cont.)

4. **Understand how debt forgiveness works**
   - Tax planning is critical to handle discharge of indebtedness (DOI) income
   - Negotiate for separate payment of practice expenses and physician compensation to minimize DOI income
     - Your collections should go first to pay your compensation, then to practice expenses

Trends: Right to Approve Settlement of Claims

Settlements and judgments are reported to the National Practitioner Data Bank. In addition, many states maintain public databases with settlement information and mandate reporting.

Some physicians are negotiating the right reasonably to approve settlement of professional negligence claims

Review liability insurance for participation rights and negotiate for inclusion in contract. Remember that your contract can't provide rights that your employer does not have under its professional liability coverage.

Final Thoughts

- Get and keep a copy of your contract and other practice policies
- Walk through the termination of your contract before you *sign* it
- Avoid contract language that makes you personally liable for claims or requires to you to repay money
- There are no handshake agreements
- Hire an attorney to review and advise

Contact Information

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(804) 370 1041 (c)

1:15 p.m. – 2:00 p.m.

New Paradigms in Gout Management
N. Lawrence Edwards, MD, FACP, FACR

Recommendations for the Diagnosis and Management of Gout and Hyperuricemia

N. Lawrence Edwards, MD
Professor of Medicine
Vice Chairman, Department of Medicine
University of Florida

CSRO Meeting
February 23, 2013

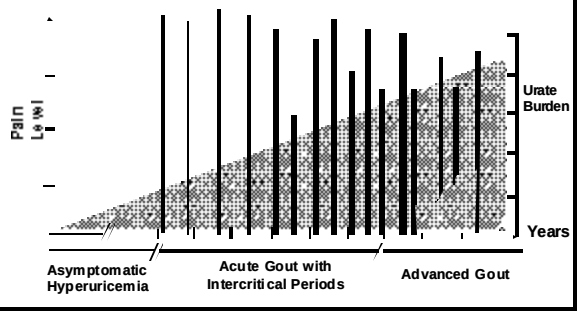
Conflict of Interest

- Dr Edwards is a consultant for the following pharmaceutical companies: Ardea Biosciences, Takeda US, Novartis, Savient, Metabolex, and Sobi North America.
- Any conflicts noted above have been resolved according to the ACCME *Standards for Commercial Support* and VCU continuing medical education policies and procedures.

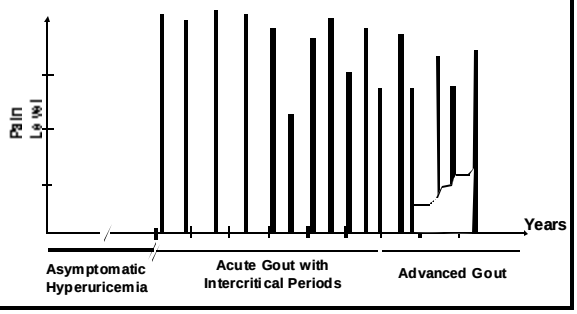

2011 Recommendations for the Diagnosis and Management of Gout and Hyperuricemia

Postgraduate Medicine 123(Suppl 1), 3-36, November 2011

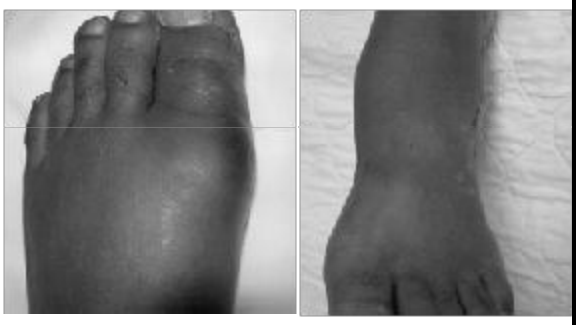
Stages of Gout



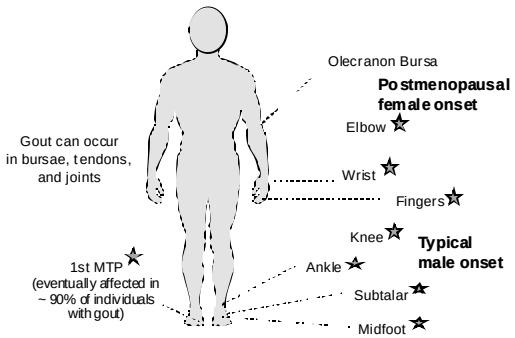
Stages of Gout



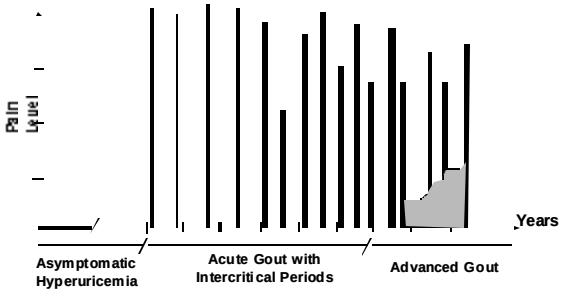
Acute Gouty Arthritis: Podagra and Ankle Inflammation

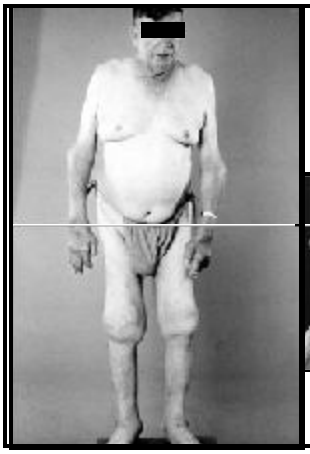


Common Sites of Acute Flares

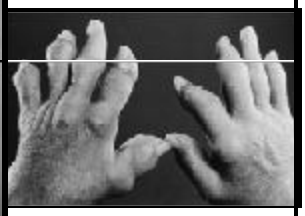


Stages of Gout

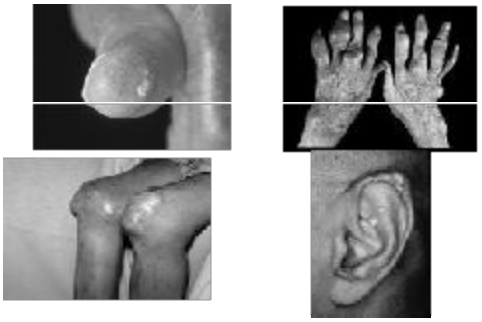




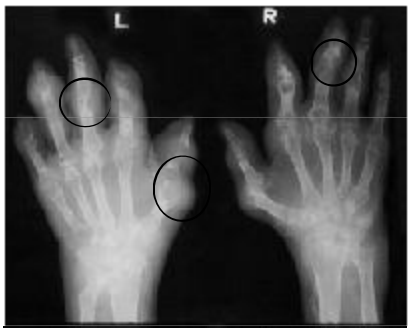
Advanced gout with bilateral, deforming polyarthritis



Advanced Gout
Clinically Apparent Tophi



Radiographic Findings in Advanced Gout

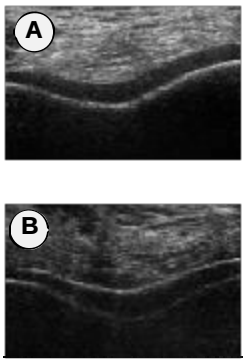


Diagnosing Gout

- **Synovial fluid crystal analysis is the gold standard**
- **Classic history and physical examination**
- **Hyperuricemia**
- **Response to colchicine**

"Diagnostic Triad"
Flawed

Ultrasound in the Diagnosis of Gout

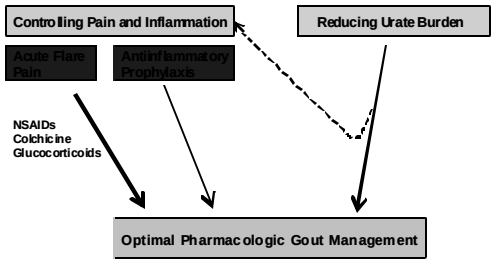


Normal

Gouty Arthritis

"Double Contour Sign"

Approach to Gout Management



Edwards NL, Crystal-Induced Joint Disease *in* ACP Medicine Textbook, 2012

Current Options for Acute Gouty Inflammation

First-line Choices

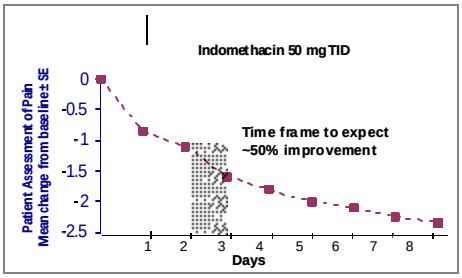
- NSAIDs : several are approved; all are effective
- Oral Colchicine: low dose
- Oral Glucocorticoids: comparable to NSAIDs

Other choices

- IA, IM or IV glucocorticoids
- Off Label: ACTH gel s.c.
- Off Label: IL-1 inhibitors
- Topical ice

Terkeltaub R. AR&T, 2009

Effect of NSAIDs on Baseline Pain in Gout



Rubin BR, et al. *Arth Rheum.* 2004;50:598-606.

