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VOLUME 18, ISSUE 1
SPRING 2021
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Save the Date 2021 CONFERENCES

FALL CONFERENCE
September 30-October 1
Shanty Creek Resort
Bellaire, MI

THIRD PARTY PAYER DAY
November 5
Soaring Eagle Casino
Mt. Pleasant, MI



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Practice Focus

Practice Focus is published four times per year by the Michigan Medical Group Management Association (MiMGMA).

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WWW.MIMGMA.ORG

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MiMGMA welcomes the submission of articles for publication in Practice Focus. Submit article proposals to Debra O'Shea at

INFO@MIMGMA.ORG

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President's Message



By Susan Lutz

Dear MiMGMA Members,
Isn't it astounding how much can change in one year? One year ago, the pandemic was only beginning. At that time, we had no idea just how much our lives were about to change. We were forced to learn, adapt and grow in

ways we weren't quite prepared for. Yet here we are — Through the good and the bad, we have remained resilient, and we have persevered amid unparalleled challenges. Now, as vaccines are becoming more readily available, we are finally able to see some light at the end of this COVID-19 tunnel.

Although our 2021 Spring Conference had to be cancelled, we are ecstatic to resume in-person events later this year. We plan to hold our 2021 Fall Conference as scheduled on September 30th and October 1st at Shanty Creek Resort in Bellaire, Michigan. The Program Committee will soon resume their regular meetings to begin planning the conference. After that, our 2021 Third Party Payer Day will take place on November 5th at the Soaring Eagle Casino in Mt. Pleasant, Michigan. We can't wait to enjoy some much-needed, traditional networking time with each of you at this year's conferences!

I am pleased to announce that Joe Rivet, Esq., has accepted the opportunity to become our new Reimbursement Committee Chairperson. Joe will be taking the reins from previous Reimbursement Chair, Janice Robinson. Thank you, Janice, for serving Michigan MGMA during such a challenging year! Joe Rivet is an experienced healthcare attorney and well-decorated reimbursement

expert. We look forward to working with him as he shares pertinent reimbursement updates and resources throughout the year.

We would also like to thank Member Services Committee Co-Chair, Steve Ebben, for his service to Michigan MGMA. Steve is embarking on a new career path away from the healthcare field, and we wish him all the best. Cindy Kinney, who was Steve's co-chair, will now be the sole Member Services Committee Chairperson. We are confident that the committee is in great hands with Cindy at its helm!

We are still looking for a member to volunteer as our Legislative Liaison. The Legislative Liaison holds a significant role in our organization as they provide timely legislative updates to our membership and serve as the chairperson of our Legislative Committee. If you are interested in this position or would like additional information about what it entails, please email us at INFO@MIMGMA.ORG.

I would like to thank Fred, Valarie, and our Business Partner Committee for the work they put in to restructure our Corporate Sponsorship Program. We are grateful to have eight sponsors this year. Please take a look at the next page of this newsletter for more information on the wonderful companies that have decided to support Michigan MGMA as 2021 Corporate Sponsors! We wouldn't be here without the amazing sponsors that choose to support us year after year.

Finally, to each one of our members: Thank you for being a part of Michigan MGMA through the obstacles and uncertainties. Your membership with us, as well as your leadership within your practice, is appreciated more than you know. Have a wonderful Spring season! ■

Executive Director Update



By Debra O'Shea,
Executive Director MiMGMA

Dear Members,
After countless changes and cancelled conferences over the past year, it seems that safe, in-person events are finally within our grasp. We are greatly anticipating the arrival of the Fall

Conference, when we will once again be able to meet in person to talk, laugh, and learn together. The Fall Conference will be held on September 30th and October 1st at Shanty Creek Resort, and it is sure to be a conference to remember. While registration won't open for a few more months, we ask that you please save the date. We also encourage you to mark your calendars for this year's Third Party Payer Day, which will be held on November 5th at the Soaring Eagle Casino in Mt. Pleasant.

I'd like to send a sincere "THANK YOU" to the eight companies who have chosen to support us this year via a Corporate Sponsorship. We are thankful for their support and encourage

members to consider their services when looking for new vendors. You will be hearing more from our sponsors throughout the year!

Because of the valuable feedback the Business Partner Committee provides, the Board decided to extend our 2021 Corporate Sponsorship registration deadline to April 30th. In addition to the appealing changes the BP committee made to the sponsorship program, our sponsorships have been further discounted to account for the cancellation of the Spring Conference. More information about our 2021 Sponsorships can be found [here](#). If you have any questions, please reach out to us at INFO@MIMGMA.ORG.

