

Visit www.MDOptions.com

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

September 2007

EDITORIAL

Treatment of Chronic Illness Offers Lessons 2

STRATEGY

Patients Finding Gaps in Coverage 3

CAREER OPTIONS

MDs Making Changes in Mid-Career 6

PRACTICE MANAGEMENT

Leasing Offers Several Benefits 9

TECHNOLOGY

E-Systems Solve Specialists' Problems 12

REIMBURSEMENT

Is Your 3rd-Party Biller an Asset? 14

Treatment of Chronic Illness Offers Lessons

Health care experts are seeking ways to improve the care of patients with chronic illness, such as arthritis, cardiovascular disease, cancer, and diabetes. Chronic illnesses are among the most prevalent, costly, and preventable of all health problems. The federal Centers for Disease Control and Prevention says chronic illnesses account for 70% of all deaths in the United States and more than 75% of the nation's medical care costs.

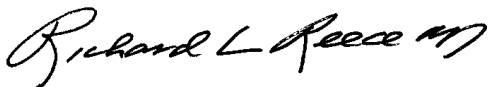
What health care experts are learning about treating patients with chronic illness is somewhat heartening. For example, having patients participate in regular physical activity is associated with needing fewer medications and having fewer hospitalizations and physician visits, the CDC says. Smoking cessation interventions are recognized as one of the most cost-effective interventions, and for every \$1 spent on an arthritis self-help program, \$3.42 was saved in physician visits and hospital costs, the CDC says.

In addition, health care providers are finding ways to care for patients with chronic conditions that help improve outcomes over time. For 15 years, HealthPartners, a large nonprofit health plan in Minneapolis, has operated a successful program designed to improve care for patients with diabetes. Physicians in any organization, even those unaffiliated with HealthPartners, could apply the key components of the program to their practices.

In 1994, HealthPartners aimed to reduce diabetes complications by 30% and to date, it has exceeded that goal. HealthPartners has helped its 20,000 members with diabetes to reduce their average HbA1c and LDL cholesterol levels while also cutting morbidity by lowering the rates of myocardial infarction and amputations and new cases of retinopathy and renal disease. HealthPartners says it has prevented 80 heart attacks, 120 amputations, and 320 eye complications each year. "Setting a goal, designing a process to achieve that goal, developing measures, and tracking progress are activities that any medical group can pursue to improve care," comments George Isham, MD, HealthPartners' medical director.

Here's another example, A. O'tayo Lalude, MD, a general practitioner in one of the poorest areas of Louisville, Ky., has helped his patients with diabetes to improve their glucose, blood pressure, and lipid levels. He has done so by following the treatment recommendations in the nationwide pay for performance program for physicians called Bridges to Excellence (www.bridgestoexcellence.org).

These and other similar programs targeted at patients with specific costly and debilitating chronic illnesses are helping health care experts to identify methods physicians and health plans can use to cut costs, reduce complications, and perhaps most important, improve patient outcomes.



Richard L. Reece, MD
 Editor in chief
 Phone: 860/395-1501
 Fax: 860/395-1512
 E-mail: Rreece@premierhealthcare.com

This newsletter is published by Premier Healthcare Resource, Inc., Morristown, N.J.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

Publisher
 Premier Healthcare Resource, Inc.
 150 Washington St.
 Morristown, NJ 07960
 973/682-9003; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor
 Joseph Burns
 508/495-0246
editor@premierhealthcare.com

Neil Baum, MD
 Urologist
 New Orleans

Daniel Beckham
 President
 The Beckham Co.
 Physician and Hospital Consultants
 Whitefish Bay, Wis.

Thomas M. Gorey, JD
 President and CEO
 Policy Planning Associates
 Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA
 Executive Vice President
 Premier, Inc. and
 Premier Practice Management
 San Diego

Harold B. Kaiser, MD
 Allergy & Asthma Specialists, PA
 Minneapolis

Nathan Kaufman
 President
 The Kaufman Group
 Division of Superior Consultant Co. Inc.
 Physician and Hospital Consultants
 San Diego

Paul H. Keckley, PhD
 Executive Director
 Vanderbilt Center for
 Evidence-based Medicine
 Nashville

Peter R. Kongstvedt, MD, FACP
 Senior Executive
 Accenture
 Health & Life Sciences Consulting
 Reston, Va.

John W. McDaniel
 President and CEO
 Peak Performance Physicians, LLC
 New Orleans

Lee Newcomer, MD, MHA
 Senior Vice President, Oncology
 UnitedHealthcare
 Minneapolis

James G. Nuckolls, MD
 Medical Director
 Carilion Healthcare Corp.
 Roanoke, Va.

Bernard Rineberg, MD
 Physician Consultant
 BAR Health Strategies
 New Brunswick, N.J.

James M. Schibanoff, MD
 Editor in chief
 Milliman Care Guidelines
 Milliman USA
 San Diego

Jacque Sokolov, MD
 Chairman
 Sokolov, Sokolov, Burgess
 Scottsdale, Ariz.

Patients Finding Gaps in Coverage

By Michael Bihari, MD

One of the biggest challenges practices and patients face under Medicare Part D is the doughnut hole, the lack of coverage beyond \$2,400 in spending this year. Many patients are confused about this provision of the Medicare Prescription Drug Improvement and Modernization Act of 2003. Often, the burden falls on practices to help patients understand how to get the medications they need.

More than 20 million Medicare beneficiaries are enrolled in prescription drug plans (PDPs), either freestanding plans or a plan that is part of a Medicare managed care plan. Most of these plans have a coverage gap, the so-called doughnut hole, during which an enrollee must pay for the full cost of prescription drugs. It is likely that some patients have hit the doughnut hole by late summer or early fall. What's more, patients enrolling in a program for 2008 may have questions now.

Plan Benefits Vary

As long as it exceeds the Medicare standard benefit, a prescription drug plan may vary in several ways, including:

- The prescription drugs available on the formulary and the tier position for any covered drug
- The amount of premium charged
- The deductible and co-payment amounts
- The extent of drug coverage in the doughnut hole. There could be no coverage or coverage for generic drugs only, or for brand-name drugs

- Which pharmacies enrollees can use.

The doughnut hole, or coverage gap, is one of the most controversial parts of the Medicare Part D prescription drug benefit and is of concern to many beneficiaries. Although all PDPs must explain the coverage gap in their literature, the doughnut hole came as a shock to many enrollees last year when they went abruptly from making co-payments for their drugs to paying 100% of the cost. In addition, many enrollees may be confused about the \$2,400 limit in their initial coverage period, thinking it is only the amount of money they have to pay out-of-pocket. In fact, the amount includes the total cost of drugs, meaning what the enrollee pays plus what the plan paid.

