A practical business manual for rheumatologists, fellows-in-training and practice administrators on starting, selling or redesigning a rheumatology practice.

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This manual should be used only as a general reference guide for outlining specific steps that you may take when managing, starting, joining, or leaving a rheumatology practice. The steps contained in this manual are general examples and information and should serve only as suggested starting points for the assistance of your practice.

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# TABLE OF CONTENTS

- **Introduction** .......................................................... 4
- **Chapter 1 – Myriad Practice Settings** .......................... 5
- **Chapter 2 – Joining a Practice** .................................... 13
- **Chapter 3 – Starting A Practice** .................................. 21
- **Chapter 4 – Human Resource Management** .................. 39
- **Chapter 5 – Managing the Practice** ............................... 53
- **Chapter 6 – Financial Operations Management** .............. 63
- **Chapter 7 – Strategic Management** .............................. 72
- **Chapter 8 – Understanding Managed Care** .................... 76
- **Chapter 9 – Leaving the Practice** ................................ 88
- **Chapter 10 – ACR Resources** .................................... 94

**Appendices**

- **Appendix I: Sample CV** ........................................... 99
- **Appendix II: Sample Cover Letter** ............................... 101
- **Appendix III: Business Plan Sample** ........................... 102
- **Appendix IV: Legal Issues Relating to Employment** ....... 118
- **Appendix V: Sample Employee Handbook** ................... 120
- **Appendix VI: Sample Patient Satisfaction Survey** .......... 135
- **Appendix VII: Sample Managed Care Contract** .............. 136
INTRODUCTION

In today’s health care world, rheumatology practices encounter many obstacles both inside and outside the practice. Staffing effectiveness and efficiency, overhead increases, new revenue constraints, managed care contracting and compliance are just some of the pressures pushing practices to their limits. These pressures cause rheumatologists to face many important, life changing decisions, such as starting their own practice, joining another practice, reorganizing or closing a practice.

This manual is designed to cover all areas of starting and running a practice. It is to be utilized as a resource for rheumatologists starting out in practice as well as for those who have been in practice for years. The manual provides excellent information on the essential components of human resource management, financial management, marketing, managed care contracting and much more.

When reading this manual, keep in mind that a practice is not only a business, but a lifelong profession and every decision made is an important one. The power to drive the direction of a practice and create an environment that is geared towards productivity, profitability, and overall patient and staff satisfaction is in your hands. After reading this manual, you should feel confident about addressing practice responsibilities.

This is a living document and the online format allows us the flexibility to add chapters and edit information as it becomes available. Also, the manual is being presented in its entirety and some chapters include information presented broadly, but then delves deeper in subsequent chapters.

This manual includes hyperlinks to resources on third-party sites. Although we have taken every effort to ensure the link information is correct, these links may move over time resulting in a broken link. Should you come across a broken link, please contact the practice management department at (404) 633-3777 and the correct information will be found for you and updated.
CHAPTER 1: MYRIAD PRACTICE SETTINGS

The key to directing the path of a rheumatology practice is to establish clear professional goals that align with your values and your ability to drive the direction of a practice. This will create an environment that is geared toward productivity, profitability, quality of care and overall satisfaction.

Once you know what you want to achieve, it should be easier to determine the practice setting that best suits your needs.

Defining Career and Practice Goals

Conducting a self-evaluation is an excellent first step to help you identify factors that will affect job satisfaction.

Linda Pololi, contributor for the British Medical Journal’s publication BMJ Careers, has detailed a nine step strategy for career development in academic medicine. Although this plan is specific for practicing in academic medicine, the overall structure for career development is universal and can be tailored for identifying the need of any career path. Use this self-evaluation to match what you expect with the opportunities that are presented to you.

**Step One – Clarify governing values.**

Pololi defines governing values as, “deeply held values and standards that govern all aspects of his or her life that act as guiding principles for choices, decisions and behaviors.” These values are typically developed through personal relationships with friends and family and the acceptance of social standards. They include truthfulness, responsibility, intellectual challenges, financial well being and security, among many others.

**Step Two – Prioritize values.**

Organize the governing values identified in step one by ranking from the most important values that drive everyday life, to those that are important but not held as closely as the others.

**Step Three – Identify strengths.**

Compose a list of strengths, abilities and talents that you naturally possess and helped you get to where you are today.

**Step Four – Identify where you want to be ten years from now.**

Pololi suggests you answer questions such as:

- What do you want out of life?
- What type of position are you ultimately seeking?
- Which pathway in medicine is exciting for you?
- Where do you want to place your intellectual focus?
- How do you want to focus your career?
- Do you want to concentrate on research, clinical practice, administration, scholarship, teaching or some combination of these?
- Define the position you want to be in ten years from now without considering how you get there. Is this consistent with your governing values?
Step Five – **Identify one-, three-, and five-year goals.** These are intermediate points in your overall plan to achieve ten-year goals. Identifying and committing these goals to paper will help you keep on track and distinguish opportunities that will facilitate overall goals from those that will deviate from accomplishing long-term career objectives.