Our Bylaws Committee will reconvene shortly to discuss making necessary changes that will keep us compliant with national MGMA's affiliation agreement. We plan to hold a brief membership meeting via Zoom to vote on these changes. More information will be released at a later date.

As always, feel free to reach out to me at 800-314-7602 or INFO@MIMGMA.ORG with any questions you may have. Enjoy the Spring sunshine and warm weather that will surely arrive in Michigan soon! ■

Welcome, 2021 Sponsors



By Fred Schaard & Valarie Parker, Business Partner Committee Co-Chairs

On behalf of the Business Partner Committee, we would like to thank all of our vendors who have registered for 2021 sponsorships. It is because of your generosity that the MIMGMA is able to provide the services that they do for the medical practices that we serve. We are so thankful for all that MIMGMA is able to do to support our healthcare heroes here in our great state of Michigan. Our highest gratitude and appreciation goes to the following companies that have supported MIMGMA during this challenging time by becoming a sponsor. ■

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Administrator of the Year



By Sandy Sprague, FACMPE

As we anticipate and plan our 2021 Fall Conference, it is not too early to start thinking about the MiMGMA 2021 Administrator of the Year Award.

We are pleased to announce that Dean Schink, President

of Specialized Insurance Services Agency, is once again sponsoring our Administrator of the Year Award. This award represents the highest honor MiMGMA has to offer its membership! The deserving recipient is presented a plaque and generous check provided by our sponsor, Mr. Dean Schink.

The purpose of the award is to recognize a medical group practice administrator affiliated with the Michigan Medical Group Management Association (MiMGMA) who has exhibited exceptional leadership/management proficiency and enhanced the effectiveness in the



delivery of health care in his/her practice and community through a recent noteworthy achievement.

This year's award brings a whole new meaning to "Administrator of the Year." In the midst of the COVID-19 pandemic, many of our administrators have been forced to step up and take charge in an unfamiliar way, whether it meant rapidly implementing telehealth options for patients, staying up-to-date with constant legislative changes, or managing a newly remote workforce. We are excited to read through the accomplishments of the many deserving individuals to be nominated.

For more information or to nominate an administrator, visit our Administrator of the Year [page](#). Nominations will be accepted through August 14, 2021. ■

MARCH WEBINAR

Cyber-Safety in the Digital Age

About the Webinar: This presentation will provide an overview of Modern Small Business Cyber Security — Defining what it is, what objectives to keep in mind, and current environment. We will also cover simple strategies you can use right away to help improve your practice's security and safety.



Presenter: Ian Richardson, CEO, Doberman Technologies

About the Presenter: Ian Richardson is the CEO and Founder of Doberman. Ian is a nationally recognized IT professional, specializing in compliance, security, and business planning. Born and raised in Lansing,

MI – Ian's passion and driving purpose is to help enough ways that the world is a better place. When not at Doberman, Ian enjoys traveling the world*, writing, photography, surfing, and spending time with his Fiancee (Carrie), and Son (Desmond).

Date/Time: Wednesday, March 31st at 1 p.m. EST

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* Global pandemic permitting

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Compliance Hotline

Did you know that Michigan MGMA offers a Compliance Hotline Service? The goal of our Compliance Hotline is to help members and non-members alike navigate the constantly changing medical environment in which we all operate. This service is available to our members for just \$100/year. Non-members can also sign up for a fee of \$250/year.

After registering for the compliance hotline, you are given a shared toll-free hotline number. When calling in, you will

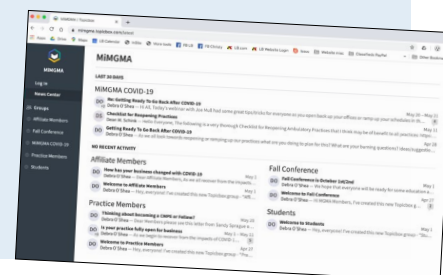


first be asked what organization or practice you are calling about. You will then be asked a series of questions regarding the compliance issue and anonymity. After all pertinent information is collected, the message is sent over to the contact person(s) at the specific organization either via fax or email.

You can find more information on our Compliance Hotline [here](#). Anyone who is interested in signing up for the service can email the completed [application form](#) to INFO@MIMGMA.ORG.

HAVE YOU JOINED OUR MEMBER COMMUNICATION CENTER?

MiMGMA recently released our new Member Communication Center through TopicBox. This is a communication tool that allows you to easily correspond with the MiMGMA community members to ask questions, share information, and converse with one another. If you have not yet done so, you can request to join at MIMGMA.TOPICBOX.COM.



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What is the MSMS Program?