Here's how it works this year. Medicare PDP enrollees pay the first \$265 of their drug costs. In the initial coverage phase, the drug plan pays 75% of the covered prescription drug costs after the deductible is met, and enrollees pay a co-payment of 25% until the total drug costs (including the deductible) reach \$2,400.

Once enrollees reach \$2,400 in total drug costs, they enter the doughnut hole and must pay the full cost for their prescription drugs until the total reaches \$3,850. This annual out-of-pocket spending amount includes the yearly deductible and co-pay amounts.

When enrollees spend more than \$3,850, the coverage gap ends and the drug plan pays for 95% of the rest of the covered drug costs for the year. Enrollees are still responsible for

either a small co-payment (usually \$2 or \$5) or a coinsurance payment of 5%, whichever is greater.

In addition, beneficiaries must also pay a monthly premium, even while they are in the coverage gap. Premiums vary widely depending on additional features available.

The size of the coverage gap is projected to increase by approximately 8.5% annually because the cutoffs are indexed to the average per person drug expenditures for beneficiaries enrolled in the Medicare drug benefit. The scheduled expansion of the doughnut hole is mandated by law.

Effect on Care

Traditionally, specialty physicians and in particular oncologists have administered medications such as chemotherapy through injection or infusion for certain patients. These medications are covered under Medicare Part B and because Medicare Part B does not cover regular prescription medications, many patients with cancer have not had coverage for self-administered medications, including supportive-care drugs for the management of chemotherapy side effects, such as pain, nausea, and vomiting.

In recent years, the FDA has approved new cancer medications for oral self-administration. For many patients with cancer, enrollment in Medicare Part D might provide welcome financial access to these new oral medications.

According to an article, "Access To Cancer Drugs In Medicare Part D:

(Continued on page 4)

Not all patients with a PDP will have drug spending that reaches the doughnut hole, and paying a higher premium for a plan with gap coverage will not always translate into lower costs overall.

(Continued from page 3)

Formulary Placement and Beneficiary Cost Sharing In 2006," published in the September 2006 issue of *Health Affairs*, the Medicare drug benefit may be financially beneficial for some of the approximately 700,000 Medicare beneficiaries who are diagnosed with cancer every year.

However, there are caveats. The PDPs introduce several levels of complexity to the process of selecting prescription drug coverage. Each state has multiple available plans and they all differ in formulary composition and formulary placement of drugs, premiums, availability of additional coverage in the doughnut hole, and barriers such as preauthorization and coverage limits.

In addition, some Medicare beneficiaries do not understand the extent of the out-of-pocket expenses in the PDPs. Although the drug plans may cover certain new drugs, some enrollees may be surprised when they hit the doughnut hole and must pay the full cost of their medications. And, due to the high cost of some of the new oral cancer drugs, patients may reach the doughnut hole after just two to three months of treatment.

Medicare B vs. Medicare D

Since some Medicare enrollees with cancer may receive both oral medications and oncologist-administered medications, it is important for them to understand the differences in coverage and benefits in Part B and Part D. Oncologists, oncology nurses, and oncology office staff need to be fully conversant with the various plans and how they affect the type of therapies that are covered.

In a report, *Cost-Sharing for Cancer Patients in Medicare: Seven Case Studies*, prepared for the American Cancer Society and published last year, the authors analyzed seven cancer treatment protocols and related cost-sharing for Medicare beneficiaries. These medications included brand-name and generic drugs, some

Resources for Patients

One of the most helpful online resources is the Medicare site (at www.medicare.gov), which allows users to compare prescription drug plans, learn about plans offered in each state, view each plan's formulary, and download appeal and exception forms. Beneficiaries can select a plan and enroll online. Patients can get the same information by calling the Medicare help line at 800-633-4227. Other sources of information for patients include:

- AARP Prescription Drug Coverage: Provides step-by-step information on how to select an appropriate plan. (www.aarp.org/health/medicare/drug_coverage/)
- Medicare Prescription Drug Plan Guide—How to Choose Your 2007 Plan. This guide is easy to follow and comes from a trade organization representing health insurance plans. (www.healthdecisions.org/guide/index.html)
- SHIPtalk: The State Health Insurance Assistance Program provides one-on-one counseling and assistance to Medicare patients and their families. (www.shiptalk.org)
- Social Security Administration: Enrollees with limited income may qualify for extra help with Medicare prescription drug costs. (www.socialsecurity.gov/prescriptionhelp/ or 800-772-1213).
- Partnership for Prescription Assistance: Some drug manufacturers offer free or low-cost drugs to qualified Medicare beneficiaries. (www.pparx.org or 888-477-2669).

—MB

covered under Medicare Part B and others covered under Medicare Part D. The report is available online (at www.avalerehealth.net).

Some of the conclusions of this report demonstrate the complexity patients face and health care providers confront when advising patients, as in the following:

- Beneficiary cost-sharing in Part D varies significantly from plan to plan, based on benefit design. Within a single treatment protocol, cost-sharing can vary by more than 2,000%, a cost difference of hundreds of dollars.
- Under Part D, beneficiaries' access to cancer drugs is relatively favorable as almost all of the plans cover many cancer drugs.
- Beneficiaries may face a difficult choice in selecting a Part D plan. Not all patients with cancer will have drug spending that reaches the doughnut hole, and paying a higher premium for a plan with

gap coverage will not always translate into lower costs overall.

- Under Part B, beneficiaries with cancer may incur thousands of dollars worth of cost sharing, though most enrollees may be able to reduce or eliminate cost sharing through supplemental coverage sources such as Medigap plans.
- Medicare Part B coverage and access to supplemental coverage are likely to continue to be significantly important for patients with cancer.

Effect on Practices

Inevitably, patients who fall into the coverage gap have questions for their physicians, nurses, and office staff. While it's impossible to answer every question satisfactorily, there are steps providers can take to ease the burden of having to explain the intricacies of a complex federal law. These strategies involve being prepared for the questions they will get,

Lowering Costs in the Gap

Medicare officials suggest the following ways patients can lower their costs:

- Explore national and community-based charitable programs that can help with drug costs. Information is available on the Benefits Checkup Web site (at www.benefitscheckup.org).
- Use pharmaceutical assistance programs. Many drug manufacturers offer assistance programs for people enrolled in Medicare Part D. (www.medicare.gov/pap/index.asp)
- Consider state pharmaceutical assistance programs that offer help with paying drug plan premiums or other drug costs. (www.medicare.gov/spap.asp)
- Apply for extra help. Enrollees who have limited income and resources may qualify for extra help through the Social Security Administration (at www.socialsecurity.gov/prescriptionhelp/).