Step Six – **Identify skills or tasks necessary to achieve first-year goals.** Develop a short-term plan with objectives and strategies that will drive the motivation to accomplish goals, and lead to where you want to be in the first year.

Step Seven – **Write a learning contract for each skill or task.** This is the culmination of your efforts in steps one through six. A learning contract is a document that outlines what you hope to achieve, and how you will do so. To create a learning contract, write each objective and the date to complete it, and then develop a list of action steps and a timeline necessary for completing the objective.

**Which Practice Setting is Right for You?**

By familiarizing yourself with various practice settings, you will be able to determine which environment will help you best achieve your career goals.

Practice options range from the solo practice that runs on minimal staff to large privately owned organizations that employ physicians as salaried staff, and non-traditional practices that focus on teaching or research and are also available in academic institutions.

**Solo practice**

Starting a solo practice, as with any other small business, is an exciting and challenging venture that can offer greater earnings potential and unlimited opportunities for personal and professional growth.

Starting and running your own medical practice requires the practice of business as well as medicine. As a business owner, financial gain depends directly on the ability to generate income and control expenses. There is a great need to develop working relationships not only with patients and staff, but also with suppliers, accountants, attorneys, and consultants. A practice owner in solo practice will encounter more non-clinical responsibilities, including employment and insurance paperwork, regulatory compliance, and financial management. It is vital to possess the determination necessary to push through slow periods and overcome burnout. Most importantly, the solo-practitioner should consider how the new business venture will affect his or her family and personal life.

Solo practices operate with a small staff and a patient base that is limited to the maximum workload that the rheumatologist can manage. Because you are the only practitioner in your practice, you will have the benefit of personally knowing every patient that steps through the door of your practice. This type of practice affords maximum autonomy, but can also isolate a rheumatologist from colleagues. The freedom of a solo practice allows you to set your own hours and make important decisions for the practice such as what type of payors to negotiate with. In solo practices, the long work hours will directly benefit you rather than someone else. A solo practitioner has complete freedom to decide how to run the business. You will never have to compromise your own personal and professional goals and values as you might in a practice setting with multiple physicians.

While there are a number of benefits to running a successful solo practice, there are significant risks and responsibilities associated with running your own business. Startups require substantial capital, commitment, hard work and long hours to get the new practice off the ground and operating on a firm foundation.

In solo practice, the rheumatologist has the responsibility for earning enough revenue to cover overhead costs and staff salaries. Overhead in solo practices is typically higher and they may be more sensitive to market downturns. Finances can be particularly unstable due to the reliance on referrals; however, much of this risk can be mitigated with the development of a solid business plan and a good understanding of what is required in the business of medical practice. ⁶
Taking vacation or sick leave will be more complicated in a solo practice, so protocols that provide for planned and unplanned time off for you and your staff are necessary. For example, many solo practitioners choose to be on call while away from the office to respond to patients’ needs, or retain another rheumatologist to cover the office and see patients who need immediate attention.

For solo practitioners with families, it’s important they support such a practice lifestyle and understand it will include significant demands on time and financial resources until the practice is established and becomes successful. For more information on determining whether entrepreneurship is the right decision to make, visit the United States Small Business Association’s website at www.sba.gov.

**Group Practice**

If the risks required to run a solo practice are too great, or you prefer to practice in a setting that provides greater sharing of patient care and peer association, joining a group practice may present the best fit.

Group practice size can vary from two rheumatologists to hundreds of rheumatologists or specialists. Earning potential may be lower than in a successful solo practice; however, an already established practice, medical group or clinic can provide financial and scheduling stability, as well as the opportunity to practice with colleagues or in a prime location.

Small group practices typically promote a balance between medical responsibility and autonomy. Having a limited number of physicians within the group provides for the advantages of peer collaboration while still promoting a degree of independence lessened in larger groups. Small group practices carry less financial risk and have fewer time constraints than a solo practice. Most decisions are shared within the group and require a consensus, but these decisions are made faster than within the bureaucracy found in larger organizations.

Small group practices typically exist within a partnership or an association. A physician association consists of physician colleagues, each with their own patient base, entering into a cooperative arrangement. In these arrangements physicians typically share office facilities, equipment and auxiliary personnel. Physician colleagues are treated as peers, and typically keep profits separate. A partnership operates much like an association, but with profits shared.⁶

Practice partnerships can be difficult relationships to build and maintain. Money matters and issues of fairness can creep into the relationship and cause it to quickly take a turn towards dysfunctional. Frequently, business partnerships are not created based on personality fit and lifestyle, but on the candidate’s specialty, academics and other traits that may prove financially profitable for the partnership. While these attributes may produce a partnership where the parties have similar interests, they may have **little else** in common. Ideally, business partnerships should be formed between people with complementing personalities and practice styles.⁴ For those partnerships that aren’t based on these commonalities, a little effort can produce a rewarding partnership and positive work environment even with rheumatologists that are polar opposites. The secret to making the relationship work is clearly defining rules and expectations, communication openness and showing flexibility.