For the past 13 years, Fitzmaurice-Garvin has had an exclusive, contractual relationship with the Michigan State Medical Society regarding various Property and Casualty Insurances, Directors and Officers Insurance, and other applicable insurance products. We have now brought out a brand-new product—in collaboration with the Michigan State Medical Society, Hanover Citizens Insurance Company, and Fitzmaurice-Garvin Insurance Agency—that offers extremely deviated rates and a dividend program on Worker's Compensation policies.

What does the MSMS Program achieve?

Hanover Citizens and the Michigan State Medical Society have agreed to offer a product exclusive to our agency that offers extremely deviated rates and a dividend program on Worker's Compensation policies. In order to qualify, your practice simply needs a low claims history. While every quoted Worker's Compensation policy may see premium reduction up to 65%, the major savings occur with policies whose premium is around or above \$2,000 annually.

How can I join this program?

This program is exclusive, and solely offered from Fitzmaurice-Garvin, thus no other insurance agency in the State of Michigan can provide this program.

What's next...

Please visit and complete the following link for your exclusive review, or call Tanner J. Kaplan today at [231-947-9532](tel:231-947-9532).

<https://fg-ins.lpages.co/msms/>

Membership Update



By Cindy Kinney, Membership Committee Chair

The Membership Committee is sad to announce that Steve Ebben will be stepping down as chair to pursue a new business venture. We wish Steve the very best and thank him for his leadership with MiMGMA. As co-

chair, I have agreed to chair the committee for the remainder of 2021. I work for Beaumont Health as Operations Director Cardiology, Cardiovascular Surgery & Transplant.

We are continuing our dual membership program with national MGMA. During the program's first year, we gained 23 dual members, 9 of which are new to MiMGMA. More information about dual membership can be found [here](#).

The Membership Committee is actively working on an Academic Sub-Committee to focus on student and faculty membership & engagement. We are excited that Jaime Sinutko has agreed to chair the committee. Jaime holds a BSN, MSN, and PhD from Oakland University focusing on nursing higher education administration. At University of Detroit

Mercy McAuley School of Nursing, she is currently teaching undergraduate and graduate nursing informatics and is a student in Health Information Management & Technology.

Rounding out our 2021 first quarter, we are focusing on retention and promotion. We will soon be conducting a random membership survey to identify areas of opportunity for retention and growth. We are finalizing incentives associated with the Fall Conference and will be presenting those new promotions soon. Finally, we are reviewing our Corporate Membership structure to add value and promote membership to Michigan health system partners. ■

HIMT Certificate and The MiMGMA Academic Committee



By Jaime Sinutko

Over 25% of the typical hospital bill goes to administration, with 80% of billing-related costs due to dealing with the complexity of healthcare reimbursement (*The New York Times*, 2018). Over 42% of the healthcare workforce is employed in non-clinical jobs which include health

information management professionals, provider office managers and patient care representatives, all positions filled by health information management professionals who possess the globally-sought Registered Health Information Administrator [RHIA] credential (Becker's Hospital Review, 2014). These statistics and the current Commission on Accreditation for Health Informatics and Information Management Education [CAHIIM] accreditation held by the Detroit Mercy Health Information Management and Technology program (HIMT) provide the basis for the establishment of a Post-Baccalaureate Certificate in Health Information Management and Technology. This will provide students with an avenue to obtain health information management and technology skills and provide the opportunity to sit for the RHIA exam. For program information contact Pat DeVoy at DEVOYPS@UDMERCY.EDU.

MiMGMA has members who are faculty and students in the above mentioned HIMT program. The brand-new MiMGMA Academic Committee is responsible for engaging with faculty and students and to grow academic participation through meaningful programming and resources for students and faculty. Contact Jaime Sinutko at SINUTKJM@UDMERCY.EDU if you are interested in joining the Committee. Great potential exists when educational and practice partners are brought together. ■

Becker's Hospital Review. (2014, November 26). *High demand continues for nonclinical and frontline healthcare positions, workforce report shows*. Retrieved from [here](#).

The New York Times. (2018, July 18). *The astonishingly high administrative costs of U.S. health care*. Retrieved from [here](#).

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Program Committee Update



*by Ken Rates, MHS, MBA
President-elect and Program Chair*

If you're anything like us here at MiMGMA, you are desperately craving a return to in-person networking. The ability to learn from each other, connect with each other, and grow both our practices and ourselves as professionals, is somewhat lost through Zoom or Microsoft Team meetings. The pursuit for professional

growth, for education, the desire to grow in our careers is what brought us to MiMGMA. It's the connectedness, the mutual friendships, the after-conference dinners, the special event outings, and the relationships that were forged throughout the years that has kept us here year after year.