The AGREE Trail
(Acute Gout Flare Receiving Colchicine Evaluation)

Low dose (1.8mg) vs high dose (4.8mg) oral colchicine regimens in patients with acute (<12 hours) gout flares is a large, multicenter, randomized, double-blind, placebo-controlled, parallel group study.

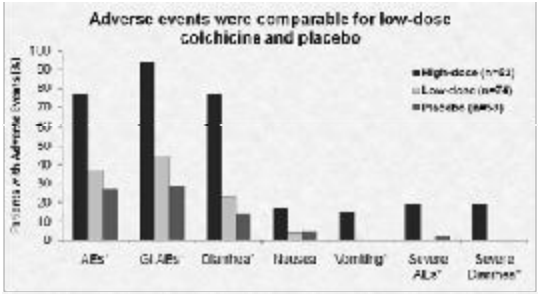
% Responders* Based on Target Joint Pain

Colchicine		Placebo
Low	High	
n=74	n=52	n=58
38%	33%	15%

Responder = 50% reduction in pain score at 24 hrs after 1st dose

Terkeltaub RA, et al. High- vs low-dosing of oral colchicine for early acute gout flare. Arthritis Rheum, 2010

Adverse Event with High dose and Low Dose Colchicine in the AGREE Trial



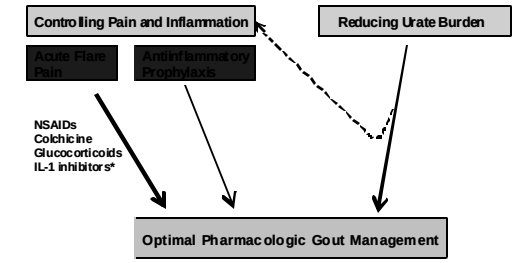
Terkeltaub RA, et al. Arthritis Rheum, 2010.

Oral Glucocorticoids Compared to NSAIDs for Treatment of Acute Gouty Pain

PREDNISOLONE 35 MG/DAY
vs. NAPROXEN 500 MG BID X 5 DAYS
Equally effective, comparable tolerance
Janssens HJ et al, Lancet. 37:1854, 2008

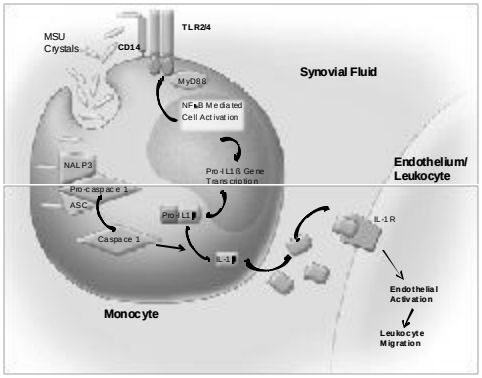
ORAL PREDNISOLONE 30 MG
(6 doses/5 days) / ACETAMINOPHEN
vs. INDOMETHACIN/ACETAMINOPHEN
Equally effective for pain; better side effect profile for steroids
Man CY, et al, 2007. Ann Emerg Med. 49:670.

Approach to Gout Management



*** Not FDA approved**

Edwards NL, Crystal-Induced Joint Disease *in* ACP Medicine Textbook, 2012



Edwards NL. Crystal-Induced Joint Disease, ACP Medicine Textbook, 2012

A Pilot Study of IL-1 Inhibition by Anakinra in Acute Gout

So A, DeSmedt T, Revaz S, Tschopp J. Arthritis Research & Therapy 2007, 9: R28 (doi:10.1186/ar2143)

- **10 patient pilot, open-labeled trial of anakinra in patients who had failed other anti-inflammatory therapy for acute gout.**
- **"All patients responded rapidly to the drug, with the most rapid onset observed within 24 hours. In all patients, subjective symptoms of gout were greatly relieved by 48 hours after the first injection."**
- **"No side-effects were observed during the study period."**

Canakinumab (ACZ885) Relieves Pain and Controls Inflammation Rapidly in Patients with Difficult-to-Treat Gouty Arthritis. So A, et al. Abstract #145, ACR Annual Meeting, 2010

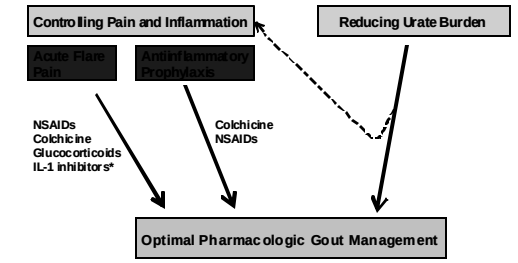
- **Purpose:** **Compare effect of IL-1β inhibition with Cannukinumab (CAN) to triamcinolone acetonide (TA) in the treatment of acute gout flare.**
- **Methods:** **Patient with gouty flares who have contraindications to NSAIDs a/o colchicine given 1 subcut dose of CAN or 1 IM dose of TA. Primary outcome: pain intensity at 72 hr post dose.**
- **Results:**

Pain reduction at 72 hours	Cannukinumab 150 mg s.c.	Triamcinolone 40 mg IM
>75%	78%	45%
>50%	96%	61%

Conclusion: Cannukinumab vs Triamcinolone

- Cannukinumab 150 mg sc is superior to IM triamcinolone 40 mg for pain relief in acute gouty flares. Markers of inflammation were suppressed by Cannukinumab but not triamcinolone for 8 weeks after injection.

Approach to Gout Management



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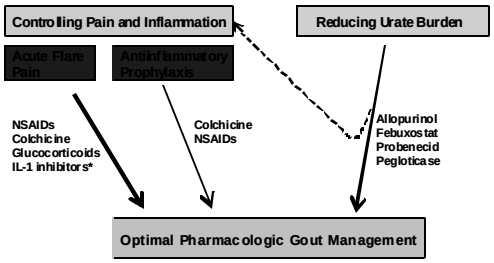
Approach to Gout Management



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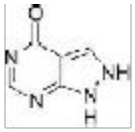
Edwards NL, Crystal-Induced Joint Disease *in* ACPMedicine Textbook, 2012

Allopurinol

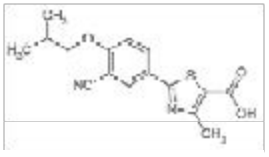


- FDA approval in 1964; most commonly used form of ULT.
- Well tolerated in ~90% of users; AHS occurs in 0.1% of allopurinol starts.
- 97% of all allopurinol prescriptions in this country are for 300 mg/d or less. At this dose, only 35% will reach target of sUA < 6.0 mg/dl.
- Like all forms of ULT, allopurinol may increase the frequency of flares after initiation if antiinflammatory prophylaxis is not co-administered.

Recommended Allopurinol Dosing Schedule

- Start low-dose colchicine or NSAIDs 2 weeks prior to initiating ULT.
- Begin allopurinol at 100 mg/d (for CKD class I-III) or 50 mg/d (CKD class IV).
- Recheck sUA level every 3-4 weeks and escalate allopurinol dose by 50-100 mg until sUA < 6.0 mg/dL up to a maximum dose of 800 mg/d.
- Allopurinol therapy should be uninterrupted and life-long.
- Antiinflammatory prophylaxis can be stopped if no flares in past 6 months

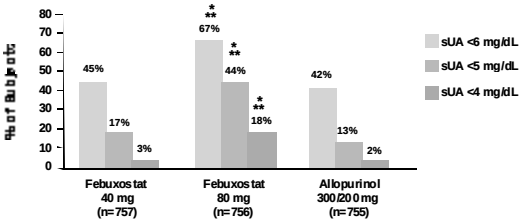
Febuxostat



- Selective xanthine oxidase inhibitor.
- Structurally dissimilar to allopurinol.
- Metabolized by the liver with no dose adjustment for CKD.
- Simple dosing schedule: 40 mg/d as initial dose, then increase to 80 mg/d after 2 weeks if sUA not at target.

CONFIRMS Final Study Visit: Subjects Stratified by sUA Levels

Proportion of Subjects With sUA Lower than 6 mg/dL, 5 mg/dL, and 4 mg/dL at Final Visit



*p<.001 vs allopurinol.

**p<.001 vs Febuxostat 40 mg.

ITT population: subjects with serum urate level ≥8.0 mg/dL on day -4.