Flexibility is a very important trait in a practice partnership relationship. When two partners with their own needs, ideas, and beliefs regarding the mutual time, money, and energy invested begin to work together, it is certain that issues will arise. Being flexible, tolerant, and willing to negotiate will prove invaluable in preserving and advancing the relationship, and may even help to bring about change and improvement in the practice.

Large group practices are often owned and operated by a third party and were made popular by health maintenance organizations. Adherence to practice guidelines and norms is high due to increased peer regulation, and autonomy is low. These groups provide for a more orderly business-like practice and have specially trained administrative staff—mainly in a central business office—to manage financial aspects of the group. This practice setting frees rheumatologists from the managerial duties common in solo and small group practices and typically provides superior equipment and technology because of greater financial capabilities than would be available in smaller practices. Large group practice will have a human resources department, information technology department and a billing department to handle most of the non-clinical duties. The trade-off is that,
generally speaking, you may have less power over billing, hiring and firing of staff and in the day-to-day management of the practice. The large number of rheumatologists associated with this practice setting allows for enhanced scheduling of hours, days worked and on-call programs. In a large group practice, you have immediate access to colleagues and mentors for help when it is needed.

**Single Specialty Group Practice**

Single specialty group practices are formed by the partnering of two or more specialists in the same field, such as two rheumatologists. The formation of single rheumatology group practice has attracted many physicians, as solo practice rheumatologists observe the significant leveraging power of groups in managed care contracting.

Single specialty groups are housed in one or multiple locations and function in a group setting. The group operates as a partnership or a professional corporation. Many groups employ rheumatologists for a short period of time in order to evaluate fit, and then extend a partnership option. These offers can require a substantial capital contribution to join. Contracts may include a restrictive covenant not to compete. So, if the rheumatologist leaves the practice, he or she must relocate a certain distance away (sometimes this can be successfully challenged). Both of these stipulations secure a financial tie between the rheumatologist and the organization, and promote overall stability, loyalty, and a common goal of quality and profitability.

For rheumatologists who enjoy working closely with their colleagues, single specialty group practices offer the advantages of peer regulation and consultation. However, with that comes the hierarchy that dictates distribution of income and call scheduling, which can lead to instability and turnover among new employees. Group cultures have a tendency to resist change which can be unattractive in the marketplace.

**Multi-Specialty Group Practice**

Multi-specialty group practices range in size from very small to over 1,000 physicians and consist of various types of specialty practitioners within one organization. The group may reside in one facility or several locations. Multi-specialty groups have a distinct competitive advantage in managed care contracting and can serve as a “one-stop-shop” for patients. The “one-stop-shop” characteristic may lead to rheumatologists covering areas of medicine outside of rheumatology.

Multi-specialty groups are able to easily recruit new rheumatologists because of stable cash flows and can usually offer more favorable benefit packages and compensation than with smaller, less integrated organizations. While benefits may be better, it is common to find that the salary is lower than with single specialty groups due to fewer working hours and higher overhead costs. The primary disadvantages to multi-specialty groups are that they are less adaptive than single specialty groups, and the larger practices tend to become more bureaucratic and policy-driven than smaller single specialty groups.

Compensation is typically calculated by taking the income generated and subtracting overhead expenses. The multi-specialty practice will typically include rheumatologists as well as primary care physicians. Both groups generate revenue, but use resources at a different rate given the nature of their field. The distribution of income may be seen as inequitable by rheumatologists in the group practice. Rheumatologists in a multi-specialty group practice may face issues with share of profits in a group with other specialties. It is crucial for a compensation plan to be constructed that is seen as fair by every physician in the practice.

**Independent Practice Association**

An independent practice association, or IPA, is a formal legal entity that initially began as a response to managed care. IPAs are formed primarily as vehicles to contract with managed care organizations in order to provide contracting leverage as a group—allowing higher reimbursement rates. In this setting, the IPA is responsible for billing the insurer; it then pays the rheumatologist as outlined in the bylaws. In addition, members of the IPA must agree on how the funds will be dispersed. Funds may be straight cut, or divided on the basis of who bills the most, has the most difficult cases, sees the most patients, or a combination of all of these.
Rheumatologist members of an IPA maintain their own offices and are able to see patients outside of the IPA contracts. IPAs need minimal startup capital, and allow its members to receive the contracting benefits of large group practices, while maintaining the autonomy associated with solo or small group practices. When considering the IPA model, remember the costs associated with an IPA can be difficult to control, and the relationships among the independent rheumatologists are not always pleasant because their only affiliation is with the IPA.