Despite progress forward towards ending the global pandemic that Covid-19 has thrust us into, a heavy amount of uncertainty remains. Here at MiMGMA, we have made the heavy decision to cancel the Spring event for 2021, typically held in April. We are, however, moving full-steam ahead with our Fall Conference planning, set for September 31 – October 1. This year's Fall Conference is set to be held in Bellaire, Michigan at the Shanty Creek Resort. We are extremely optimistic that this will be an in-person event, and we can't wait to see you there later this year.

We at MiMGMA and the Program Committee are forever grateful for you, the loyal member, for remaining with our organization during these troubling and uncertain times. We look forward to the day when we can once again connect with each and every one of you in person for some traditional networking. ■

MARK YOUR CALENDARS FOR OUR 2021 FALL CONFERENCE!

We can't wait to see you
September 30 – October 1
at Shanty Creek Resort in Bellaire!



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ACMPE Certificates

MGMMA offers ACMPE Certificate opportunities through its certifying body, the American College of Medical Practice Executives (ACMPE).

As an important aspect of professional development for structured education, MGMA curates relevant and accessible resources via live and on-demand formats to allow participants a format to demonstrate their knowledge of specific topics and skills for their professional development and benefit of the organizations they serve.

What is an ACMPE Certificate?

ACMPE Certificates are verified documents through MGMA's certifying body proving completion and understanding of topic or skill-specific seminars or online courses.

Certificates are widely accepted throughout the industry and offer valuable immersions that share knowledge and enhance skills. These certificates are available and extremely beneficial for administrators who have or who have not achieved their CMPE and FACMPE credentials.

Why Earn an ACMPE Certificate?

Upon completion, certificate recipients showcase the completion of learning set knowledge areas or skills that can supplement resumes or be shared with employers. Certificate

programs provide a timely opportunity and proof of your commitment to excellence.

MGMA Resources Eligible For ACMPE Certificates

■ Domain Certificate Programs: Credential Bearing

Financial Management package

Aligned with the MGMA-ACMPE Body of Knowledge, this package is an in-depth online learning experience that provides healthcare leaders with a mastery of financial management concepts. After successful completion, the candidate will have earned the credential of FMC. Currently, the Financial Management package is the only credential bearing; others will be forthcoming.

MEMBER PRICE: \$999; NON-MEMBER PRICE: \$1400

■ Topical Certificate Programs – on demand

Best Practices for Optimizing a Successful Telehealth Program

Understand action steps needed to enhance patient access, cycle time, workflows, staffing, coding, billing and revenue cycle to achieve best practices for your telehealth program.

MEMBER PRICE: \$299; NON-MEMBER PRICE: \$399

Payer Contracting

Register for the Payer Contracting Certificate Program to gain the skills you need to manage your payer contracts.

MEMBER PRICE: \$399; NON-MEMBER PRICE: \$540

Accounts Payable, Payroll and Cash Flow Management

This three-hour ACMPE Certificate Program covers the building blocks for managing your accounts payable and payroll management and developing strategic processes for cash flow management.

MEMBER PRICE: \$199; NON-MEMBER PRICE: \$270

Financial Reporting and Budgeting; on demand

This two-hour, on-demand ACMPE Certificate Program covers the principles of financial reporting and budgeting for a medical practice, as well as audit management and tax reporting.

MEMBER PRICE: \$149; NON-MEMBER PRICE: \$270

Revenue Cycle Management; on demand

This certificate program will empower participants to operationalize aspects of the revenue cycle as well as provide actionable insights for individuals tasked with managing the revenue cycle.

MEMBER PRICE: \$399; NON-MEMBER PRICE: \$540

Looking to demonstrate your knowledge further?

ACMPE Board Certification (CMPE) evaluates knowledge and skills you already hold based on a standard of competencies in our industry in a broad scope acknowledging comprehensive knowledge and performance excellence. ACMPE Fellowship is achievable once CMPE designation has been attained.

Please visit the mgma.org or mimgma.org websites for additional information on these exciting opportunities to further your expertise, knowledge, and career! ■



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- Binders for Organization (TJC, HFAP, Etc.)



Reimbursement Update



By Joe Rivet

It is with great pleasure to announce that I have accepted the baton from Janice Robinson as the incoming Reimbursement Chair. I am committed to continuing to bring reimbursement information forward to all members.

Regardless of how long any of us have been in the profession, reimbursement issues continue to become more complex. As we continue in these not-so-ordinary times, we will diligently be working as a team on current issues relevant to members.

Prior to becoming a reimbursement attorney, I started my career in registration, later moving into coding, compliance, auditing, and revenue cycle. I also worked five years on the payor side in fraud and abuse. I bring a different lens to reimbursement matters, which I am hopeful will be a direct benefit to the reimbursement section of MiMGMA.