—MB

identifying a staff member to answer most of them, and preparing material that patients can read at home.

Since physicians are at the forefront, they must be familiar with the basic structure of Part D and be able to answer questions, discuss potential issues, and know where to refer patients (or family members in some circumstances) for more assistance.

Physicians may also need to deal with the prospect of patient compliance issues in the doughnut hole. Patients who cannot afford the high cost of medication, even for a relatively short period of time, may stop taking medications on a regular basis or reduce dosage.

Many patients will have questions for their physicians about the Medicare prescription drug benefit in general, including which plan to choose. Doctors and their office staff should be prepared to help patients understand the complexities of the program and where to send patients for advice and support. Although the end-of-year enrollment period is of great concern to patients, physicians can expect questions throughout the year as new patients become eligible for Medicare and others, already enrolled in a drug program,

approach the doughnut hole.

At a minimum, physician offices may want to consider:

- Designating a nurse or assistant to be an expert on Part D. Having one individual responsible for counseling patients may help reduce patient confusion and improve efficiency of response.
- Having patient education materials available for patients or their caregivers. These materials should anticipate commonly asked questions about local prescription drug plans and about formularies and ways to decrease drug costs.
- Providing a list of online and community resources.
- Encouraging patients to ask questions after they read the information to make sure they understand it. Doing so may help prevent surprises and may decrease the number of unfilled prescriptions due to cost.

Patients will want to know if their PDP will cover their prescribed medications. Physicians and their office staff should be familiar with the formularies of the more popular drug plans in their communities and be prepared to make adjustments in a patient's regimen, if appropriate and feasible.

Patient Counseling

Patients new to Medicare who have not yet chosen a drug plan should be counseled about their options based on their medication profile. For patients on few or inexpensive medications, the appropriate option may be a plan with a lower premium and no or a small deductible. For a patient with high drug costs, the appropriate option may be a plan with a higher premium and deductible, some coverage in the doughnut hole, and a formulary with wide coverage and a favorable tier placement of commonly prescribed drugs.

For patients who are receiving medications such as chemotherapy through the Part B benefit and supportive-care drugs through Part D, one way to help them lower their prescription drug costs is to switch to lower cost or generic drugs, as available and appropriate. Doing so can help patients in two ways. The co-pay for lower-cost or generic medications may be lower than that for other drugs and since the total cost is lower, it will take patients longer to reach the coverage gap. Most plans include several choices within the same drug class.

Another tactic to help patients save money is to write a prescription for an extended supply of a medication, such as for 90 days. Some PDPs offer enrollees a discount for using a mail-order program and local pharmacies often provide an extended supply of medications for the same price as a mail-order program.

Some patients need more information than the physician's office can provide, especially new enrollees who want to compare prices and formularies from PDPs. Staff can refer these patients to appropriate online and community resources.

—Reported and written by Michael Bihari, MD, in Falmouth, Mass. More information on physician practice strategies is available on our Web site (see page 16).

MDs Making Changes in Mid-Career

An orthopedic surgeon worked for 17 years before realizing he wanted another area of medicine. Another surgeon started a training business. A third started writing an advice column. Each of these physicians offers an example of how it is possible to make a mid-career change and inject more excitement into one's career.

"In the business world, people change jobs 12 times in their work lives," reports Robert Mestas, MD, medical director of Physicians Career Practice LLC, an assessment and counseling firm in Denver (at www.pcp LLC.org). "But physicians never used to do so. They would stay in one job whether they were satisfied or not."

Dissatisfied with his work, the orthopedic surgeon met with Mestas to discuss his options. "During counseling, we found he thought more like an internist," Mestas explains. "He made the switch, and loves it. And he didn't even take much of a pay cut." Mestas had another client, a successful cardiologist earning over \$1 million annually, who was unhappy after 10 years in cardiology. Instead of leaving the profession, he cut back to part-time work. "He's removed some of the stress, and is sorting out what he might like to do," Mestas explains.

Injecting Variety

While cutting back on work will add time for other activities, physicians also might be interested in adding an activity to stimulate one's work and add variety. Michael S. Woods, MD, a surgeon in Santa Fe, N.M., did so by founding the Center for Physician Leadership, a training organization in Santa Fe. Or, consider writing a monthly question and answer column in a community newspaper, allowing one to relate to

Top Five Physician Complaints

When the American College of Physician Executives in Philadelphia surveyed 1,205 MDs in 2006, nearly 60% had considered leaving medicine. The top five complaints of clinical practitioners were:

1. Low reimbursement
2. Loss of autonomy
3. Bureaucratic red tape
4. Patient overload
5. Loss of respect.

—CM

patients' problems in a different manner.

Internist Lisa Sanders, MD, practices at Waterbury Hospital in Connecticut, and writes the popular "Diagnosis" feature for *The New York Times Magazine*. Peter Gott, MD, a family physician in New England since 1966, writes a daily, nationally syndicated medical advice column, "Ask Dr. Gott." He still sees patients as well.

One of Mestas' clients has started a Web site to provide answers to patients about health questions. "If you have a talent for writing or public speaking, you can establish credibility by volunteering those skills for a small audience," Mestas says. "You can become an expert on things that are important to you."

A Need for Change

After practicing medicine for five to 10 years or more, physicians often consider making a professional shift. "We see a lot of people who want to do other things," says Mestas. "Some realize within a few years. For others, it's more of an evolution to recognize that they're not happy." Mestas should know. He retired after 21 years as an obstetrician-gynecologist and now works for Physicians Career Practice. He finds his clients often ask, "It took me years to become a

doctor, what else can I do if I'm not practicing medicine?"

A physician's actual source of discontent may not be one's profession, but simply one's current job. Many doctors unhappy with certain aspects of their work can stay in clinical medicine after making relatively modest changes. Consider changing location, for example, perhaps by moving the office from a city to a nearby suburb, which might allow for a shorter commute or more varied hours. It may be possible to join a smaller or different group practice.