**Group Practice Without Walls**

A group practice without walls is an entity formed by private practice rheumatologists organizing a practice without being dependent on hospitals for support or services, and to gain leverage for contracting with managed care organizations. The group is owned by the member rheumatologists and is a legal merging of all assets. The rheumatologists continue to practice in their own individual locations and appear to patients as an independent private practice. As a medical group, individual incomes are affected by the practice profitability of the entire group, and peer pressure can be asserted to correct negative practice patterns that can impact the group’s bottom line. Many rheumatologists who practice as part of this type of integrated delivery system model see very little difference in their practice as this organization preserves a high degree of physician autonomy. These organizations tend to exist in a predominantly full-risk capitation environment, and benefits associated with practicing in this environment include centralized billing within the group, group purchasing and data sharing.²

**Health Maintenance Organizations**

Staff-model health maintenance organizations are based on the traditional employment model in which rheumatologists are salaried employees of the organization and are eligible for bonuses and incentive pay. The rheumatologists within this model all practice at one central location owned by the HMO, and provide care only to their beneficiaries. HMOs contract with specialists, such as rheumatologists, hospitals, and other providers in order to provide specialized care for patients. Advantages of staff model HMOs lie in the continuity of patient care. Because the HMO is responsible for deciding which specialists a patient can see, staff-model HMOs serve as a gatekeeper of physician access for patients, which promote greater patient compliance.

Rheumatologists typically work regular hours and do not have the burden of handling paperwork or regulatory compliance under this model. One disadvantage of the staff-model HMO is it provides no incentive for productivity; all rheumatologists are salaried employees and higher performance does not translate to higher pay. Additionally, staff-model HMOs foster little loyalty to the organization and are often linked to high rates of physician turnover.

Variations of the staff-model HMO include contracting with a group practice or an independent practice association, rather than an individual. In the group model, an organization contracts with a multi-specialty group, which is classified as either a “captive group” that can provide services only to patients of the HMO, or as an “independent group” that is able to treat non-HMO patients. The captive group is often formed by the HMO strictly to serve its purposes and under specific guidelines. Since the HMO is contracting with a group, and not an individual physician, this model can be costly for rheumatologists to develop and difficult to manage.

The IPA-model HMO contracts with an association of rheumatologists and is similar to a traditional IPA, where physicians maintain privately owned offices, see patients outside of the HMO, and own their medical records. The IPA is paid through inclusive capitations and must provide all services outlined in the contract. The IPA pays the participating rheumatologists as outlined in the association agreement.

**Academic Model**

If you’re looking for an opportunity to focus your professional development in the areas of research and education, consider an academic setting. Traditionally, medical academia has focused on three tiers of clinical care: teaching, education and research. The academic rheumatologist is in the unique position to conduct clinical research that will produce better health and health
care, shape and mold the next generation of physicians, and provide advanced clinical care, not only to members of the community, but also to patients with some of the most complex or acute health problems not readily treated at other medical centers. Academic health care centers provide access to the most up-to-date technology and a harbor from many restrictions of the health care marketplace and the business of medicine. Working in an academic setting allows for a rheumatologist to collaborate with peers and other subspecialists daily. Success in this setting is typically measured through professional achievements such as contributions to a specialty area or through funding derived from research, rather than through patients seen and codes billed.

Academic medicine is not without its drawbacks, as there can be a high level of bureaucracy. Department funding is dependent on legislative subsidies, research grants, philanthropy, and hospital accounts, all of which are subject to change annually. Historically, positions in this environment offer lower compensation than in private practice, but this may be changing. Academic medical groups are trying new ventures based on private practice models and marketing to a global patient base to increase compensation and attract and retain rheumatologists. 

**Retainer Based Practice/Concierge Medicine**

The retainer based, or personalized, medical practice is a rapidly growing trend that has been sweeping the U.S. since the late 1990s. Also known as a “concierge medical practice,” these practices give patients the opportunity to pay a fixed annual fee to join the practice’s limited patient base in exchange for premium medical services.

The theory behind personalized medicine is that the physician can capture the same or higher revenue levels by charging a flat fee per patient. The limited patient base allows rheumatologists to spend more time with each individual patient in order to identify their needs and formulate a total health management plan that is custom fit to his or her lifestyle.

Fees required to join a retainer-based medical practice range from $1,000 to $20,000 per year. The special services offered by concierge medical practices typically include a larger, more lavish waiting area and exam rooms; priority same day or off hours appointments; home visits; preventative care that includes nutrition, weight loss, wellness programs, house calls, telephone or e-mail consultation; and, an extensive annual physical. There seems to be no lack of patients signing up for this type of service, as they report receiving better and immediate access to care and a feeling of undivided attention by their rheumatologist.