As we launch into the first quarter of 2021, we head into the year with some continued trends and hot topics impacting revenue cycle in some manner:

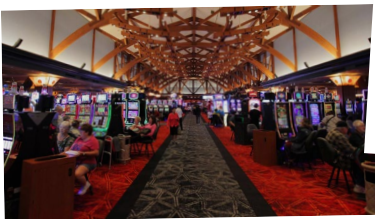


- Telehealth Coverage
- E/M historic changes
- Supervision requirements
- Michigan Surprise Billing law
- COVID-19 Vaccination
- Third-Party Audit Enforcements

I look forward to keeping the Michigan MGMA membership updated on all these topics and more throughout the year. ■

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November 5 at Soaring Eagle Casino
in Mt. Pleasant, Michigan



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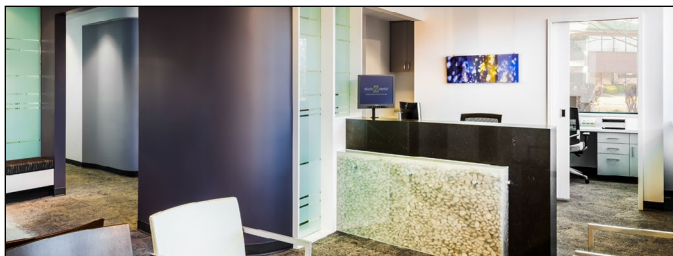
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2021 Advocacy Agenda

The foundation of MGMA's advocacy agenda is to ensure the sustainability of medical group practices and advance their ability to provide high-quality patient care. In January, national MGMA released its 2021 Advocacy Agenda, which provides a description on the following legislative topics:

- Supporting Group Practices as They Confront COVID-19
- Protecting the Financial Viability of Medical Group Practices
- Reducing Prior Authorization Burden
- Advancing Value-Based Care
- Improving Quality Reporting (MIPS)
- Promoting Standardization and Efficiency
- Maintaining Access to Care Through Telehealth
- Expanding the Physician Workforce
- Modernizing the Stark Law and Anti-Kickback Statute



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You can read MGMA's full 2021 Advocacy Agenda [here](#). ■

Did you know?

National MGMA provides an easy way for you to let your representatives know how you feel regarding issues impacting the medical practice community. With the click of a few buttons, you can find your elected officials and send them a pre-written message about important legislative issues. Click "Contact Congress" below to learn more about MGMA's current legislative initiatives and contact your representatives today!

CONTACT CONGRESS

Provider Relief Fund: New provisions appear positive for those who accepted payments

By Don McAnelly, CPA/ABV, CGMA

It is hard to believe we are discussing appropriate use of Provider Relief Fund (PRF) payments nine months after they have been received – the money surely has been spent by now.

When Congress late last year passed the Consolidated Appropriations Act, which includes renewed stimulus payments to individuals and businesses, it changed the scope of the Provider Relief Fund Program. These updated provisions for how PRF payments may be used appear to be positive.

Background on PRF

Healthcare providers in areas heavily hit by COVID-19, as well as those who struggled to keep their practice and facility doors open due to canceled elective services and healthy patients delaying care, received this federal funding through the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

The U.S. Department of Health and Human Services (HHS) quickly distributed PRF payments in April 2020. Since few strings appeared attached to these funds, many providers happily accepted them even though guidance outlining the allowable uses of the funds was anything but clear.

Per the program's original terms and conditions, funds were to be used to reimburse for health care-related expenditures or lost revenue attributable to coronavirus. And, while this sounded simple, it led to a lot of confusion. Under the new legislation, Congress required HHS to permit eligible providers to calculate lost revenues using the following HHS guidance issued in June 2020:

- You may use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if you have a budget prepared without considering the impact of COVID-19, the estimated lost revenue could be the difference between your budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year.

Some good news

The new law appears to reverse HHS' recent statements on the determination of lost revenues and allows for provider flexibility in accounting for lost revenues attributable to coronavirus.

The new law allows PRF recipients flexibility to transfer funds among their corporate parents and subsidiaries. Specifically, Congress required that any reimbursement from the Provider Relief Fund may be allocated (through transfers or otherwise) among subsidiary eligible health care providers, including reimbursement that was marked by HHS as "targeted distribution" payments.



Reporting requirement update

On Jan. 15, 2021, HHS announced it will be amending the reporting timeline for the Provider Relief Fund Program due to the recent passage of the Coronavirus Response and Relief Supplemental Appropriations Act, which is the federal government's follow-up to the CARES Act.