Data on file, Takeda Pharmaceuticals America, Inc.; 2008

Other Pharmacologic Strategies to Lower Serum Urate Levels

Effect of Non-Gout Drugs on Serum Urate

	Urate Retentive	Urate Neutral	Uricosuric	Ref
Diabetes Obesity Nutrition		Sulfonylureas	Vitamin C Milk (casein) Metformin Meridia Orlistat	Berger L et al, Am J Med, 1977 Garrel DR et al, Am J Clin Nutr, 1991 Gokcel A et al, Diabetes Care, 2001
Hormones			Calcitonin HRT	Fiore CE et al, J Endocrinol Invest, 1981 Sumino H et al, Lancet, 1999
NSAIDs		Ibuprofen Indomethacin Meloxicam	Diflunisal Sulindac	Tiitinen S et al, Clin Rheumatol, 1983

Effect of Non-Gout Drugs on Serum Urate

	Urate Retentive	Urate Neutral	Uricosuric	Ref
Blood Pressure		Lisinopril Captopril Enalapril Ramapril Verapamil Amlodipine Felodipine Nicardipine	Losartan	Softer BA et al, Hypertension, 199 Leary WP et al, Cardiovasc Drugs Ther, 1987 Weidmann P, et al, Eur J Clin Pharmacol, 1989
Diuretics	HCTZ Furosemide	Spironolactone		Falch DK et al, Acta Med Scand, 1983
Lipid-lowering	Niacin	Simvastatin Pravastatin Lovastatin	Fenofibrate Atorvastatin	Elam MB et al. JAMA, 2000 Liamis G et al, Am J Kidney Dis, 1999 Yousseff F et al, Euro J Vasc Endovasc Surg, 2002

Relative Risk of Incident Gout in Hypertensive Subjects on Different Treatments

Monotherapy	R.R.
Losartan	0.81
CCB (overall)	0.87
amlodipine	0.79
diltiazem	0.86
nifedipine	0.87
ACEi	1.24
ARB (non-losartan)	1.29
β-blocker	1.48
Diuretic*	2.36

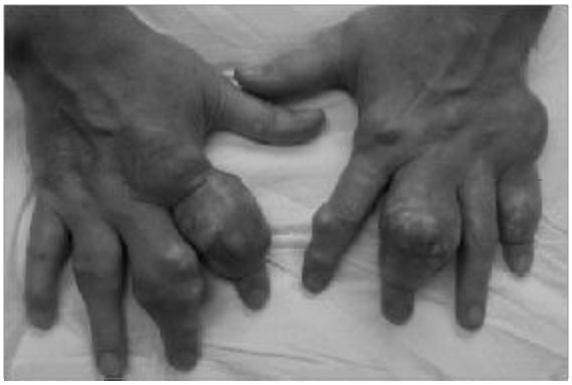
Combination	R.R.
CCB + Losartan	0.66
CCB + ACEi	1.13
CCB + β-blocker	1.7
CCB + diuretic	2.1
Diuretic + ACEi	3.2
Diuretic + β-blocker	3.3

Triple Therapy	R.R.
Diuretic + ACEi + CCB	2.30
Diuretic + ACEi + β-blocker	3.88

* Diuretics were not otherwise classified as thiazides or loop diuretics>

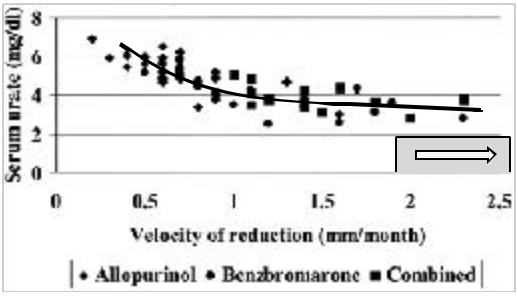
Choi HK, Soriano LC, Zhang Y et al. Antihypertensive drugs and risk of incident gout among patients with hypertension: population based case-control study. 2012. Brit J Med 344:d8190 doi:10.1136/bmj.d8190

But what about patients with advanced gout?



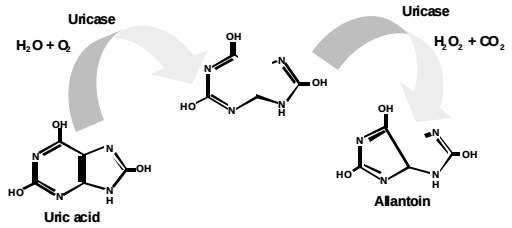
Effect of Urate-Lowering Therapy on the Velocity of Size Reduction of Tophi in Chronic Gout

Perez-Ruiz F, Calabozo M, Pijoan JI, et al. Arthritis Rheum 47: 356–360, 2002

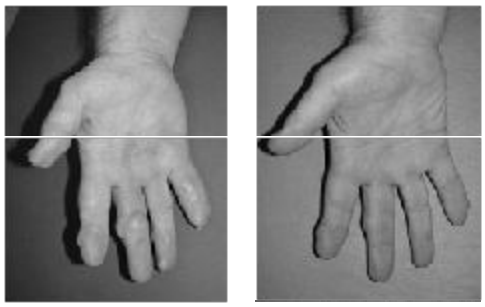


Uricase enzymes

Uricase (uric acid oxidase) catalyzes the conversion of uric acid to allantoin: A more soluble, readily excretable form



Pegloticase
Resolution of Tophi

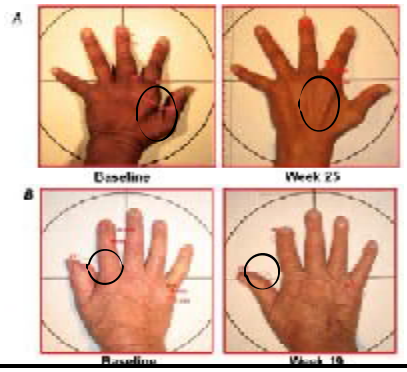


Baseline

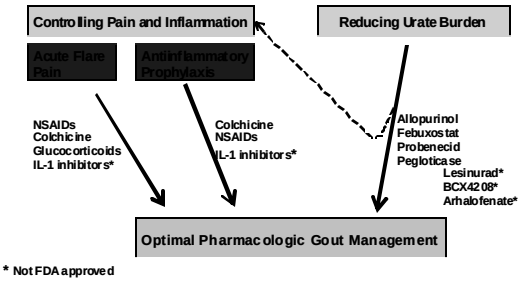
Week 15

Sundy and Hershfield, unpublished data

Tophus Resolution Using Pegloticase

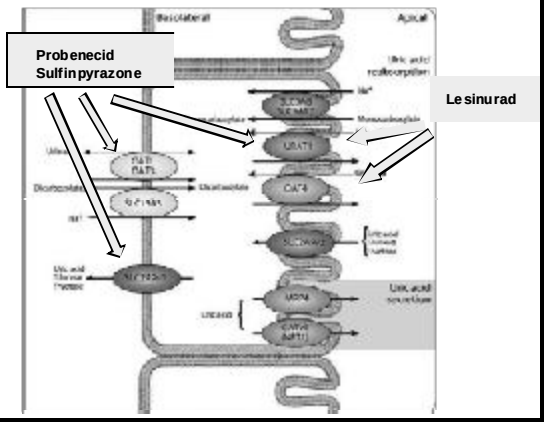


Approach to Gout Management

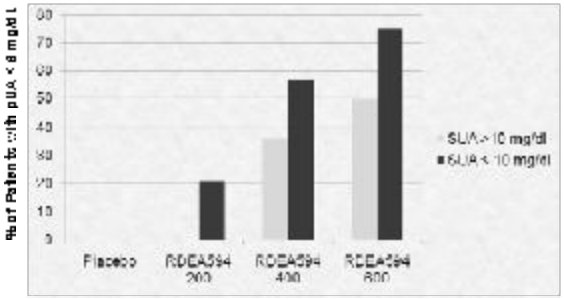


* Not FDA approved

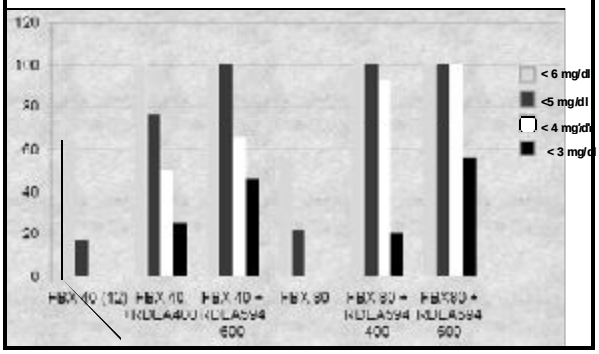
Edwards NL, Crystal-Induced Joint Disease *in* ACPMedicine Textbook, 2012



RDEA 594 (Lesinurad) Monotherapy: Reduction of PUA by Baseline Urate – Study 202



Febuxostat and RDEA594 Combination and SUA Response – Study 111



Conclusions

- **Existing urate therapies are safe and effective in the vast majority of patients with gout**
- **Keys to success include: proper patient education (www.gouteducation.org), gout flare prophylaxis, treating to target, and monitoring SUA**
- **Developments in the near future**
  - **determining the role of uricases**
  - **determining the right dosing schedules of existing drugs**
  - **combinations with new uricosurics**

2:00 p.m. – 2:45 p.m.

Medical Malpractice
Jeffrey S. Penner, MD

Medical Malpractice and Risk Management

Jeffrey S. Penner, M.D., F.A.A.O.S.