Fortunately, there are opportunities for experienced physicians that are diverse, interesting, and available in a range of fields and settings inside and outside of medicine. Before exploring options, it's important to take an honest look at the factors one needs to modify. Some physicians want more time for family life. Others want greater control over the time when they're on call. Fortunately, for many dissatisfied doctors, creative solutions can remedy discomforts.

Non-Clinical Options

Since 2003, Seak, Inc., a company in Falmouth, Mass., that runs career programs for physicians, has held an annual course in non-clinical careers for physicians. The program helps

Strategies for Finding a Niche in a New Career

When searching for a new position or career, one of the best places to start is by asking colleagues and other professionals to assess one's strengths and weaknesses. Many physicians take for granted what they do well and so may be surprised to learn what others think.

An excellent source of information could be a course or workshop on career change. Often, the trained counselors who lead these programs can provide assessment, planning, and encouragement. Also, the other members of the course or workshop may be able to offer ideas as well. Specialty firms, such as Physicians Career Practice, LLC, in Denver, work closely with individual doctors exploring new directions. When you reach some tentative goals, an executive recruiter in the medical field can share information about available positions, current salaries, and ways to revise a resume.

When seeking a new position or career, remember that most physicians have at least the following skills:

- Dealing with complex situations
- Multitasking
- Communicating
- Educating (patients, staff, and other medical professionals)
- Remaining calm under fire
- Coping with adversity
- Absorbing new information quickly
- Resolving difficulties
- Managing staff, interns, or residents
- Running a business
- Concentrating and staying focused for long periods
- Knowing computers and other technical equipment.

—CM

participants clarify their aims and develop a plan.

"So many skills are transferable that each participating physician leaves with a series of specific steps," reports Steven Babitsky, Seak's president. "Networking begins right there. Attendees are all eager to help each other. The conference also attracts people who want to hire physicians for various positions. It's a very intense two days." The Non-Clinical Careers for MDs conference will be Oct. 6 and 7 in Falmouth. Seak has more information on its Web site (at www.seak.com).

Babitsky himself changed careers after 20 years as a trial lawyer. "I decided being a lawyer was a lot of

hard work and not that much fun," he said. So, he started Seak, Inc., to provide CME courses, educational conferences, and training for physicians, lawyers, and other professionals. "We put on high-quality programs, and it was much more creative for me, far more interesting, and more fun," he says.

Several physicians who participated in the Seak program have found new jobs as consultants. One physician participant, for example, provides medical-legal consulting by doing case reviews for law firms and insurance companies. "A lot of that work can be done by telecommuting, often as a consultant setting your own hours," Babitsky says. "New

careers can be quite lucrative. We know physicians who make twice their previous earnings."

Valued Skills

As Babitsky found, for-profit companies value physicians' expertise and research skills. Many physicians shift into medical device or pharmaceutical companies, or medical information systems developers, all of which rely on the first-hand knowledge that physicians can bring. Venture capital and brokerage firms that invest in health care also need analysts who know that industry. Michael McLaughlin, MD, attended a Seak program in 2004 and then joined Peloton Advantage, a publishing and project development company in Parsippany, N.J.

McLaughlin earned a Bachelor of Science degree in Biology from Harvard College and a medical doctorate degree from Columbia University's College of Physicians and Surgeons. He did residencies in general surgery and in plastic and reconstructive surgery at Columbia-Presbyterian Medical Center in New York City and a fellowship in hand surgery and microsurgery at the University of Utah. He then spent four years in clinical practice in Bethlehem, Pa., before going into a career in medical communications.

Insurance companies, HMOs, and PPOs often have physicians in key management roles, says Mestas. Such positions may involve examining claims, managing physicians, or establishing guidelines. "These jobs will keep you out of the operating room, no one dies, and you get to sleep at night," Mestas comments.

Some health care companies use physicians as medical directors to help them manage the costs and quality of care delivered to patients. Richard Strickland, MD, FACP, serves as medical director of four long-term care facilities in the Dallas-Fort Worth area. Board certified in internal medi-

(Continued on page 8)

(Continued from page 7)

cine and geriatrics, he developed an expertise in long-term care.

Combining Interests

Other physicians combine several interests while continuing to work as a physician. Louis Kirchhoff, MD, MPH, is a professor of internal medicine, infectious disease, and epidemiology at the University of Iowa Carver College of Medicine. He specializes in tropical medicine and disease prevention in developing countries. He researches experimental vaccines to improve diagnosis and prevent transmission of Chagas Disease, a major cause of death in Latin America. About 100,000 U.S. residents harbor the parasite.

After gaining tenure, he established Goldfinch Diagnostics, Inc., which has developed an assay for screening blood samples for Chagas. It was recently licensed by a pharmaceutical company. He currently works at the university about 40% of the time in the medical and infectious disease services, and Kirchhoff also works as a consultant. Since 2001, he's been collaborating with other scientists on-site in Mexico and Argentina.

Teaching and Writing

Another physician who has combined her interests is Orly Avitzen, MD, MBA, a neurologist in Tarrytown, N.Y. Her interests include back and neck pain, nerve testing, headaches, and pinched nerves. A medical consultant to the New York Rangers of the National Hockey League, she teaches at the New York University Medical College and the Yale University School of Medicine. She also writes a monthly column in *Neurology Today*, and provides health information for neurology patients on www.webmd.com.

Experts suggest physicians seeking to combine various interests should consider working for businesses in related areas and attending conferences in these fields to find like-

Strategies for Networking

One of the best ways to find a new job or new career is to talk with everyone you know because most positions are found through personal contacts. Networking is simply casting a wide net.

If staying in the medical field, make an effort to talk with people at all professional gatherings such as continuing medical education classes, association meetings, and conferences. Of course, one should always be discreet because colleagues may stop referring patients to you if they hear you may be leaving.

Ask casually if associates know about openings at hospitals, medical schools, or physician groups. Gather business cards and then stay in communication particularly with those who have the most contacts. Also, attend alumni meetings and call medical school classmates for suggestions. Also, call classmates who currently work in your field of interest.

To explore non-medical careers, ask everyone you know including professionals in other businesses. Follow up with any name you're given and begin gathering useful information, such as trends in the field, the best companies, and the most useful persons to contact. Remember that when networking, each contact leads to another.

—CM

minded individuals or to inquire about job openings.

Follow Your Passion

A piece of advice career experts often give is to follow your passion. Mestas worked with an emergency room physician seeking a change who had long been interested in film and photography. He had produced and directed a short film spoofing a residency program and directed a documentary too. After counseling, he elected to move into screenwriting, having already acquired a few contacts in the film industry. "It's who you know, who can open doors for you," Mestas comments.