HHS has been working to provide updated reporting requirements that comply with this recently passed legislation. Consequently, PRF recipients (who originally thought they would have to report on the usage of this funds during a reporting period window of Jan. 15, 2021 to Feb. 15, 2021) will now be required to submit their reporting requirements on their use of these funds at a later date to be determined.

Starting Jan. 15, PRF recipients may begin registering for gateway access to the Provider Relief Fund Reporting Portal, where they will ultimately submit their information in compliance with the new reporting requirements HHS is issuing. (The HHS website features portal FAQs and a portal user guide.)

Recipients of PRF payments exceeding \$10,000 in aggregate must register in this portal. At present, there is no deadline for completing registration in the portal. Recipients will later receive a notification about when they should complete the second step of submitting reporting requirements information on the use of funds. HRSA will send a broadcast email to the email address provided during the registration process.

The registration process will take at least 20 minutes to complete and must be completed in one session – partially complete registrations will not be saved. Be sure to have all of the information required to register before beginning this process.

Our take on these latest developments

Hopefully, things relative to the PRF are finally starting to firm up. Providers should continue to carefully track HHS' FAQs and other guidance. When not contradicted by Congress, this guidance will define HHS' expectations for the permissible use of the funds and help providers prepare for reporting and audits. ■

If you would like to talk through the Provider Relief Fund and how we can help your practice or facility understand the latest guidance and navigate the auditing and reporting requirements, please reach out to your Rehmann advisor. You also may contact us at info@rehmann.com.

Rehmann is focused on providing practical guidance and insights to help empower organizations and individuals as we navigate through the uncertainty and complexity of this pandemic, together. Find resources and guidance at our COVID-19 Knowledge Center. Please click here to subscribe to our communications to ensure you remain up to date during these uncertain times.

Real Estate: The Second-Highest Expense in Your Practice



By Fred Schaad, CARR
Healthcare Realty

When it comes to managing expenses in your practice, there are dozens of categories to evaluate: equipment, technology, loan costs and interest rates, sundries, marketing, and on and on they go.

Many practice owners are quick to shop-out what they believe are the most obvious expenses, but few understand the impact of one of the largest expenses and how it can be dramatically reduced to increase profitability. The highest expense for most practices is payroll, followed by real estate. Real estate encompasses your monthly rent or mortgage payments, along with the property's operating expenses, maintenance fees, utilities, and janitorial costs.

If you consider these top two expenses, payroll and real estate, only one of them is really negotiable. With payroll, you can either pay people their value or they usually find another job that will. You may decide that you can cut staff, but if you need people you need to pay them what they deserve or they will eventually leave.

Real estate however, is 100% negotiable. You have the choice

of leasing or owning, as well as being in an office building, retail center, a stand-alone building, or large medical complex with many other providers. You can choose the size of your space, the design, and the landlord you want to work with—or to be your own landlord. And if you do own, you get to decide whether to buy an existing building, an office condo, or to develop your own building from the ground-up.

When negotiating the economic terms of a lease, you get to have a say in the length of lease, the desired concessions including build out period, tenant improvement allowance, free rent, lease rates, annual rate increases and many other provisions.

With this many choices to evaluate and understanding that each one affects the final economic outcome, why is it that so many practices fail to capitalize on their real estate opportunities? The short answer is that most practice owners and administrators simply don't have the knowledge and expertise in commercial real estate to understand how to make the most of these opportunities. They view real estate as a necessary evil instead of an incredible opportunity to improve profitability, reduce expenses and improve the quality of their patients' experience. When the correct approach is taken, you may actually look forward to it instead of dreading your real estate negotiation.

Let's take a look at three key ideas that will help you make the most of your next real estate transaction. >>



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1. Timing

Every type of transaction has an ideal timeframe to start the process. When starting too early or too late, you communicate to the landlord or seller that you don't really know what you're doing. When that message is communicated, it hurts your ability to receive the best possible terms. For example, don't wait for your landlord to approach you on a lease renewal negotiation. Start by consulting with a professional so you can understand the ideal timeframe to start your transaction, come up with a specific game plan for what you want to achieve, and then you be the one to approach your landlord with renewal terms.

2. Representation

Landlords and sellers prey on unrepresented tenants who don't really know the market or what their options are. If the tenant was a Fortune 500 company, the landlord would approach them with a high level of respect, expecting that they either have a real estate broker hired to represent them or have a team of professionals internally that are well equipped to handle the transaction.