Atlantic Orthopaedics

CSRO Fellows Conference
February 23, 2013
San Francisco, CA

Mal-Practice

- Medical care which is below acceptable standards (National not local)

Depositions

- Depositions are sworn statements
- There are number of Questions and Answers
- There is a Plaintiff and a defendant
- You need to know which side you are testifying for
- Conference with the attorney ahead of time
- Need to know what the requesting attorney wants you to say
- You are an advocate for your opinion

Depositions

- Need to have your own records and any other records you may be questioned
- Your deposition may be read in Court

Mal- Practice
Do's and Don'ts

- Do not alter patients' Medical records
- All documentation should be made in a timely manner
- Do not point fingers
- Telling a patient on the phone that he/she has cancer is not mal-practice- it is **STUPID**
- Make sure billing is appropriate (yours and your colleagues)
- Don't give a deposition in your office

Mal- Practice
Do's and Don'ts

- Do not try to settle a case on your own
- Do not ignore a patient when there has been a bad result (Ostridge Method)
- Do not treat a patient out of the area of your expertise
- Make sure all correspondence is brought to your attention

ABCs of a Medical Malpractice Deposition

- Prepare.....Prepare.....Prepare
- Tell the truth
- Never guess or speculate
  - **"I don't know" is OK**
- Don't answer a question you don't understand
- Answer only the asked question
- Answer the question succinctly
- Do not let the plaintiff attorney put words in your mouth
- Pause before answering

ABCs of a Medical Malpractice Deposition

- Do not think out loud
- Listen to your attorney's objections
- Be professional at all times
  - **The deposition is a court record- Do NOT Joke**
- Dress professionally and conservatively
- Never show indifference
- Take breaks as necessary
- Don't volunteer to supply any documents- leave that up to your attorney

ABCs of a Medical Malpractice Deposition

- No text or journal is authoritative
- Don't agree with what the plaintiff lawyer says
- Don't let the questioner interrupt your answer
- Listen to the hypothetical question
- Summarize complicated events
- Don't volunteer more than what you are asked
- Deposition may be video taped- Be aware of your body Language
- Get a good night's sleep

Risk Management

- **Definition:**

  Risk Management is the process of planning, organizing, reading, and controlling the activities of an organization in order to minimize the adverse effect of Accidental Loss on that organization at a reasonable cost.

Risk Management

- Definition:

  Structured Common Sense Applied to Loss Exposure

Risk Management

- Definition:

  Common Sense Avoidance of Loss

Loss

- You Can Lose:
  - Key Person
  - Time
  - Money
  - Aggravation
  - Equipment
  - Patients

Loss

- Key Person:
  - Administrator
  - Computer Operator
  - Book Keeper
  - PT/PTA/ OT
  - Receptionist
  - Typist

Loss

- Key Person
  - Marketing
  - Scrub Tech
  - Detail Person

Loss

- Time
  - Underutilization
  - Overbooking
  - Staffing

Loss

- Money
  - Insurance
    - Life
    - Disability
    - Health
    - Mal-practice
    - Workers' Compensation
    - General Liability
    - Pension Plan

Loss

- Money
  - Accounts
  - Contracts (Insurance)
  - Acceptable Charges
  - Law Suit
  - Overtime (Time Clock)
  - Sexual Harassment
  - Colleagues

Contracts

- Employment
  - Restrictive Covenant
- Intellectual Property (IP)
- Research Projects

Loss

- Aggravation
  - Occupational Safety and Health Administration
  - Laws and Regulations
    - Written Exposure Plan
    - Blood Born Pathogens
    - Hepatitis B Vaccine
    - Universal Precautions
    - Post-Exposure counseling prophylaxis
    - Education/Training Infection Control
    - Just to name a few..... GET THE MANUAL

- Practicing in a fish Bowl!
  - HMOs/PPOs
  - Medicare (Appropriate Coding)
  - Hospitals
  - Peer Review Organizations
  - PFP (Pay For Performance)
  - Meaningful Use
  - E-Rx

PPACA

Patient Protection and Affordable Care Act

OBAMA CARE

Loss

- Equipment
  - Proper in-service as to the use of the equipment
  - Proper maintenance of the equipment
  - Is the equipment approved for hospital use or office use

Loss

- **We Lose Patients to:**
  - **Referral Patterns to HMOs and PPOs**
  - **Bad Public Relation/ Marketing**
  - **Bad Location**
  - **Ex- Associates**
  - **University Programs 3000 Miles Away**
  - **Bulletin Boards and Websites**

Loss

- **We lose because of:**
  - **Law Suits**
    - **Associates**
    - **Employees**
    - **Colleagues**
    - **Patients (Mal-Practice)**
    - **Audits (Medicare/ HMOs/ PPOs)**
    - **You name it..... OIG/ OMG**

Personal Injury Practice Areas

- **Medical Device Litigation**
- **Medical Malpractice**
- **Pharmaceutical Litigation**
- **Toxic Torts/Mesothelioma**

Medical Device Litigation

Current Cases

- Davol Bard Kugel Mesh
- Medtronic Sprint Fidelis Lead Wire
- Duragesic/Fentanyl Pain Patch
- Charite Artificial Disc
- Zimmer Artificial Hip
- Zimmer NexGen Knee Replacement
- Depuy ASR Hip Implant

Past Cases

- Guidant Defibrillator
- Medtronic Defibrillator

Pharmaceutical Products Litigation

Current Cases

- Pradaxa
- Darvocet
- Fosamax
- Levaquin
- Paxil

Past Cases

- Ephedra
- Fen-Phen
- Prempro
- Vioxx, Celebrex and Bextra

- **King of Torts:**

Melvin Belli

In the eyes of the law
the best doctor in the
world is only as good as
his worst employee

Messages and staff

- **You are responsible for your staff**
- **Have mechanism for handling messages**
- **Sign off on lab and x-ray results**
- **Know when a doctor-patient relationship starts**

Personal Injury, Medical mal-practice, and wrongful death is all we do!

The real problem is not
The law suit minded patient
BUT
The law suit causing Physician
or their Assistants!

People don't care how much you know
until they know
how much you care!

- Remember to be
  - Caring
    - Concerned
      - Competent
        - Compassionate and
          - Careful

BECAUSE

If you miss their Cancer,

They won't forget your Name!

2:45 p.m. – 3:30 p.m.

Coding for the Practitioner
Jean Acevedo, LHRM, CPC, CHC, CENTC

Coding for the Practitioner

Jean Acevedo, LHRM, CPC, CHC, CENTC

Prepared for
Coalition of State Rheumatology Organizations'
National Rheumatology Fellows Conference
February 2013

Disclaimer

- The information enclosed was current at the time it was presented. Medicare and other payer policy changes frequently. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- Acevedo Consulting Inc. employees, agents, and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this information.
- This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and coding information, but is not a legal document. The official CPT® codes and Medicare Program provisions are contained in the relevant documents.

Agenda

- Payer Documentation Requirements
- Medical Necessity
  - a/k/a being able to keep the money!
- Evaluation & Management Services
  - Modifier-25
- EMR pitfalls

"10 Iron Rules of Medicare"*

*Quote from Attorney Larry Oday; Modern Healthcare/June 19,2000

1. Just because it has a code, that doesn't mean it's covered.
2. Just because it's covered, that doesn't mean you can bill for it.
3. Just because you can bill for it, that doesn't mean you'll get paid for it.
4. Just because you've been paid for it, that doesn't mean you can keep the money
5. Just because you've been paid once, that doesn't mean you'll get paid again.
6. Just because you got paid in one state doesn't mean you'll get paid in another state
7. You'll never know all the rules.
8. Not knowing the rules can land you in the slammer.
9. There's always some schlemiel who doesn't get the message.
10. There's always some schmendrik (jerk) who gets the message and ignores it.

PAYER DOCUMENTATION REQUIREMENTS

Medical Record Documentation

- Validates
  - The site of service
    - Is it appropriate for the service and patient's condition?
  - The appropriateness of the services provided
    - Not experimental
    - Meets but doesn't exceed patient's medical need
    - Ordered and performed by qualified personnel
  - The accuracy of the billing
    - CPT/HCPCS codes accurately represent what is documented
    - ICD-9 (ICD10) codes are supported by clinical documentation
  - Identity of the care giver (provider)
    - Who personally performed the service?
    - Legible signature

Medical Record Documentation

- Each encounter should
  - Be complete and legible
  - Every page in the chart should have the patient's name and date of service.
  - Document the reason for the encounter
    - a/k/a "medical necessity"
  - Have a documented impression
  - Have a documented plan of care/f-up
  - Be dated and have the identity of the provider
    - Sign, initial, typed name on dictation
    - All providers and staff

7

Alphabet Soup of Fraud & Abuse

- CMS
  - MACs
  - ZPICs
  - RACs
  - CERT contractor
- Don't forget the Private Payers!
  - SIUs
  - Contracted audit companies (private RACs)

8

Medical Necessity

Medicare law requires that in order for expenses incurred for items or services to be covered, they must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

CMS Glossary for Beneficiaries defines medical necessity as: "Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor. "

9

Medical Necessity

(Pub 100-4, Medicare Claims Processing Manual, Ch. 12, §30.6)

"Medical necessity is the overarching criterion for payment, in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of service than is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service billed."

