

Health care systems must do more to prepare residents for the business of medicine

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The practice of medicine is as much a business as a science. Successfully managing a practice requires new physicians to master economic and regulatory complexities that are growing exponentially. As a business, the practice of medicine is heavily regulated by all third-party payors, particularly by Federal health care programs such as the Centers for Medicare and Medicaid Services (CMS). Failure to understand these complex and ever changing regulations may lead to loss of revenues on the one hand and potential exposure to severe sanctions and civil monetary penalties on the other.

Yet very few medical schools, academic medical centers and teaching hospitals include any comprehensive training in practice management and medical economics to prepare residents for the business of medicine before they enter private practice, either as a solo practitioner or as a member of an existing group practice. In part, this deficiency is the result of traditional residency programs developed in academic medical centers that provide little exposure to the challenges of practice management. In part, training programs must focus on clinical skills and specialized knowledge to help residents prepare for board certification upon graduation rather than on the business of medicine.

Even in community-based teaching hospitals, residents receive less than optimal preparation for the daily challenges of practice management. Only a few residency programs based in hospital-affiliated ambulatory care centers devote some time to prepare residents for the business of medicine through informal mentoring sessions with community practitioners.

How Health Care Institutions Can Help

Academic medical centers and teaching hospitals with residency programs have begun to recognize the need for preparing their graduates for private practice. However, traditional models leave little time to add this type of training to an already burdened curriculum.

Institutions that are committed to providing this additional effort to complete resident training should consider adopting some of the following strategies by leveraging the expertise of their faculty, management and staff. It is fairly common for graduating residents to remain affiliated with the teaching institutions where they are trained or to seek appointments on their medical staff. Therefore, teaching institutions stand to reap long-term benefits from adopting some of the strategies listed below to prepare residents for the business of medicine.

For example, orientation programs for residents should include materials related to credentialing, compensation, quality management and compliance. The CEO, CFO and CCO of the teaching institution may be invited to introduce PGY1 and PGY2 residents to: medical economics, reimbursement; physician compensation; and relevant healthcare regulations.

Attending faculty and teaching physicians can help by conducting regular training sessions on proper, compliant documentation for PGY1 and PGY2 residents. PGY3 and PGY4 residents will benefit from rotations with clinical or volunteer faculty in private practice. They can also benefit from targeted training by professionals in medical record departments, compliance programs and billing and coding services. Outcomes of internal reviews of documentation, coding and billing practices should be shared with residents who often are excluded from this valuable feedback.

Practice management coordinators from professional societies and representatives from Federal health care programs, commercial third party payers, health plans and managed care organizations should be invited to Grand Rounds for focused discussions and Q&A sessions with residents in all specialties. See the figure below for questions that every resident should have the opportunity to explore. The Medical Staff Office in each institution should also make available a list of resource materials related to every aspect of the business of medicine.

Conclusion

In our review of the curricula of residency programs nationwide, we have found little evidence of substantial time and efforts dedicated specifically to this essential need. At the same time, we noted that surveys of recent graduates of such programs clearly identified the need for and importance of formal preparation in practice management.

In our experience, the lack of such preparation is detrimental to both the residents and the institutions where they train. For graduating residents, facing the growing complexities of managing a practice together with the increased demand for services and decreasing reimbursement is a daunting and sometimes discouraging challenge. Navigating the regulatory and economic landscape without adequate preparation often leads to career and financial disillusionment. Furthermore, even when he/she joins an existing group practice, a new physician who fully understands this landscape and proper coding and documentation procedures brings substantial value to the enterprise.

For their teaching institutions, the same lack of preparation contributes to operational inefficiency, uncompensated expenses, less than optimal reimbursement and increased exposure to potential liability. Optimal preparation can help these institutions address these financial, organizational and regulatory liabilities and improve organizational health.