In contrast, when a landlord or seller starts speaking with a tenant who isn't represented, and who they don't believe knows the market as well as they do, that tenant is not going to get the same level of respect through the process. This is because the landlord senses an opportunity to take advantage of a small tenant who is not an expert, doesn't have a full complement of real estate knowledge and skills, and who doesn't have adequate representation.

When you understand that commissions are paid in commercial real estate just like they are in residential real estate—they are set aside in advance for two parties, not just one—then you understand there aren't any savings by not having a broker. And if there aren't any savings by not having a broker, then showing up without one only further detracts from your credibility.

3. Leverage and Posture

It is nearly impossible to emerge victorious from a negotiation without leverage and posture which are created by having multiple options in the market. If you limit yourself to one property, you are at the mercy of that owner. Since most landlords and sellers negotiate professionally, it is easy for them to know when you don't have other viable options.

Simply telling a landlord that you have a proposal from another landlord won't give you a strong enough posture. Most landlords look at unrepresented tenants and assume they do not know the market, do not understand all their options, and are not really serious about making the landlord compete for their business. Leverage and posture are created when you have the right timing, professional representation, an understanding of all your available options, and a detailed game plan of what you want to accomplish in order to capitalize on the market.

These three key ideas are the first of many factors that allow healthcare tenants and buyers to reduce their second highest expense which dramatically impacts profitability and cash flow. ■



CARR Healthcare Realty is the nation's leading provider of commercial real estate services for healthcare tenants and buyers. Every year, thousands of healthcare practices trust CARR to achieve the most favorable terms on their lease and purchase negotiations. CARR's team of experts assist with start-ups, lease renewals, expansions, relocations, additional offices, purchases, and practice transitions. Healthcare practices choose CARR to save them a substantial amount of time and money; while ensuring their interests are always first.

Visit CARR.US to learn more and find an expert agent representing healthcare practices in your area.

Evaluation and Management Office/Clinic Visit Documentation Detour: A Bumpy Road Ahead (Medicare and Medicaid)

By Autumn Hull, CPMA, CPC, CEMC, CPAR and Kelly Loya, CPhT, CPC-I, CHC, CRMA

Change is frequently difficult; however, without it, progress is stifled. As part of the Medicare Physician Fee Schedule Final Rule, in 2019 The Centers for Medicare and Medicaid Services (“CMS”) announced significant revisions are coming for reporting physician time and effort as it pertains to office / outpatient Evaluation and Management (“E/M”) visit services. These changes are tied to the 2018 ‘Patients over Paperwork’ initiative and they bring the biggest shift in documentation and reporting visit services since the early 1990s. Below we will discuss these changes and how to manage the necessary adjustments.

The COVID-19 public health emergency (“PHE”) took center stage in 2020. As a result, CMS has more widely embraced telehealth, phone visits, and other distanced healthcare options in the name of public safety. Despite the upheaval, changes impacting the new 2021 E/M guidelines for coding and reporting did become effective January 1, 2021, with very little fanfare. Despite being overshadowed by the PHE, the new rules finalized and published by CMS require physicians implement these important changes now.

Documentation and coding guidelines have not changed for E/M services in the past twenty-three (23) years. To put this into perspective, if we consider a physician’s career averages thirty-five to forty (35–40) years, providers who began their career in 1992 could realistically be facing retirement soon and must learn yet another major change in how to document their most frequently billed services! On November 1, 2018, CMS finalized bold proposals addressing provider burnout and their intent to provide clinicians immediate relief from excessive paperwork tied to outdated billing practices. Healthcare professionals impacted by these processes will find this requires a significant shift in their methodology. Though this change will have a major impact on almost every specialty practice in the United States, other than in coding and auditing circles, little attention has been given to the anticipated changes in documentation, code assignments, and the corresponding reimbursements for these commonly utilized codes. Unless the provider organization has taken the initiative to prepare for these changes, providers may still be unaware of the change and impact this may have on their coding and documentation practices.

E/M visits are reimbursed less than many diagnostic and procedure codes; however, E/M codes are by far the most common charges submitted regardless of medical specialty or billing provider type. According to CMS’ interim final rule (“IFR”) outlining changes through CY2020 and those planned for CY2021, in total, E/M visits of all types represent approximately 40% of allowed charges for physician fee schedule (“PFS”) services; and office/outpatient E/M visits, in particular, comprise approximately 20% of allowed charges for PFS.



A notable change includes reducing the impact of the history and examination component for office / outpatient E/M code selection. This change allows the E/M level to be selected solely upon medical- decision-making or time. Without being in the trenches of coding, billing, and auditing it can be difficult to grasp how these changes could significantly impact revenue, compliance, quality, and even patient care. To some degree, every provider offering outpatient / office services will be affected.