Mestas also counseled a pediatrician who was an expert in adolescence issues and who wanted to have her own talk show. She has not yet accomplished her goal but is making progress. "She's using her time writing articles, giving talks, and raising her family," Mestas adds. "She's building credentials in a whole new area by building on her medical credential."

Some physicians enter politics when convinced it's their best chance to affect an issue of personal interest. In 2006, Steven Kagan, MD, an allergist and Democrat, won a Congressional seat in a traditionally Republican Wisconsin district. His campaign platform emphasized his background in health care. "You don't have to be a Republican or a Democrat to be ill, and to understand that the health care system doesn't work," he said in his campaign literature.

Others start or join nonprofit organizations. In 1991, Donald M. Berwick, MD, MPP, FRCP, founded the respected Institute for Healthcare Improvement, in Cambridge, Mass. A clinical professor in health care policy and pediatrics at the Harvard Medical School, Berwick has helped build the IHI into one of the leading organizations fostering improvements in health care quality and patient safety.

—Reported and written by Carol Milano, in Brooklyn, N.Y. More information on physician practice strategies is available on our Web site (see page 16).

Leasing Offers Several Benefits

By John W. McDaniel

Hospitals are seeking new and innovative ways to affiliate with physician group practices that are much different than the affiliations hospitals used in the 1990s. These new relationships could involve some form of physician employment, meaning both the hospital and physicians would have a more formal business relationship than they have had in the past. In addition, these arrangements could reflect lessons both parties have learned over the years through relationships that were somewhat less than satisfactory.

Every hospital has a physician integration strategy as a part of its overall strategic long range plan, and hospitals are physician-driven organizations. Therefore, hospitals and health systems must explore alternatives to physician affiliation aside from the traditional employment model.

Beyond Employment

For both parties, hospitals and physicians could develop much more meaningful relationships than they have had in the past and these arrangements could go beyond the traditional physician employment and professional services arrangements that were popular years ago.

For strategic reasons, many large hospitals and health care systems and even many small and rural hospitals are likely to be interested in developing new and various affiliation models. The large hospitals

John W. McDaniel is the president and CEO of Peak Performance Physicians, LLC, physician practice improvement advisers, in New Orleans. Readers may contact McDaniel by phone at 800/764-2633 or by e-mail at info@peakphys.com.

Hospitals and physicians could develop much more meaningful relationships than they have had in the past and certain organizational structures could go beyond the traditional physician employment and professional services arrangements that have been popular.

are seeking to increase their reach in the communities in which they operate and the small rural hospitals are interested in developing these arrangements in part because they have had so much trouble in recent years recruiting physicians.

Experts who study physician-hospital relations say integration between hospitals and physician specialists is occurring at a growing rate in part because hospitals recognize that developing successful partnerships with specialists can enhance revenue. "Specialists have higher incomes than primary care physicians have, and they have money to invest in joint ventures for specialty centers," says Daniel Beckham of the Beckham Co., in Whitefish Bay, Wis. "In some instances, the relationship involves employment. When hospitals directly employ some specialists, the question becomes, what is the inevitable evolution of that model?"

A Customer Focus

When developing new affiliation models, hospitals and health systems should be focusing their attention on their most important customer: the physician. In the past, hospitals have had various employment arrangements with physicians. But many are re-examining those arrangements now in part because the arrangements they used in the past have underper-

formed. What's more, some hospitals have found it is not necessary to own a medical practice or employ physicians to develop a meaningful relationship. They also have learned that a merger between two companies does not necessarily strengthen their business relationship.

In the 1990s there were reports that hospitals lost vast sums after purchasing physician practices because once the physicians became employed, they were no longer interested in working as hard as they did when they worked for themselves in their own practices.

While these reported financial losses may have been true in part, there were likely many reasons that hospitals failed to get more from practices they purchased. In any case, hospitals are showing an interest in realigning both parties' various incentives today by developing an alternative to physician employment known as practice leasing.

A Nonequity Venture

A practice lease is a model through which a hospital and medical practice could enter into a nonequity joint venture.

This model helps the hospital develop relationships with its key physicians through a sustainable private practice model. Indeed, a prac-

(Continued on page 10)

(Continued from page 9)

tice lease could be a solution for hospitals, health systems, and physicians searching for a meaningful affiliation strategy by establishing a centralized mechanism to allow both parties to be involved in improving patient care, enhancing information technology, and using their collective expertise.

Forming a New Entity

These relationships could be structured in a manner consistent with various Stark exceptions and safe harbors under the federal Anti-Kickback Act.

This structure would involve having the hospital create a new company (let's call it NewCo), through which NewCo could enter into an employment agreement with physicians who are part of an existing practice. The practicing physicians would work solely for NewCo. Given that this entity could be structured as a group practice under the Stark laws, NewCo could compensate the physicians through a combination of salary, bonus, or by offering a share of NewCo profits.

To the extent that NewCo would provide ancillary services in a manner consistent with the in-office ancillary services and group practice exceptions under the Stark laws, each employed physician could share in the profits. Included in this sharing of the profits would be any profit from providing designated health services under Medicare or Medicaid, except under certain exceptions.

Referral Rules

In addition, the employed physicians may be required to refer patients to a specific hospital for all services unless the patient requests otherwise. The best interests of the patient would dictate or another exception-required referral rule under the Stark laws would apply.

NewCo could contract directly with the practice to provide all or some of the following:

- Space for the physicians NewCo employs

Strategies for Collections

Many practices struggle when it comes to dealing with accounts receivable. But some practices have procedures in place that help them ensure that payments are collected on time without requiring staff to spend an inordinate amount of time chasing overdue payments.

The practices that have most success with patient accounts ensure that patient statements are sent every 30 days. If no payment has been made after 90 days, these practices send the patient one final demand letter, either requesting payment in full or asking the patient to call the office to make payment arrangements. If, after 10 days, the office gets no response from the patient, these accounts should be referred to a collection activity.

Indeed, the most efficient practices typically have written policies and procedures that outline these approaches to collecting overdue funds. In addition, these practices have appropriate processes in place to define amounts that can be written off. These processes help the practices expedite the accounts receivable process.

One little used tool that practices may find useful involves IRS Form 1099-C. Using this form, the physician would essentially be reporting the debt to the IRS as income to the individual who owes the debt. In this sense, it is a serious tool that is likely to incur the individual's wrath. Therefore, physicians should use this tool with great caution. In essence, it is a technique used to assist in collecting a large outstanding account for a patient you are not likely to see again.