10

So, in plain English

- Think of Medicare as any other health insurance
- Certain items/services are covered
  - And others are not
- And those that are, must meet the coverage criteria
  - That the service is "reasonable and necessary" or be one of the preventive benefits
- Much of this is defined in NCDs and LCDs for non-E&M services provided by physicians.

11

Evaluation & Management Basics

12

E&M Coding….what the??

- Where am I?
  - Inpatient, home, SNF/NF, office codes
- Is this a new or established patient visit(outpatient)?
- Or, is this the initial or subsequent visit for this admission (inpatient)?
- Once you answer those questions….
  - 3, 4 or 5 levels of service to choose from.

13

CPT – 2013: E&M Services Guidelines

- **New and Established Patient**
- "solely for the purposes of distinguishing between new and established patients, **professional services** are those face to face services rendered by physicians and other qualified health care professionals who may report [E&M] services…
- "An established patient is one who has received professional services from the physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice within the past three years.
- "….where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician."

Payer perspective

- Follows CPT only?
- CPT and CMS E/M DG?
  - 1995
  - 1997

7 Components Define E&M Services:

- Key components in selection of level
  - History
  - Examination
  - Medical decision making
- Ancillary elements in selection of level
  - Counseling
  - Coordination of care
  - Nature of presenting problem (medical necessity)
  - Time

Use of Time: If a visit consists **predominantly** of counseling or coordination of care, time is the key element to assign the appropriate level of E&M service

- Office/outpatient setting
  - Face-to-face time refers to patient time with the physician only.
  - Counseling by other staff does not count.
  - Duration of c/cc may be estimated but must be recorded
  - Total duration of the visit also documented.
  - Do not round up!
    - 99214 = 25 minutes
    - 99215 = 40 minutes
    - 35 minute visit is a 99214

"Results" visit

At least 45 minutes w/patient >50% discussing lab results, lifestyle changes and medications to help manage symptoms; new diagnosis of Lupus. All patient questions answered. Long discussion regarding her desire to get pregnant.

18

Let's look at the 3 Key Components
1. History
2. Physical Exam
3. Medical Decision Making

19

#1: Documentation of History

- History elements
  - Chief Complaint (CC)
  - History of present illness (HPI)
  - Review of systems (ROS)
  - Past, family and/or social history (PFSH)

Chief Complaint

- Concise statement describing symptoms, problems, condition, physician recommended return, or other factor that is the reason for the encounter.
- Chief complaint must be explicitly stated or easily inferred from documentation:
  - "Chest pain for past 8 hours" (explicit)
  - "Doing well on increase to Atenolol 100 mg daily" (inference is that visit is to f/up on medication change)

History of Present Illness

- History of Present Illness elements:
  - Location – body area (chest)
  - Quality – sharp, burning, deep
  - Severity – intensity of illness (9 on a scale of 1 10)
  - Duration – how long symptoms last (past 8 hours)
  - Timing – relation to events (constant)
  - Modifying factors – precipitating or alleviating factors (improved with statins)
  - Associated signs (objective evidence) or symptoms (subjective evidence) (e.g., nausea)

Review of Systems

- Constitutional symptoms; e.g. fever
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/ Lymphatic
- Allergic/Immunologic

Review of Systems (ROS), cont.

- Complete ROS addresses system related to problem plus all add'l body systems.
  - At least 10 organ systems, must be reviewed
  - Those with positive and pertinent negative findings must each be documented,
  - For remaining systems, notation indicating "all other systems negative" may be permissible

Past, Family and/or Social History consists of:

- Past history (the patient's past experiences with illnesses, operations, injuries and treatments);
- Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- Social history (an age appropriate review of past and current activities).

History Documentation Guidelines

- History documentation is dependent upon the physician:
  - Clinical judgment
  - Nature of presenting problem(s)
- CC, ROS, and PFSH - list separate or w/ the HPI
- ROS and/or PFSH obtained prev. does NOT have to be re-recorded. Documentation should reflect that the physician reviewed the previous entry noting the date and location.
- ROS and/or PFSH can be recorded by the patient or ancillary staff.
- If you are unable to obtain a patient history, document why and your attempt to obtain from another source.

History Documentation Guidelines

- Do not list the chief complaint as 'follow up'
- Do not document a history area as 'noncontributory'
- Do not list a history area just to meet a high level code

Selecting *Level of History

HPI	ROS	PFSH	Level
Brief (1-3 elements)	n/a	n/a	**Problem Focused**
Brief (1-3 elements)	Problem Pertinent (system directly related to problem identified in HPI)	N/A	**Expanded Problem Focused**
Extended (4 or more elements)	Extended (system directly related to problem identified in HPI & a limited # of add'l systems - 2-9 total	Pertinent (at least 1 specific item from any of the 3 areas)	**Detailed**
Extended (4 or more elements)	Complete (system directly related to problem identified in HPI + all add'l systems or a minimum of 10 systems)	Complete (2 or all 3 of the PFSH depending on E/M category)	**Comprehensive**

*To qualify for a given level of history, **all 3 elements** in the history table must be met.

#2: Documentation of Exam (1995 DG)

- Comprehensive: Gen'l multi-system **(8+ OS)** or complete single system organ system exam.

Body Areas:

- Head, including face
- Neck
- Chest, incl. breasts & axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, incl. spine
- Each extremity

Organ Systems:

- Constitutional
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Documentation of Exam*

Problem Focused	A limited exam of the affected body area or organ system **(1+ BA/OS)**
Expanded problem focused	A limited exam of the affected body area or organ system and any other symptomatic/related area(s)/system(s) **(2-7 BA/OS)**
Detailed	An extended exam of the affected body area(s) or organ system(s) and any other symptomatic or related area(s)/system(s) **(2-7 BA/OS)**
Comprehensive	Gen'l multi-system **(8+ BA/OS)** or complete single organ system exam.

*Note: there are geographic differences in these definitions

EPF v. Detailed Exam - Example

- ***Expanded Problem Focused exam*** "a limited examination of the affected body area or organ system and other symptomatic or related organ system(s)." 2 7 BA/OS

Constitutional: VSS
Heart: RRR
Lungs: Clear

- ***Detailed exam*** "an extended examination of the affected body area(s) and other symptomatic or related organ system(s)" 2-7 BA/OS

Constitutional: VSS. Well developed, well nourished white female in no acute distress.
Heart: RRR, S1 S2. No murmurs, rubs or gallops.
Lungs: Clear to P&A. Normal expiratory effort w/normal breath sounds noted. No rales or rhonchi.

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#3: Medical Decision making

(2:3 variables required)

1. The number of possible diagnoses/number of management options that must be considered
2. Amount/complexity of medical records, diagnostic tests, &/or other information obtained, reviewed and analyzed
3. Risk of significant complications, morbidity &/or mortality, as well as comorbidities associated w/the patient's presenting problem(s), the diagnostic procedure(s), &/or possible management options

Each variable can be one of four levels: from minimal/none to extensive/high.

of Diagnoses or Management Options

- For established diagnosis: improved, well-controlled, resolved (less complex), or inadequately controlled, failing to change as expected (more complex).
- For problems w/o established diagnosis: differential diagnosis, "possible," "probable," or "rule out" diagnosis
- Document initiation of or change in treatment
- Document to whom or where a referral or consultation is made.

Amount/Complexity of Data

- Review and/or order clinical lab tests
- Review and/or order tests in the radiology section of CPT
- Review and/or order tests in the medicine section of CPT
- Discussion of test results w/performing physician
- Decision to obtain old records and/or obtain add'l history from someone other than the patient
- Review/summarize old records (document findings) and/or obtaining history from someone other than patient
- Independent visualization of image, tracing or specimen itself (not just review of report)

Documenting Risk

- Comorbidities/underlying diseases that increase the complexity of medical decision making by increasing the risk of complications, morbidity, or mortality
- If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E&M encounter, document the type of procedure
- If a surgical procedure or invasive diagnostic procedure is performed at the E&M encounter, document the specific procedure
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied

Table of Risk

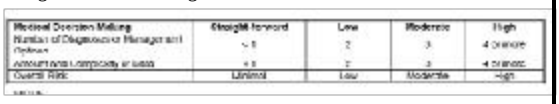
TABLE OF THE RISK OF COMPLICATIONS, MORBIDITY AND MORTALITY

Level of Risk	Presenting Problems	Diagnostic Procedures Ordered	Management Options Selected
Minimal Level I - II	One self-limited problem, eg, cold, insect bite, tinea corporis	Lab test requiring venipuncture Chest X-rays Urinalysis Ultrasound [e.g., echocardiography] KOH prep	Rest Gargles Elastic Bandages Superficial Dressings
Low Level III	Two or more self-limited or minor problems One stable chronic illness [e.g., well-controlled hypertension or non-insulin-dependent diabetes, cataract, BPH] Acute uncomplicated illness or injury [e.g., cystitis, allergic rhinitis, simple sprain]	Physiologic tests not under stress [e.g., pulmonary function tests] Non-cardiovascular imaging studies with contrast [e.g., barium enema] Superficial needle biopsies Clinical lab tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate Level IV	One or more chronic illnesses with mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis [eg., lump in breast] Acute illness with systemic symptoms [e.g., pyelonephritis, pneumonitis, colitis] Acute uncomplicated injury [eg., head injury with brief loss of consciousness]	Physiologic tests under stress [e.g., cardiac stress test, fetal contraction stress test] Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors [e.g., arteriogram, cardiac catheterization] Obtain fluid from body cavity [e.g., lumbar puncture, thoracentesis, culdocentesis]	Minor surgery with identified risk factors Elective major surgery [open, percutaneous or endoscopic] with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High Level V	One or more chronic illnesses with severe exacerbation, progression or side effects of treatment Acute or chronic illness or injuries that may pose a threat to life or bodily function [e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure] An abrupt change in neurologic status [e.g., seizure, TIA, weakness or sensory loss]	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiologic tests Diagnostic electrophysiologic tests Diagnostic endoscopies with identified risk factors Discography	Elective major surgery [open, percutaneous or endoscopic] with identified risk factors Emergency major surgery [open, percutaneous or endoscopic] Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

The criteria must be met or exceeded.