Many rheumatologists frustrated by lower reimbursements, higher practice costs, claims processing hassles, and administrative chores are choosing concierge care. Where it was once met with some resistance from patients and rheumatologists alike, the landscape is becoming more friendly and accepting of retainer-based medicine. Many physician practice owners who have made the move into personalized medicine have met with mixed results from both colleagues and patients. Some applaud the concierge care movement, and the positive changes and personal attention it brings to patient care, while some criticize it as elite medicine encouraging a double standard of care.

Upon startup, concierge practices should consider hiring a publicist to create media buzz through local news stations, business journals, and newspapers. When a suitable marketing campaign is pursued, many of these practices can sign on a full patient base within just a few years. Most rheumatologists not only generate substantial profit, but are able to practice medicine in the way they have always wanted.

**Micro Practice**

The micro practice is a newly emerging style of practice that combines the two key ideas of low overhead and high technology. In a micro practice, the rheumatologist is the sole provider of care and performs all administrative functions with little or no staff. This results in dramatically lower overhead than traditional practices, which allot roughly thirty-six percent of income to pay staff salary, according to the ACR 2009 Rheumatology Benchmark Survey. The reduced overhead then allows the rheumatologist to see fewer patients and open the opportunity to assign more time to each patient.
At the center of this practice type is the utilization of technology to promote efficiency and ease in conducting administrative and patient care tasks. With the right electronic medical record system and billing software, a rheumatologist can conduct a patient visit, electronically submit a prescription, and remit a claim within a short period of time. A few clicks of the mouse are all the rheumatologist will need to quickly create the reports that had formerly been the duty of administrative staff.

The micro practice model also typically promotes patient responsibility and encourages the use of online systems that patient’s access independently to book appointments, and to enter and track their medical history. Putting some responsibility on the patient can actually benefit the patient by speeding up the patient encounter. The time spent with a patient may be more productive if a patient is afforded the opportunity to enter information electronically prior to a visit.

With little or no staff, the micro practice physician owner must be prepared to perform many duties in addition to medical care. These include answering and returning phone calls, billing, preparation of exam rooms, and many other non-clinical tasks. Rheumatologists starting a micro practice tend to earn less than those in a large practice, especially while establishing a new patient base.

If you are self-motivated and highly independent, the lifestyle advantages and lower stress of a micro office may be right for you.

**Locum Tenens**

The term locum tenens means, “to hold the place of or to substitute”, and describes a physician who can temporarily fill in for an absent partner in a practice. Locum tenens may be utilized to cover for vacations or leave of absences, and can be advantageous as long as the rules are followed for proper reimbursement.

Locum tenens is an option for rheumatologists who want to travel, work when it suits them, sample different practice types and settings, learn new techniques, or ease into retirement. It offers freedom from the business aspects of practice and many physicians find it advantageous to be a locum tenens, when they are trying to make a decision as to where and what size practice they want to join or aid in the decision to be an employee or a practice owner.

Keep in mind that being a locum tenens has its advantages and disadvantages. Physicians have reported that they chose this side of practice because you have the chance to have a more flexible schedule. This has become a viable option for young physician mothers, who want to spend more time with their children and still pursue their career. Other advantages of being a locum tenens include: travel opportunities, earn extra income and clinical experience.

But as with anything else, there are disadvantages – and working as a locum tenens is not excluded. This area can be difficult work, as there are few opportunities to develop long-term relationships with patients and colleagues as well as limited (if any) health coverage or other benefits. It also requires the ability to constantly change and adapt.

Rheumatologists who decide to work as locum tenens can either sign on with an agency or contract alone. Contracting with a health care organization is rare (and can be risky), but there are some rheumatologists who do it. These rheumatologists develop their own referral network, typically live in a large urban area and fill in for local organizations to cover vacation or maternity leave. They are also responsible for directly negotiating a contract with the organization and, in many cases, must carry their own malpractice insurance (although some practices that cover their physicians also will cover the locum tenens). Generally, locum tenens are not offered health care coverage or retirement plans, so a rheumatologist choosing this path needs to be financially savvy with investments to compensate for lack of coverage.

A locum agency will, in general, take care of details such as local licensure, credentialing, and travel arrangements, and malpractice insurance and often pay rheumatologists directly. There are many agencies all vying for rheumatologists to sign on. It may help to ask the human resources department at the local hospital which agency they use and to talk to other locums about their experience.
Part-time Practice and Job Sharing

Part-time practice is a rapidly growing trend in medical practices today. Rheumatologists in every stage of their career are looking for a better way to balance practices, family, and social lives. New rheumatologists are graduating from medical school and looking to balance time between work and raising a family. Mid-career rheumatologists are looking to reconnect with their families, cope with burnout, or travel while still young, and late career rheumatologists are looking to reduce workload as they near retirement. Rheumatologists practicing part time may devote their off time to social causes, entrepreneurial enterprises or furthering education.