Figure: Ten Questions Every Resident Should Ask

- 1. Should I build a practice from scratch or join an existing group?** While it is usual for new graduates to join an existing practice in urban areas, it is becoming more common for some graduates to establish new practices in designated underserved rural areas to take advantage of economic incentives not available in urban areas. Each decision must be carefully considered on the basis of many factors, including the resident's specialty and the demographics of the target patient population, general payor mix, the resident's "fit" into an existing practice and availability of support resources and mentors, proximity to hospitals for admitting privileges, compensation packages and administrative duties, and lifestyle preferences.
- 2. Who pays for my services as a private physician?** In general, reimbursement for professional services is driven by the payor mix of the target patient population. Most commonly, depending on the new graduate's specialty, reimbursement may come from Federal health care programs such as Medicare and Medicaid, and commercial third party payors such as traditional insurance organizations, managed care plans and other provider organizations.
- 3. What do I need to do to be reimbursed by Federal health care programs and commercial third party payors?** Unless well-prepared during their residency programs, new graduates should devote time and efforts to research and become familiar with the plethora of applicable rules and regulations that drive reimbursement practices. For example, many new graduates are often "shocked" by the amount of "paperwork" needed to obtain pre-authorization for certain types of outpatient and inpatient services. Practices that serve Medicare or Medicaid patients should consider adopting a compliance program modeled after the guidance provided by the Office of the Inspector General (OIG) of the Department of Health & Human Services (DHHS). Implementing such a program helps to optimize reimbursement, minimize exposure to sanctions and mitigate the severity of such sanctions if applied.

4. **How should I organize my office or clinic to address issues such as business and personnel management, scheduling, billing and coding, and medical record maintenance?** According to current industry benchmarks, a physician in private practice may need as many as 3.0 full-time equivalents (FTEs) in support staff to address the obligations listed above. Some practices may elect, as a result of a “make-buy” decision, to outsource several of these functions such as coding and billing. Outsourcing such functions requires careful evaluation and recommendations from respected colleagues to avoid potential liability since the physician remains ultimately responsible.

5. **How do I ensure that I’m meeting my obligations for quality assessment, risk management and practice efficiency?** In recent years, Federal health care programs and commercial third party payors have introduced initiatives that link reimbursement to physician performance (P4P). In addition, many health plans have linked compensation to standardized quality improvement standards as well as reliance on evidence-based medicine. All payors continue to scrutinize evidence of medical necessity as a critical factor in determining reimbursement.

While risk management is often thought in terms of malpractice insurance, it has become increasingly apparent that the quality of care and of communication with patients is an essential mitigating factor. As noted above, practice efficiency and cost effectiveness require careful attention to personnel recruitment, retention and management. Newly established practices often benefit from the investment in seasoned and experienced office professionals who are invaluable in navigating through the maze of rules and regulations while allowing the new graduate to focus on the practice of medicine.

6. **How should I work with hospitals or other provider organizations to address credentialing, malpractice insurance coverage, on-call and administrative duties and referrals?** Typically, residents initiate state licensure applications near the completion of their second year of residency. Applications for credentialing and privileging should be initiated soon after graduation and before the new graduates enter private practice in order to obtain admitting privileges at hospitals. As the process is initiated, the new graduate should consider communicating with the selected institutions to negotiate recruitment incentives, compensation for additional duties such as call coverage. In addition, the new graduate must become familiar with the Anti-kickback Statute and Stark Rules. In a few states, state law permits physicians to be directly employed by healthcare institutions. In these states, it becomes even more important for physicians contemplating this option to seek legal advice to ensure fair market value for their services.

7. **How do I document my services in the medical records to ensure proper reimbursement?** For all payors, medical record documentation is critical to regulatory adherence, quality of care and reimbursement for professional services. In all institutions, failure to adhere to standards for health information management is often considered grounds for suspension of privileges and other sanctions. Physician services provided in an office or hospital setting and not supported by complete and accurate documentation are not reimbursable.

8. **Should I invest in information technology for Electronic Health Record (EHR or EMR) Systems?** As of May 2007, DHHS has issued strict parameters allowing hospitals to support the national EHR/EMR initiative by providing affiliated physicians with the platform needed to implement EHR/EMR systems in their offices. New graduates should explore this option and actively participate in system selection to ensure that adoption contributes to quality of care and practice efficiency.

9. **What are the common pitfalls that hurt reimbursement?** While there are numerous pitfalls, the most common ones include:

- Unacceptable or poor medical record documentation;
- Illegible documentation;
- Lack of demonstrable medical necessity;
- Incomplete or inaccurate charge capture practices;
- Inaccurate or erroneous coding and billing practices; and
- Non-adherence to pre-authorization requirements of insurance payors, managed care organizations and health plans.

10. **How do I stay out of trouble while legitimately optimizing reimbursement?** Based on our experience, we believe the single most important answer is for new graduates to understand and adopt compliant and ethical practices in every aspect of care delivery.