Determining MDM

Putting these elements together…



Medical Decision Making	Straight forward	Low	Moderate	High
Number of Diagnoses or Management Options	≤ 1	2	3	≥ 4
Amount and/or Complexity of Data	≤ 1	2	3	≥ 4
Overall MDM	Minimal	Low	Moderate	High

Which equates to…

Straight-forward	99201, 99212
Low	99203, 99213
Moderate	99204,99214
High	99205, 99215

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But…

- Don't forget the other 2 Components
- New patient visits require that all 3 Key Components meet or exceed the code's requirements
- Established patient visits require that at least 2 of the 3 Key Components meet or exceed the code's requirements.

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Common Errors Identified:

Documentation is incomplete/insufficient:

1. Documentation does not support the level of service billed (i.e., up-coding or down-coding of services).
2. Required components (as required by the CPT book) are not documented in the medical record.
3. The history component is incomplete or absent.
   1. This is where you describe the patient's presenting problem(s)
4. The medical decision-making documented is inappropriate or incomplete.
   1. Just a list of conditions/diagnoses

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Common Errors Identified:

- Services were rendered by one provider and billed by another provider.
  - Understand incident-to and shared visit billing
- Documentation does not support a face-to-face encounter between physician and patient.
  - Discharge summary is a document
  - Face-to-face visit required for 99238/99239

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Common Errors Identified:

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- Conflicting information in the medical record
  - the diagnosis on the claim is not consistent with the diagnosis in the medical record;
  - "denies erectile dysfunction," female patient's ROS
  - ROS states "denies chest pain," in a patient presenting with chest pain as the chief complaint.
  - documentation in the patient's history conflicts with the examination;
- Date of service in the documentation is different from the date of service billed
- Medical documentation does not support medical necessity for the frequency of the visit.
  - 99214 every 3 weeks for a stable patient

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Briefly: Medical Necessity & EMRs

- Documentation software may facilitate carry-overs and repetitive fill-ins of stored information.
- Even when a "complete" note is generated, only medically necessary services for condition of patient at time of encounter as documented can be considered when selecting appropriate level of E/M service.
- Information not pertinent to patient's condition at time of encounter cannot be counted.
  - Patient seen in 'routine' follow-up of stable Htn. History is "comprehensive" including past, family & social history. Was it "medically necessary" to repeat these history elements?

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Level 3 E&M

New patient visit/consults

- 99203/99243/99253
  - Detailed history
    - HPI – 4+
    - ROS – 2-9
    - PFSH – 2:3
  - Detailed exam
    - 2-7 BA/OS
  - Medical decision making of low complexity

Established patient office visit

- 99213
  - Expanded problem focused history
    - HPI – 1 3
    - ROS - 1
  - Expanded problem focused exam
    - 2-7 BA/OS
  - Medical decision making of low complexity

99204/99244/99254/99222

Documentation Required (all of the below)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past/Family/Social History
2. Comprehensive Exam (8 or more organ systems)
3. Medical Decision Making of Moderate Complexity (at least 2 of the following)
   - Moderate # of diagnoses or management options
     - New problem with or w/o a work-up
   - Moderate amount or complexity of data (to be) reviewed
   - Moderate degree of risk
     - Prescription drug management

99214

Documentation Required (2:3 Key Components)

1. Detailed History
   - Chief complaint
   - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 2- 9 systems
   - One of Past Medical/Family/Social History
     - Listing medications= medical history
2. Comprehensive Exam (8 or more organ systems)
3. Medical Decision Making of Moderate Complexity (at least 2 of the following)
   - Moderate # of diagnoses or management options
     - 3 stable chronic conditions
   - Moderate amount or complexity of data (to be) reviewed
   - Moderate degree of risk
     - Prescription drug management

99205/99245/99255/99223

Documentation Required (all of the below)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past/Family/Social History
2. Comprehensive Exam (8+ organ systems)
3. Medical Decision Making of **High** Complexity (at least 2 of the following)
   - Extensive # of diagnoses or management options
   - Extensive amount or complexity of data (to be) reviewed
   - High degree of risk

In summary…

- Key Components: History, Exam, Medical Decision Making
- Time only matters if more than 50% of your face-to-face time with the patient was for c/cc.
- Must meet or exceed requirements for level of service
- Medical Necessity
- Documentation is key
  - For all places of service
  - Reduces liability
  - "Safe" reimbursement
  - Fair reimbursement

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Using the Web….

- www.cms.gov/pqrs
- www.cms.gov/rac
- www.cms.gov/cert
- http://www.cms.gov/center/coverage.asp
- http://www.cms.gov/manuals
- http://www.aetna.com/cpb/cpb_alpha.html
- http://www.humana.com/
- www.unitedhealthcareonline.com

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OFFICE OR OTHER OUTPATIENT SERVICES
(1995 Guidelines)

New Patient Visit or Consultation

(Requires all 3 Key Elements [Hx, Exam, Decision Making] be met)

Code	History	Physical Exam [3]	Decision Complexity [1]	Counseling/ Coordination of Care – Visit Time[2]
99201/99241 Problem Focused	CC; HPI (1-3)	Limited exam 1+ Body areas/Organ systems	Straightforward	10/15 minutes
99202/99242 Expanded Problem Focused	CC; HPI (1-3); ROS (1)	Limited exam 2-7 Body areas/Organ systems	Straightforward	20/30 minutes
99203/99243 Detailed	CC; HPI (4+); ROS (2-9); PFSH (1:3)	Extended exam 2-7 Body areas/Organ systems	Low	30/40 minutes
99204/99244 Comprehensive	CC; HPI (4+); ROS (10); PFSH (3)	Gen'l multisystem 8+ Organ systems	Moderate	45/60 minutes
99205/99245 Comprehensive	CC; HPI (4+); ROS (10); PFSH (3)	Gen'l Multisystem 8+ Organ Systems	High	60/80 minutes

[1] Two of the following must meet or exceed the requirements for the level chosen:
1. Number of Diagnoses and/or Management Options
2. Amount and/or Complexity of Data to be Reviewed
3. Risk of Complications and/or Morbidity or Mortality

[2] Time should only be used to choose the level of service when the visit consists <u>predominantly</u> (>50%) of counseling or coordination of care

[3] BODY AREAS: Head, incldg. face; Chest, incldg. breasts & axillae; Abdomen; Back, incldg. Spine; Neck; Genitalia, groin, buttocks; Each extremity

ORGAN SYSTEMS: Constitutional (e.g. vitals, gen. app.); Ears, nose, mouth, throat; Respiratory; Hem/lymph/immn; Skin; GI; Eyes; Cardiovascular; GU; Neuro; Musculo; Psyche

OFFICE OR OTHER OUTPATIENT SERVICES (1995 Guidelines)

Established Patient Visit

(Requires 2 of 3 Key Elements [Hx, Exam, Decision Making,] be met)

Code	History	Physical Exam	Decision Complexity [1]	Counseling/ Coordination of Care – Visit Time
99212 Problem Focused	CC; HPI (1-3)	Limited exam of 1+ Body Areas/Organ Systems	Straightforward	10 minutes
99213 Expanded Problem Focused	CC; HPI (1-3); ROS (1)	Limited exam of 2-7 Body Areas/Organ Systems	Low	15 minutes
99214 Detailed	CC; HPI (4+); ROS (2-9); PFSH (1)	Extended exam of 2-7 Body Areas/Organ Systems	Moderate	25 minutes
99215 Comprehensive	CC; HPI (4+); ROS (10); PFSH (2:3)	Gen'l multi-system exam of 8+ Organ Systems	High	40 minutes

[1] Two of the following must meet or exceed the requirements for the level chosen:
1. Number of Diagnoses and/or Management Options
2. Amount and/or Complexity of Data to be Reviewed
3. Risk of Complications and/or Morbidity or Mortality

[2] Time should only be used to choose the level of service when the visit consists predominantly (>50%) of counseling or coordination of care

[3] BODY AREAS: Head, incldg. face Chest, incldg. breasts & axillae Abdomen
Back, incldg. Spine Neck Genitalia, groin, buttocks Each extremity

ORGAN SYSTEMS: Constitutional (e.g. vitals, gen. app.) Ears, nose, mouth, throat Respiratory
Hem/lymph/immn Skin GI Eyes
Cardiovascular GU Neuro Musculo Psyche

3:45 p.m. – 4:30 p.m.