The reasons for going part time vary, almost as much as the ways in which to go about it. Many part-time rheumatologists take part in job sharing. In this situation, two rheumatologists may work as one full-time equivalent. These rheumatologists may divide work by days (with one rheumatologist working three days, and the other working two), weeks (two on, two off), or even months. Other physicians simply take a part-time position, as many group practices actively seek part-time rheumatologists to pick up a certain number of shifts. This gives the practice the coverage it needs, while the full-time rheumatologists are on vacation or to work after hours.

Working part time is becoming more and more common as new technology, such as electronic medical record systems and personal digital assistants, make working remotely feasible. Additionally, many malpractice carriers now offer customized, prorated solutions for acquiring coverage, making part-time practice a more affordable practice option.

The employment agreement should address those issues unique to part-time work, such as scheduling, space considerations, administrative expectations, malpractice coverage and patient care. Working full days is advisable over half days, as getting out of the office can sometimes be difficult and full days allow for better staff interaction. On the days that the rheumatologist is in the office, he or she should practice at full capacity and to the same performance standard as full time colleagues; therefore, the rheumatologist will need as many exam rooms and as much access to staff as equivalent to a full-time employee. The practice should have detailed systems to coordinate patient care, prescription refills, test results, messages, and other situations that may arise when part-time rheumatologists are not in the office.

Although part-time practice is becoming more common, there may be resistance from colleagues who unfairly label them as not interested in working hard. Surprisingly, many patients accept and understand the reasons for working part time more readily than physician colleagues. The key to achieving acceptance and support from colleagues is flexibility. Part-time rheumatologists who appear to have zero flexibility, especially in the case of attending administrative meetings, are often viewed negatively by both colleagues and administrators.

If you are interested in working less than full time but have a flexible schedule to offer, part-time practice may be worth exploring.

Conclusion

When deciding which type of practice to pursue, having clearly articulated professional objectives and personal needs will be crucial to success.

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CHAPTER 2: JOINING A PRACTICE

After deciding what practice type best suits you, it is time to prepare for the job search.

Preparing for the job search takes time and careful consideration of your career options, as well as an understanding about how to present yourself favorably on paper and in person. Once the job has been landed, you must know what to expect when negotiating the employee contract and how to establish successful relationships with colleagues.

The Job Search

Beginning a job search can be overwhelming. You may be bombarded with telephone calls and e-mail from headhunters and physician recruiters— all claiming to offer the best practice opportunity. It is important to remember that the goal of the job search is to find the right fit for what you want, and not to be sold on the wrong job. Thorough preparation and taking a systematic approach to both narrowing the field and to interviewing the organization will give you the best chance for finding and securing the ideal practice. Determine what is valued the most and make a list of characteristics desired in the job, including size of practice, level of autonomy and peer interaction, even geographic location (bearing in mind that location plays a part in malpractice rates and competition).

Local medical societies may be able to provide information about the health care needs of the community and the number, and specialty, of physicians practicing in that area. You can also contact the Chamber of Commerce or research a city online to obtain information about the community and its schools, services, growth, and economic profile.

Once you’ve decided on the practice type and narrowed down your geographic preferences, it’s time to start looking for jobs that meet those minimal criteria. The American College of Rheumatology offers an online job posting and resume database that is free for job seekers (see www.rheumatology.org); other medical societies may also offer job search resources. A headhunter may find you the position of your dreams, but beware; some headhunters are paid based on making a placement and may attempt to sell you on the position even if it’s not the best fit. Other recruiting resources include ads listed in professional journals and health career websites that allow you to filter results by the ideal characteristics. Academic institutions can be helpful in finding positions; this is usually most helpful for those applying to an academic position rather than to a practice. Word of mouth from other rheumatologists can be very helpful in the search for a position. It would be wise to contact practices even if they are not hiring to ask for their suggestions.

Developing a CV

Chances are you’ll be asked to submit a curriculum vitae as part of an application for any job. You may opt to hire a professional service that creates CVs for health care professionals. These services will develop an aesthetically pleasing resume for you, but they are often expensive. Remember that the CV a company creates will only contain the information given to them, and this money may be better spent elsewhere. The ACR has mapped out a guide to follow in crafting a CV and included a sample CV in Appendix I for reference.