To report income of an individual regarding cancellation of debt, the following conditions must be met:

- The account must be at least \$600
- The accounts must be cancelled and returned from any collection agency
- The practice must have determined that the account is uncollectable in the current year
- The practice must give up trying to collect the account
- The practice must write the account off or remove it from the books.

A better step may be to notify the debtor that the practice intends to report this cancellation of debt as income to the IRS unless payment in full is received or appropriate payment arrangements are made. No one wants to be reported to the IRS or have to pay taxes on such "income" that is basically a cancellation of debt.

—JWM

- Equipment for the physicians NewCo employs
- Practice management services.

Indeed, NewCo and the physicians would need to structure their space and equipment leases and management services agreements in a manner consistent with the applicable Stark law exceptions and the relevant safe harbors under the anti-kickback laws.

This structure would provide physi-

cians with two sources of revenue: employment compensation (salary, bonus, and share of profits) and proper distributions from the practice, which would function as a management services organization. While the benefits to the physicians are obvious, the hospital could enjoy all of the benefits of owning a practice with no significant expenditure of capital. Furthermore, should the venture become unsatisfac-

Structured Arrangements Can Help Patients Who Struggle to Pay Their Bills

A number of reports are available to most practices with respect to the monitoring of accounts receivable management. These reports include days in accounts receivable or percentage of accounts receivable in excess of 90 days. By reviewing these reports each month, the practice can ensure that its respective accounts receivable fall within acceptable parameters. But physicians and staff must monitor these benchmarks continually.

Indeed, the most efficient practices invest in areas such as accounts receivable that have the greatest opportunity for return on investment.

One strategy that practices can use when a patient has a large outstanding debt is to establish a structured payment arrangement. Since some patients may have difficulty in satisfying account balances on a timely basis, the practice can establish structured payment plans as long as the practice monitors the patient's performance in paying off the amount owed.

These accounts then can be suspended from any collection activities as long as the patient makes monthly payments under the agreement the patient has with the practice.

Recently, *The New York Times* reported on a similar strategy that physicians are using. Car dealers, furniture stores, and other purveyors of big-ticket items are offering no-interest loans to consumers. The article said millions of consumers have arranged financing through more than 100,000 doctors and other providers who offer a year or more of interest-free monthly payments. Obviously, the doctor's bill would need to reach a certain threshold of say \$1,000, and this amount would be after the practice has collected all insurance payments, if any, on the patient's behalf.

Banks and credit card companies are willing to assist physicians who are interested. The drawback would be that patients who fail to make the required payments may find they are penalized by then having to pay a high interest rate on the remaining debt, the article said.

—JWM

tory or unsuccessful, this arrangement would be much easier to unwind than a practice acquisition.

Compensation Considerations

When developing any new venture, hospitals, health systems, and physician groups should be aware of the rules regarding reasonable compensation as outlined in the 2000 EO CPE (Exempt Organizations Continuing Professional Education) text from the Internal Revenue Service (called CPE for FY 2000). The IRS has a series of training arti-

cles on its Web site that are of interest to tax-exempt organizations published as the Exempt Organizations Continuing Professional Education Technical Instruction Program for FY 2000. On the site, there are articles that address the corporate practice of medicine and physician incentive compensation.

In the case of nonprofit organizations, the IRS considers many factors in determining whether the compensation arrangement between a hospital and physician violates any laws against private inurement and imper-

missible private benefit. Since the enactment of intermediate sanctions in 1997 and implementing regulations in 2001, the IRS says physicians who are considered "disqualified persons" risk federal excise taxes for compensation that results in an excess benefit transaction with an exempt organization. This tax ranges from 25% to 200% of the excess benefit. Also, organization managers responsible for the arrangement can be liable for a tax of 10% of the excess benefit up to \$10,000 per person.

Due Diligence Required

Of course, when hospitals and health systems embark on establishing a more formal organizational strategy with physicians, all parties should be certain to follow due diligence procedures to ensure that all parties agree on the steps to take. The hospital or health system also should take all deliberate steps to ensure the feasibility of the new hospital-physician affiliation model.

The key physician leaders who are likely to be involved in the proposed relationship also should be certain that their opinions are considered when the hospital and health system administrators are discussing the project internally. If possible, it would be best to organize a steering committee of physicians to meet with hospital and health system administrators when developing the strategic vision for the new physician-hospital alignment.

And, finally, physicians should be aware of the rules involving the corporate practice of medicine. Many states have statutes regarding such practice, including California, Texas, and Iowa. These and other states have a variety of exceptions that allow organizations that are not owned or controlled by physicians, such as charitable institutions and professional limited liability corporations, to employ physicians.

—More information on physician practice strategies is available on our Web site (see page 16).

E-Systems Solve Specialists' Problems

By Suzi Koss

Two years ago, Grand Valley Medical Specialists, PLC, had a problem. The company that made the DOS-based practice management system we were using to help us shift to paperless documentation decided it would no longer support the system. Our group of 20 physicians and 3 nurse practitioners was facing the prospect of having to invest in a new Microsoft-based system that could easily be integrated with our other systems, and most important, maintain the high quality standards on which our practice was founded.

Physicians and staff at GVMS knew that as a specialty practice, we had certain needs that not all systems could address appropriately. A few of our concerns were managing referrals from multiple groups, managing appointments, complying with the federal Health Insurance Portability and Accountability Act (HIPAA), communicating with patients, and writing prescriptions electronically. We wanted to take all of these factors into consideration while searching for a practice management system to complement our electronic health records system. We needed a system that had state-of-the-art technology, comprehensive functionality, and scalability.

Meeting Various Needs

Once we started our research, we considered programs from Allscripts, in Chicago, because in 2002, we had chosen an electronic health records (EHR) system from Allscripts. We researched other systems on the market, but Allscripts offered the best of

Suzi Koss is the practice administrator for Grand Valley Medical Specialists, PLC, a multispecialty group of 20 physicians in Grand Rapids, Mich.

The systems have been especially useful given that GVMS physicians can see patients in one of two offices. Physicians can easily access patient records, regardless of where the physician is seeing the patient or which office the patient visited.

what we needed for our group and so we chose Allscripts' HealthMatics Ntierprise Practice Management system for two reasons. First, we believed it would integrate easily with our HealthMatics EHR system and second, our search team believed HealthMatics Ntierprise could successfully accommodate a specialty practice with patients of varying needs and challenges.