What effects are we talking about exactly? These new guidelines will have far-reaching effects in outpatient professional-fee clinics, and offices. The new documentation rules establish new concepts and can be confusing to those who practice in more than the office / outpatient area, since the ‘old-school’ E/M documentation and coding logic will remain in place for all settings except outpatient clinics and office settings. Now providers must learn a new way to document and value their services in their office / clinic but continue to apply old rules when delivering services outside of their office. Imagine a provider review during which both office / outpatient and inpatient services are scored for accuracy. If the provider fails to remember to adjust their code selection based on the service area, it will result in decreased quality scores,

provider frustration, possible missed revenue, additional staff time to make corrections and time spent on additional education efforts.

Since there are no guarantees other carriers will follow suit, it is almost certain to lead to some level of confusion for providers.

Potential hazards include providers over- or under-valuing their visits, providing inadequate documentation, overcompensating to meet new guidelines – and all while trying to treat a patient and keep their care first and foremost. CMS' recognition of the need to decrease paperwork burdens and allow greater focus on patient care is to be commended. However, if providers lack the time or resources to prepare for the change it could have the polar-opposite effect.

Information Highlights and What Next?

Stepping Back: Reducing the Documentation Burden after January 1, 2019.

In 2019, CMS released documentation guidelines indicating when relevant information is already documented in the medical record, practitioners may choose to focus their documentation on what has or has not changed since the last visit. Providers need not re-record the defined list of required elements if there is evidence the practitioner reviewed the previous information and updated it as needed.

New and established patient office / outpatient E/M visits do not require the practitioner to re-document the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner must document in the medical record that he or she reviewed and verified this information.

Stepping Forward: Reducing the Impact of History and Exam in 2021.

Continuing CMS' 2019 focus on providing guidelines to reduce physician burden, 2021 rules indicate ancillary staff may document relevant history and providers may include an examination pertinent to the current encounter; however, using the new "MDM-only method," the history and exam would not be counted towards the level reported. This will allow practitioners to focus their documentation on what has or has not changed since the last visit and code based on MDM or time.

Without diving into coding jargon, the new 2021 medical-decision-making methodology simply disperses the former, separate table of risk throughout the diagnosis and data portions, resulting in one table with three (3) columns instead of three (3) distinct tables for medical decision making. This is a significant change from the prior table structure and will be used differently.

CMS will engage in further conversations with the public over the next two (2) years to further refine policies.

Other Changes to CMS Payment Rates and Logic in 2021.

There was discussion CMS would finalize a single payment rate for E/M levels two through four (2-4) for office/outpatient visits: one rate for new patients and one rate for established patients; however, that currently appears to be on hold. For 2021, CMS has removed the lowest level new patient visit code and slightly increased the values of the others; in addition, there will be new



codes and requirements for related prolonged services. All of the time requirements for each of the codes have been altered in the code definitions to accommodate billing on time, clarify what time can be counted and how it must be documented.

What should you do now to implement the change? Start by reviewing the final rule at the link below. Review or attend Medicare Administrative Contractors ("MAC") education sessions or review their published information for providers. Focus on how the medical-decision-making scoring and documentation requirements must appear in the record and what documentation may no longer be needed by reviewing the new MDM table using the American Medical Association link below. Ensure coding and auditing staff have access to the appropriate resources and hold provider preparation meetings. We have spoken to several providers who were unaware of the E/M changes described as of the writing of this article!

The 2021 E/M rules are now the new standard, changing how office/outpatient E/M code levels are reached and the corresponding reimbursement for these codes.

What Changes?

- Logic and leveling will affect all medical specialties
- Old E/M guidelines to remain in place for all other settings, e.g., inpatient visits
- New codes and requirements for related prolonged services
- Ancillary staff may document relevant patient history
- Billing providers may include an examination pertinent to the current encounter
- Documented history and examination of E/M office/ outpatient visit not counted towards visit leveling
- Code selection solely based on medical decision making or time
- Disperses the table of risk throughout the diagnosis and data portions, resulting in one table with three (3) columns instead of three (3) distinct tables for medical decision making
- CMS removes the lowest level new patient visit code and slightly increases values of the others

Challenges

- Providers and coders will need to know when (and where) to use these new E/M guidelines versus old E/M guidelines
- While the codes and definitions change in CPT text, it is unclear if all other payers will follow the new CMS scoring and leveling requirements
- Preparing for major change during a health care crisis, e.g., orienting providers to the guidelines, providing staff education and additions / revisions to some documentation templates depending on how and which requirements will be followed across payors

For further discussion, questions, or information about our provider coding and documentation training services please contact us online or give our coding compliance experts a call at 303-801-0111. ■



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