A CV is simply a summary of your attributes and career experience, including publications and presentations, which answer basic questions a prospective employer will have, such as:

- What are the individual’s qualifications and experience?
- What does the individual expect to gain from this job?
- Will the individual fit into our team?
Elitham Turya wrote a book, *Growing Your CV*, in which she gives information and ideas on the areas that an employer will usually look at to determine if a candidate has what the organization is looking for in the practice:

- **Effective communication**: Employers will be judging a potential employee's CV and application as a representation of his or her ability to communicate effectively with both colleagues and patients. They will pick apart not only the content, but the structure, organization, and language of these documents. The employer wants to know if the potential employee will give patients the information they ask for in a way that will be easily understood, and if he or she will communicate adequately with other health professionals. An individual applying for a position can further demonstrate skills in these areas through speech, body language, and ability to be an active listener during the interview.

- **Qualifications and clinical skills**: A CV should include work experience with relevant skills learned from each position as well as any honors, publications and research. Attendance at relevant courses and conferences and professional memberships should also be listed.

- **Working in teams**: Include any activities, both social (if you are comfortable) and professional, which document your ability to be a team player. Rheumatologists treat patients as part of a larger care team made up of other physicians and support staff, and must be able to effectively communicate, delegate, and consult with this team. The CV should list the names and contact information of professional references with whom you’ve worked, who are willing to confirm your skills.

- **Clinical risk management**: Describe any risk management activities you’ve taken active part in, and be prepared to discuss the role that risk management plays in your professional activities. Clinical governance programs that promote recognition and prevention of risks are of high importance in today’s health care environment, and potential employers will want to see that you appreciate the importance of these programs and take an active role promoting risk management.

- **Leadership skills**: As a physician member of a group practice, you will be expected to take part in management and administration of your services. The employer will be looking for evidence that you will be an effective leader and supervisor for your support staff. The CV should document any activities in which you played a leadership role, including appropriate activities outside the rheumatology profession such as becoming the president of a Homeowners Association, or the captain of a rugby team, to show the ability to take an active role in leading a team toward a common goal.

- **Non-clinical skills**: Highlight any non-clinical skills or talents that will add value to the practice. For example, skills in technology and writing can prove to be of great benefit to a practice, and listing them on the resume will not go unnoticed.

Please note not all CVs will have every category listed above. You will need to determine what categories apply to you and what is important for the position being applied.

Academic institutions often offer a standard CV format to follow. If you’re in fellowship training, start with the Electronic Residency Application Service CV that can be created during the transition into residency, and make additions when fellowship training is completed.

A CV should be neat, concise, and easy to read. Employers will be gauging, in part, your level of commitment and interest in the position by how much effort was put into constructing the CV. Tailor a CV specifically to the position being applied for by highlighting different selling points that are of concern to that employer. Write in an active language that shows confidence in your abilities and enthusiasm for the potential job. Use statements such as “I will,” “I can,” and “I know,” to hook the reader and inspire confidence.

The purpose of submitting a CV is to obtain an invitation for an interview. It would be wise to have other seasoned rheumatologists review and provide feedback on how to improve your CV. They will have a better idea of what will intrigue or deter a potential employer. Most importantly, check grammar and spelling and proof as many times as necessary before distribution.
A CV should be sent with a cover letter when applying for a position. The cover letter is a lead-in to the CV and should be limited to one page in length. It should grab the reader’s attention and make them want to know more about the person applying for the position. The cover letter will consist of three sections:

1. The introductory paragraph tells the employer how you learned of the position and expresses your enthusiasm for it, or it will inquire about possible positions available. It will also clearly identify who you are and why you are writing.
2. Core paragraphs sell your skills and explain why you will be great for this position.
3. The final paragraph will address a specific action for follow up and will provide contact details. This paragraph will also give the final push for showing your interest in and enthusiasm for the position.²

To view a sample cover letter, please see Appendix II.

Next Step: The Interview

The interview process may consist of a series of telephone and in-person meetings, rather than one single interview. During this time, the health care organization is seeking to determine whether or not you fit their needs in terms of clinical skills and abilities, as well as personality fit. Equally as important, you should be examining the practice to establish that it fits with your needs and provides a working environment that will contribute to your professional success and gratification. The interview process is as much about your liking the business as the business liking you.

During the interview, smile, be friendly and try to relax, but remain professional. The interviewer will be assessing your ability to communicate to determine how you will interact with patients. Remain genuine throughout the interview. Don’t get so caught up in perfectly handling the interview that you forget to assess the practice. Begin observing the functioning of the practice as soon as you walk through the door. View the practice from a patient’s perspective: do you like what you see? Talk to the staff to determine how day-to-day operations are handled and look around for evidence of privacy and security efforts, tidiness, and respectful communication.⁸ Inquire about the workload of the practice in terms of number of patients seen daily and average hours worked by each rheumatologist. Be aware of the turnover rate within the practice as well as the local environment, including competitors and outside relationships. Ask the potential employer for a copy of the organization’s mission statement. The mission statement will reflect the values of the organization’s owners, and it is important that these values and vision are in line with the personal and professional values that you operate under.