My First Year in Practice
Ashley D. Beall, MD, FACR

My First Year In Practice

Adventures in Rheumatology

Fellowship Ending

- What kind of practice do I want?
- How hard do I want to work?
- Do I want to stay in this area, or branch out?
- How do I connect with future employers?
- What will I see in "the real world"?

Practice Environment

- solo practice
- small group single specialty
- small group multi specialty
- employee of a large organization

Key Questions to Consider

- Am I a good business person?
- How much autonomy do I need?
- Do I want to work part-time, full-time, or overtime?
- Do I think I'll stay in the same geographical area for the long term?
- Am I willing to accept the risk of a non-salaried position?

Finding the Right Position

- Know what you want
- Use the *contacts* of *your mentors*
- Interview a small handful of key prospects
- Understand your contract
- Evaluate the long-term growth potential

Things to Consider

- Contract--read it carefully, ask questions
- Know the path to partnership--buy in, time period, etc
- How profitable is the practice?
- Where do the profits come from?
- Who is responsible for your disability, malpractice/tail coverage, CME payments?
- Signing bonus? Relocation allowance?

You're Hired!

- It's the beginning of a very exciting time!
- But there are a lot of adjustments!
- You will need help building your practice
- The learning curve is steep

The First Three Months

- Boards--studying, and passing
- New office environment
- New colleagues
- New patients
- New referring physicians
- New challenges

The BOARDS

- Boards are tough, but fair
- Use your late fellowship time wisely--study!
- Develop a study schedule and stick to it
- If you can, avoid extra duties (call, hospital consults) until after you have completed the test

The Office

- Learn everyone's name, and what their job is
- Delegate the administrative duties
- Utilize the office manager
- Ask for what you need to succeed

Your Colleagues

- Ask Questions
- Be honest about your weaknesses
- Find a mentor, or two!
- Observe different patterns of work flow
- Be considerate, but don't be a doormat

Your Patients

- Consider every patient as a potential referral
- It's not as complicated as it was in fellowship
- Even if it's not complicated, it may be new to you
- Utilize ancillary services, it will help you make an informed decision, and help you build revenue
- Stick to Rheumatology

The "Real World" Patient

- Osteoarthritis/Sports Medicine
- Rheumatoid Arthritis
- Positive ANA
- Osteoporosis
- Gout
- Everything else

Private Practice

- Is ANYTHING but Boring!
- Requires different skills from academia
  - making the initial diagnosis
  - communicating with patients about diseases, medications, and "other options"
  - building relationships with patients and peers
  - being a good (? great) business person

The Initial Challenges

- Workflow
- Documentation
- Learning New *Skills*
- Confronting Unknowns
- Building a Referral Base
- Time Management
- Coding

Referring Physicians

- Have your office send out announcements of your arrival
- Join your local medical society
- Market yourself
- Look up the specialty of every referring doctor
- Communicate your findings, on paper and by phone
- Expect some bumps in the road

The Second Act

- Filling Your Schedule--going from 5 to 15
- Confronting the difficult patient
- Adjusting your workflow
- Developing your new skill set
- Re-evaluating your coding and your use of ancillaries
- The inevitable mistakes

Schedule Management

- Take less time with your new patients, but see them back more often
- Schedule frequent follow ups with chatty or complicated patients
- Evaluate how far behind you are running, and make adjustments if you can
- Talk to your MA, front desk about how he/she can help you function better
- Show up early, review your patients for the day

The Challenging Patient

- The sick patient who is getting sicker
- The non compliant patient
- The hypochondriac patient
- The needy patient
- The malingering patient
- The impossible to please patient

The One Who Keeps You Up At Night

- Don't forget the value of a great history--consider revisiting it
- Order the tests you need
- Go back to the books
- Ask for a consult from your peers
- If they aren't responding the way they should, re-evaluate your diagnosis
- If you are stuck, send them to an academic center

The One Who Ignores Your Orders

- Make sure they understand what you want them to do and why
- Document heavily
- Consider external factors (cultural, social, economic) which might affect their ability to comply
- Be flexible if you can
- Never lose your temper

The Chicken Little Patient

- If they have myriad complaints and a positive review of symptoms, it's probably fibromyalgia
- Listen to their full story at least one time
- Do not dismiss their fears out of hand
- Bring them back often, and give them extra time
- Build trust and don't over treat
- Get information from all their providers

It's All About Me . . .

- Provide the best service you can
- Create realistic expectations
- Keep the lines of communication open
- Follow through on your promises
- Maintain your boundaries

The Malingering Patient

- Beware of the amazing sob story
- Trust your instincts. If something seems off, it probably is
- Document, document, document, but avoid a chart war
- Get records from other providers, and their pharmacy
- Remember your right to dismiss a patient

The Impossible to Please Patient

- Consider every patient a potential referral
- Some patients are not a good fit for you
- Get to the heart of the problem
- Be polite, and be helpful in finding them another provider
- Don't take it personally

Your Bad Days

- You will make multiple mistakes
- When you discover them, evaluate why they occurred
- If you are overwhelmed, make adjustments in your schedule, and ask for advice from your mentor(s)
- Don't beat yourself up
- Keep your life as balanced as possible

The Third Act

- Most days are full days
- More follow up patients than new patients
- Confidence and autonomy is growing
- You now have a small trusted group of referring doctors
- It feels more like "your practice"

Workflow Changes

- As you get busier, your days get longer
- Utilize your lunch hour for lab review, phone calls, and forms
- Make sure that if it can be done by another person, it is
- Consider saving the notes for later

Developing Your New Skills

- Now's the time to take a break, and do some CME
- Read about things you haven't read about before
- For new skills, practice makes perfect
- If applicable, get involved in practice management

Making a Profit

- Coding is an art they don't teach in fellowship
- Over coding and Under coding are a Problem
- If you can get access to your coding patterns, evaluate them and make adjustments if needed
- If you have ancillaries, use them. They are what makes a practice profitable and they serve your patient well
- Meet with Business Manager, CFO to evaluate your productivity

The Questions To Ask

- Do I have the kind of practice I envisioned?
  - If not, should I market more aggressively?
- Am I happy in this environment?
  - Do I want to renew my contract?
- What are my new interests?
  - How can I grow my expertise in these areas?

The Bottom Line

- The first year is incredibly exciting!
- Be prepared for big challenges
- Rewards are great if you are in the right place
- The contract is the engagement, the partnership is the marriage--choose wisely!

The END!
Good Luck!

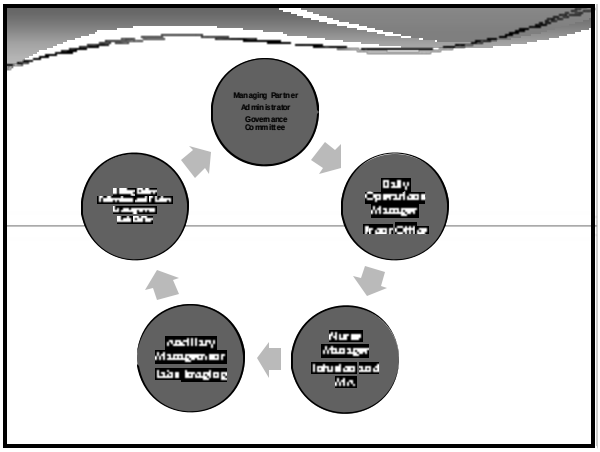
4:30 p.m. – 5:15 p.m.

Practice Management
Ethel Owen

The Dollars and Sense of Practice Management

Ethel Owen - Administrator
Arthritis & Rheumatology Associates
of Palm Beach, Inc
West Palm Beach, FL

The Team



Written Protocols for Every Operation

- Policies and Procedure Manual
- Employee Handbook
- Review protocols regularly with staff.
- Staff members require constant supervision, and retraining.

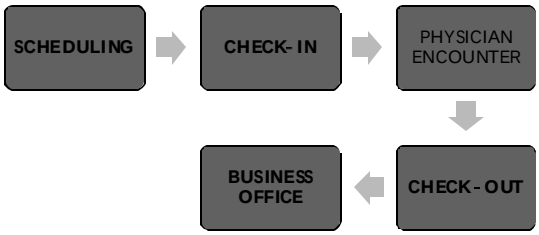
Effective Office Management

- Assign Responsibility
- Regularly review staff performance
- Continued training and updates
- Ensure compliance and regulatory standards
- Establish and maintain an atmosphere conductive to staff cohesion and cooperation
- Procedures and conflict resolution

Effective Office Management

- Team Effort
- Continuing Education for staff
- Staff in-services
- Physician and front office communication
- Front office and back office communication
- We all do well when we all do well!