In 2005, GVMS implemented the HealthMatics Ntierprise practice management system. The results were immediate and continue to be phenomenal. Just as we had found when we implemented the EHR system, the implementation was easy because the company made a support team available to us throughout the transition period. Another reason the implementation went smoothly was that we identified the specific departments that would be using Ntierprise and provided customized training to each one. This step helped to ensure that each department could get the most out of the system. The only drawback to this step was that it required a significant investment of time initially. But it paid off when we started to use the system.

Clinical Practice Results

GVMS was pleased with how we could adapt the practice management system to the practice's needs. Both

systems work together to help our office maintain accurate, up-to-date records and maintain the most beneficial management practices for our staff and patients. Not only is scheduling easier across our two offices, but GVMS has produced results in three important areas: delivering clinical care, billing, and reporting.

For a specialty practice, it is particularly important that physicians and patients have correct information about the latest care strategies. Our practice strives to maintain the best method of providing patients with the most up-to-date information on their health and prescriptions to ensure patient safety.

The combined systems have been especially useful given that GVMS physicians can see patients in one of two offices. Even though the main office is less than 2.5 miles from the other office, physicians can easily access patient records, regardless of where the physician is seeing the patient or which office the patient visited. The EHR charts include all lab results so that physicians have those at hand as well. The system is particularly useful for physicians who see the same patients frequently because their records are never misplaced or lost as can happen with paper charts.

A specialist in pulmonary medicine might want to see a patient again in six months while a specialist

performing a colonoscopy might want to see the patient in five to 10 years. The specialist can easily enter that information into the system. Once a month, we simply open the recalls function in the system and it automatically sends a letter to each patient as needed.

The EHR also aids physicians and staff seeing patients by providing reminders at the point of care. For example, the system will inform them about HIPAA regulations so that they are reminded about whom they are allowed to speak with regarding a patient's health. Such automatic reminders help physicians make the best medical decisions and inform their patients about appropriate next steps.

Another application of the EHR system is the e-prescribing function. First, the EHR immediately notifies physicians about possible drug interactions or drug allergies for each patient. Patient safety is of utmost importance to all practices today and the e-prescribing function helps protect against adverse events. In addition, some patients can request a refill of a prescription directly on the GVMS Web site without having to wait on hold for authorization. Or they can request refills via the pharmacy and the pharmacy can send an electronic refill request directly to the physician's EHR.

Cost Cutting

The EHR also has helped the practice reduce the costs of transcriptions and of maintaining paper charts. With the EHR, doctors can document all necessary information directly into the system, yielding two significant results. First, it is not necessary to record lengthy transcriptions, meaning physicians can spend more time working directly with patients to ensure that they can answer all questions a patient may have. Time to meet with patients is particularly important in specialty practices because these patients

GVMS at a Glance

Grand Valley Medical Specialists has two-offices in Grand Rapids, Mich. The practice has 20 physicians and most are board certified in internal or family medicine. Among the doctors, 13 specialize in internal medicine, four specialize in pulmonary/critical care or sleep medicine, two specialize in gastroenterology, and one specializes in family medicine.

Number of patients: 40,000

Number of patient visits per year: more than 25,000

Phone: 616/459-3158

Web site: www.gvims.com

often have greater concerns than they might have when seeing a primary care physician and often have more questions. Using information technology in this way helps the physicians make the most of their time, a critical benefit for any EHR or PM system.

The new system also has helped the practice cut costs by more than \$145,000 over two years. Eliminating two full-time transcriptionists has helped the practice save more than \$70,000 annually. And the practice no longer needs four employees in medical records, saving \$75,000 annually.

Additionally, the PM system has allowed GVMS to simplify the billing process and encourage doctors to use the appropriate codes for their work. Our billing office now easily enters physicians' billing codes into the system and then electronically processes claims. Doing these functions electronically cuts the time it takes insurers to pay us for the work we do. Currently, we're receiving most payments within 30 days.

In addition, a few of the physicians previously were undercoding their visits. They might have performed the requisite work for a level 3 code, for example, yet charged only for a level 2 code. As a result, the practice would have been paid less than it deserved. Now the physicians can see that they have sufficient documentation in the EHR to justify the proper evaluation and management level code. In this way,

more accurate billing improves efficiency and revenue.

Reporting also is much improved over what we could do with paper charts. Using the EHR, a physician or staff member can easily call up any type of report.

Data Management

As specialty physicians, medical research is of particular value because it can yield advancements in treatment, which allows physicians to improve the care they provide to patients. Since adding the PM system, GVMS has collaborated with the Van Andel Institute, an independent medical research organization in Grand Rapids, to provide patients with information about medical studies. Using electronic records and the PM system, GVMS can pool patients that would be appropriate for research. Being able to further the study of medicine while benefiting our patients is an unexpected, but appreciated, result of new technology.

Implementing health care information technology such as an EHR and upgrading our practice management system have helped to make a growing practice like ours more efficient and more responsive to our patients. These systems have allowed us to accommodate the specific needs of our patients, physicians, and administrative staff.

—More information on physician practice strategies is available on our Web site (see page 16).

Is Your 3rd-Party Biller an Asset?

By Jonnie Massey, AHFI, CPC, CPC-P

As physicians running busy medical practices seek to become as efficient as possible, many often consider outsourcing billing and coding. When considering a third-party billing company, the practice should ask a number of probing questions such as: What goal is the practice trying to reach? Is the practice seeking greater efficiency? Is it seeking to be better organized? Does it want more credibility with patients and payers? Or is it simply seeking accurate billing and reimbursement?

Asset or Audit

After a physician group asks itself these questions, it will be well on its way to making a sensible decision about hiring a company that will help it meet its goals. But before the billing company is engaged, there are a number of questions the practice should answer (see sidebar) and the practice should have its attorney review any contracts the practice signs with the billing company.

Once the billing company is engaged, then the physician group should continuously be asking one more question about its third-party biller: Is this billing company an asset to the practice, or could its actions trigger an audit of the practice?

Physicians should take a vital interest in billing because this func-

A biller might suggest that the practice bills its evaluation and management codes at a 99214 level, when previously the practice used a 99213 level. Unless the patient care supports using the higher code, the practice should be wary of how the biller would justify using this new code.

tion is how physicians get paid for the services they perform, meaning accurate and timely billing and collections are critical.

What's more, physicians should remember that whether the billing is done in house or by a third party, all bills must include the physician's identification number. That means the physician is ultimately responsible for billing properly.