Practice Management



Scheduling

- First Impression
- Professionalism
- Courteous
- Set the expectations
- Bring outside records
- Prompt
- What does the patient need to bring to their appointment
- Cancelation policy

Check In – New Patient

- Smile and greet patient
- Review "Patient Information Form (PIF)" with patient
- Copy of insurance card (both sides)
- Patient Signature
- Check referral status
- Review Office Policies
- Collect co-payment

Check In - Demographics

- Enter Patient Information
- Enter Insurance Information
- Enter Co-pay Information
- Enter Pharmacy Information
- Enter Medical Information Release

Check In – Established Patient

- Review Demographics Each Visit and Collect Outstanding Balances
  - Review Phone Numbers
  - Review Home Address
  - Verify Insurance
  - Verify Pharmacy Information
  - Collect Outstanding Balances

Consequences of Improper Check In

- Consequences
  - New number must be tracked down
  - Wasted staff and/or physician time
  - Physician cannot reach patient during workday
  - Cannot implement response to abnormal tests until evening or next day
- Result: Delayed care and ***Stress***
- ***Stress and wasted time impact quality of care***

Physician Encounter

Physician Encounter

- Physician obtains history
- Examines patient
- Orders diagnostic imaging and laboratory tests
- Enters data in to EHR or paper chart
- Calculates disease activity score
- Assessment
- Implements treatment plan

Physician Encounter

- Charge Capture
  - Office Visit Level
  - In Office Labs
  - Injections
  - Medications
  - Procedures
  - X-rays

Physician Encounter – Diagnosis Coding

- Diagnosis to Support Medical Necessity
  - ICD-9 – Is more than a method to communicate a patients diagnosis to an insurance carrier to receive payment
  - Reduces Compliance Risk
  - Diagnosis Codes Support Procedures and Orders
  - Paints the Picture for the Payer
  - Proper ICD - 9 documentation enables quality patient management and ensures proper reimbursement

Check Out Ancillary Protocols

- Verify physician orders
- Schedule ancillary service in accordance with orders
- Document service provided
- Track services provided in-office and at referral facility
  - Tickler or alert system to ensure follow through and patient compliance
- Follow up appointments
- Comply with payer requirements for Ancillary Services
  - In office vs. referral lab

Check Out

- Review follow-up care with patient
- Verify insurance information
- Provide patient with applicable written/printed instructions
- Review outside referrals, Imaging, PT, Labs
- Collect deductibles and coinsurance,
- Schedule follow up visit

Consequences of Improper Check Out

- Result: Delayed care and ***Stress***
- ***Stress and wasted time impact quality of care.***

Documentation to Support Medical Necessity

- Managing documentation within practice is vital

Coding and Documentation

- Monitor coding and documentation compliance with regularly performed internal reviews
- Better to find problems in house
- Utilize services of coding consultants to perform periodic audits
- Employ outside consultants through legal council so all findings are attorney-client privilege

Coding and Documentation

- Third-parties may conduct coding audits
- Practice Management System: provide assistance
  - Develop profiles on each physician,
  - Characterize coding patterns
    - Analyze reasons for inter-physician variance
    - Analyze in comparison to benchmarks

Documentation to Support Medical Necessity

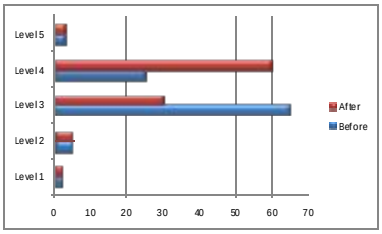
Office Encounter | **Tests or Imaging** | **Procedures**

Labs | **Outsides Orders**

Documentation is Key to Everything!

- Tell the story
- Support medical necessity
- Excellent Patient Care
- Claims Payment
- Keeping your Money
- Successful Practice

Consequences of Up-coding and Down-coding



- If documentation and coding protocols were in place and adhered to, proper E&M coding for Level 3 and 4 for these two physicians would have resulted in an increased annual reimbursement commensurate with work done.

Business Office Management

Effective Business Office Billing

- Define roles
- Cross train
- Knowledge of contracts and allowables
- Updated fee schedules
- Procedures – Up to Date bundling edits
- Knowledge of managed care policies and procedures
- Effective communication

Business Office

- Documentation and coding
- Conduct daily billing audits
- Daily claims submission
- Document proof of timely submission
- Maintain current fee schedules
- Reports
- Track denials by procedure, by department, by doctor
- Appeals and review

Accounts Receivable Management

- Accounts Receivables (A/R) is money owed for services rendered
- Sources of Revenue
  - Insurance Companies
  - Foundations/Industry Co-Pay Cards
  - Patients
    - Co-pays
    - Coinsurance
    - Deductibles

Accounts Receivables Management

- Robust Practice Management System
  - Provide Reports
  - Aged Account Balances
  - Income by Location
  - Income by Doctor
  - Rejected Claims Report
    - By Doctor
    - By Location
    - By Procedure

Features of a Good Practice Management System

- Robust system for preparation and submission of claims
- Ability to load and maintain payer fee schedules
- Ability to track claims
  - Knowledge of payment terms by payer
- Ability to code check
  - Modifiers
  - Diagnosis code and procedure mismatch

Consequences of Improper Fee Schedule

- Payer reduces all evaluation and management codes by 15%
- Payer reduces J code reimbursement by 2%
- Lost revenue to practice
- Inaccurate data collection by payer

Importance of Effective Claims Management

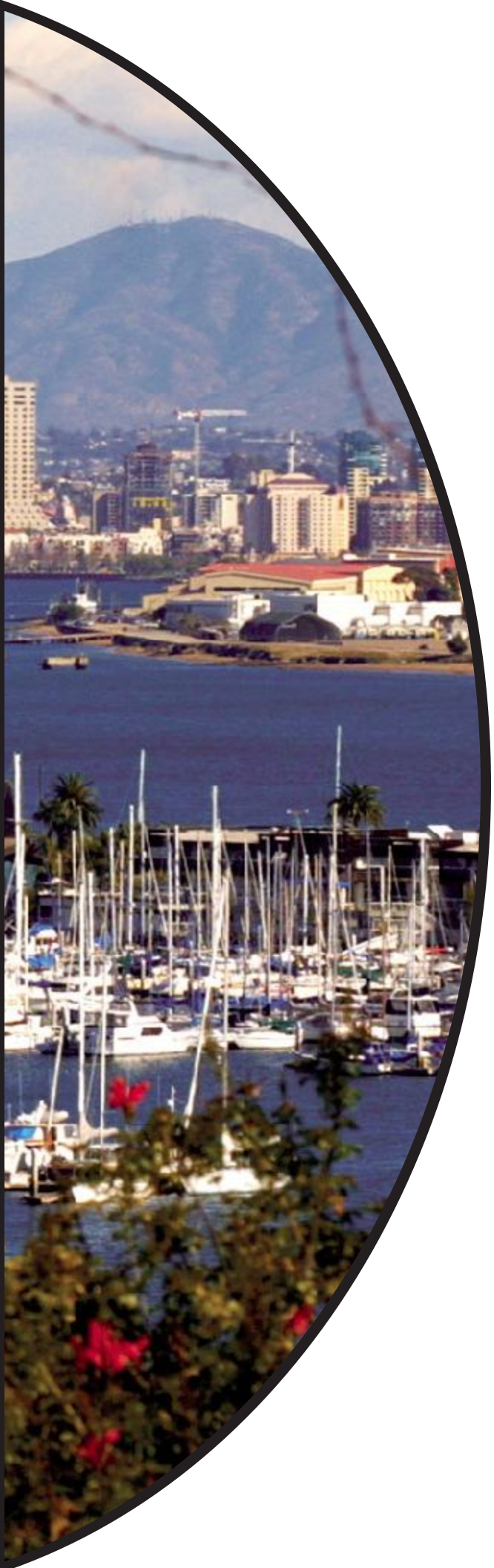
- Practice economic viability under increasing pressure:
  - Operating costs increasing; reimbursement declining
  - Revenue needed to replace equipment, hire trained staff, expand services and locations, etc.
  - Ancillary revenue sources under pressure
  - Consumer-directed health plans on the rise to combat employer health costs - more pressure on price
  - Consolidation among insurers giving payers leverage
  - Under Insured Patients

Managing A/R

- Key Objectives
  - Using the right people, tools and processes to maximize cash flow
  - Collect on every procedure
  - Collecting the contracted amount
  - Time Management
  - Claims Management
  - Maintain Accountability
  - Appropriate work loads

Summary

- Hire the right person for the job
- Education and training
- Communication
- Documentation
- Front office collections
- Back office billing and collections
- Customer Service
- Physician Involvement



CSRO

COALITION OF STATE RHEUMATOLOGY ORGANIZATIONS

SAVE THE DATE

CSRO Annual Meeting & Board Meeting

October 27 – 28, 2013

San Diego, California