Documentation Required

Proper coding involves much more than checking a box for a CPT code. Documentation and the claim form itself are considered legal supporting materials for the services performed. Given that the documentation must support the services billed, it is prudent to have both the billing agency and the physician practice invest in new coding books, CDs, or software every year. Using the wrong code could result in having the practice failing to get the proper reimbursement for the service provided, or it could result in an audit.

Since codes are revised frequently, not using the correct code can be the difference between being underpaid or overpaid. In either case, the practice puts itself at risk. Chronic underpayment could mean the practice would not have the requisite amount of capital to continue operations. But

overpayment can expose the practice to federal or state fraud charges, criminal prosecution, and a judgment requiring repayment and fines, and possibly prison time.

Therefore, physicians and coders should never guess at a code. Continuing education for coders is a must. One source of continuing education is programs from nationally recognized organizations that sponsor local and national coding and billing seminars.

A Certified Professional Coder (CPC) must maintain a standard of competency each year by attending continuing education courses, which means hiring a certified coder can be an effective preventive step against an audit. What's more, many insurers are employing certified coders (called a Certified Professional Coder-Payer or CPC-P) to review claims.

Keep in mind that claims processors at insurance companies do not care if a third-party billing company has filed the claim. In most cases, the processors will not know if a billing company filed a physician's claims or if it came directly from a physician's office.

Billing companies offer a broad spectrum of services from coding and submitting bills to fully servicing and processing claims including handling accounts receivable and collecting bad debt. A reputable company

Jonnie Massey, AHFI, CPC, CPC-P, is a senior investigator in the External Audit and Investigation Department of Regence, in Portland, Ore., a company that oversees the operation of BlueCross BlueShield plans in four western states. She also serves on the National Advisory Board of the American Academy of Professional Coders (AAPC), in Salt Lake City.

Questions to Ask

A physician group considering hiring a third-party billing company should ask a number of probing questions of any company under consideration. The group will want to ensure that the company will protect its assets adequately.

To ensure that the company will do so, here are some questions to ask before hiring:

- How long has the company been in business?
- Have other physicians registered any complaints against this company?
- Who does the company employ for coding and billing? Do they have any experienced certified coders on staff, for instance?
- For physician specialists, do the coders have any specialty certificates?
- What is the level of experience among the coders with specialty certificates?
- Does the billing company certify its work?
- What does the company offer if your practice is audited?
- Will the company stand behind the practice in an audit defense?
- Can they be easily reached by telephone?
- Does the firm work with insurance carriers directly?
- Does the company have a compliance plan?

keeps abreast of the applicable state and federal laws and regulations and individual carrier determinations.

In-House Billing

Many of the same rules apply when physicians decide to keep billing in house. The physicians should know who is doing the billing and what level of experience they have. Experienced coders should always supervise inexperienced coders. For this reason, physicians should consider job openings in billing and coding to be much more than entry-level positions.

A certified coder will ensure that the practice complies with documentation and coding standards recognized nationally. The quality and quantity of the physicians' work is measured not only in the documentation but also by the CPT, ICD-9, and HCPCS codes used for the services rendered. An experienced coder will ensure that proper reimbursement is obtained for services, and accurate coding and compliance will help the practice avoid red flags that alert insurance carriers or authorities at the Centers for

Medicare & Medicaid Services (CMS) about the need to pursue questions about the group's work.

At worst, of course, such red flags can lead to an audit. Typically in an audit, documentation in patient files are compared with codes used on claims to ensure that the practice has made an accurate accounting of the services rendered and has the necessary documentation to support the claim. Providing such documentation sounds simple, but many physicians are surprised when documentation does not sufficiently support the services billed.

Avoiding Red Flags

When an insurer or other payer finds poor documentation, it is sometimes sufficient justification to request refunds on overpayments. In more egregious cases that show a pattern of inaccurate billing and poor documentation, the payer or insurer will sever its contracts with a physician group. In other cases, a payer could refer a case to a state licensing board for further investigation, possibly jeopardizing a physician's license to practice.

A physician group should take particular note when a billing company or coder promises to enhance revenue. Simply up-coding without providing the requisite services or changing treatment practices accordingly is dangerous.

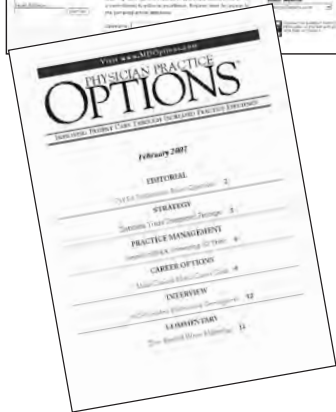
Practices that suddenly change billing patterns may raise questions at insurers' offices. For example, a biller might suggest that the practice bills its evaluation and management codes at a 99214 level, when previously the practice most frequently used a 99213 level. Unless the patient care supports using the higher code, the practice should be wary of how the biller would justify using this new code. The reimbursement may be higher, but is the increased income worth the risk if the work and documentation do not support the higher code?

Billing and coding can be so technical that it is often difficult for staff to explain it to patients. But if the practice has a staff member who can explain the billing, coding, and reimbursement processes to a patient, the practice will help make patients more comfortable. Disgruntled patients who are frustrated with billing errors, particularly balance due statements, are more likely to be frustrated with the entire practice and go elsewhere or even report the practice to payers or other authorities.

And finally, practices should strongly consider instituting a compliance plan. Such a plan would allow the in-house billing and coding staff or an outside consultant or billing expert to review paid claims for accuracy. The staff member or consultant would review only a small percentage of the total claims paid in a given period, but any errors might help the staff member or consultant recommend ways the practice can improve its billing and coding procedures. The practice should conduct its compliance procedures at least annually.

—More information on physician practice strategies is available on our Web site (see page 16).

MD
OPTIONS.com



Our FREE online resource includes:

- ▼ Strategies and tactics to build your practice
- ▼ A complete database searchable by keyword, subject, or issue
- ▼ Interaction with experts on all aspects of the Business of Medicine™
- ▼ Links to business resources, such as practice management, marketing, and CME
- ▼ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let MDOptions.com come to you! MDOptions.com can keep you up to date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOptions.com or fill in your name and e-mail address below and fax it to us at **973-682-9077**.

Name: _____

E-mail: _____

PHYSICIAN PRACTICE OPTIONS™



Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960

PRSR STD
U.S. POSTAGE
PAID
Permit No. 30
NEWARK, NJ