Lastly, question the future of the practice and your future within it. Ask if the practice has a three- to five-year plan and if the practice has any expansion plans in its near future. If the practice will be expanding, ask if it will be through the addition of other providers or services. Look at demographics of the community. What is the physician to patient ratio? Will the local population be able to support the practice, and in turn, what you can expect to earn?

Always promptly follow up an interview with a short note to thank the interviewer for the time he or she took to meet with you and to further express your interested in the position.

Dear Dr.__________,

It was truly a pleasure to meet with you today. Thank you for taking the time to allow me to experience a day at your practice. I specifically enjoyed (something you observed about the practice). I appreciate the opportunity to observe your accomplished practice and can only hope to have the opportunity to become a part of it.

You indicated your practice is seeking a rheumatologist who can build a referral base, enjoys working with the patients, is available to serve on call for approximately 20 hours each month and desires a strong management role in the practice. I believe my background and experience make me an ideal candidate for this position.

It would be an honor to fulfill this position, so that I may have the opportunity to contribute to the success of the practice. I look forward to hearing from you in the near future. Please do not hesitate to contact me should you have any questions.

Sincerely,

Your Name

Sample thank you letter
This gesture serves to keep you in the forefront of an employer’s mind among other applicants and to reiterate your desire to work at the practice. On the previous page is a sample thank you letter.

**Congratulations on Getting the Job! Now, the Employment Contract**

After you’ve found the perfect practice opportunity all that is left is to sign a contract, right?

Don’t get too excited yet. What may be the most important part of the job search remains: negotiating the employment agreement. You do not have a solid and secure deal until you have reviewed all the terms of the contract and both parties have signed on the dotted line. The importance of the employment contract cannot be understated. This legally binding document will govern your working environment, and it states far more than just salary. A solid and clear employment agreement will solidify the working relationship and will help when dealing with any difficulties that could arise in the working relationship.

Carefully review every detail of the document and know how each term is applied and what it will mean for your career. It’s also important to review what is left out of the contract. While it’s tempting to have faith in your new employer to honor all verbal agreements, you should always put everything in writing. The contract should be a good and reasonable compromise between both parties. It is always good practice to have an attorney participate in the negotiating process and review the contract to identify any details that could potentially cause problems. The contract was written by lawyers, so it will be easier for a lawyer to review the contract with you and explain any legal jargon. The consultation fee for the lawyer to review the contract will absolutely be worth it so you feel secure in what is being signed. A little money spent now can save a big headache later.

Before entering the negotiation process, make a prioritized list of items you want to accomplish within the contract. This exercise will help determine what’s most important to you, and what you can live without. Know that it is unlikely for both parties to get everything they desire and a compromise will have to be reached. To maximize the outcome of the negotiation, be prepared to forfeit certain items in order to successfully negotiate for those of utmost importance to you. Coming into a negotiation with an open, flexible attitude will help to create a cooperative environment for negotiation proceedings.

**The Essentials of the Employment Contract**


**Letter of Intent:** The letter of intent shows that the rheumatologist and employer intend to enter into a legal agreement. It is a brief, non-binding letter written by the hiring organization that outlines the job offer and serves as a foundation for the legal agreement. It is drafted prior to the formal agreement and should incorporate all of the points that were agreed upon verbally when the position was offered.

**General Statement of Employment Relations:** The general statement of employment relations sets forth the relationship of the two parties entering into the agreement. It explains the employer-employee relationship and establishes whether the relationship is part time or full time and exclusive or non-exclusive.³

**Scope of Duties:** The scope of duties describes the rheumatologist's responsibilities in broad terms. It identifies the specialty and, in the case of multiple locations, where the rheumatologist will practice. This is the section where on-call duties, practice schedules, and coverage obligations should be discussed. Be sure that they are explicitly stated and agreed upon to avoid conflicts in the future. This section is typically very general, but can be made as specific as needed. If there are specific aspects of the rheumatologist's duties that are important, they should be discussed and stated here.

**Standards of Conduct and Other Activities:** The standards of conduct list those standards of the organization that the rheumatologist will be subject to while employed and the penalties for not following the standards. This section mostly requires the rheumatologist to follow the ethical standards of the practice and legally sets an agreement that the rheumatologist will practice exclusively with the organization. This statement will usually prohibit the rheumatologist from earning outside income. Any exceptions, such as expert testimony, teaching or speeches, will be established here.³
**Term of Agreement:** This specifies the term in which the agreement is in effect and may include the option for either party to extend the agreement at any time. The agreement is either evergreen (automatically renewed for a like term), or definite (having a fixed term and requires a new agreement to renew employment). Unless otherwise stated, all obligations of both parties terminate with the agreement.³

**Compensation:** The compensation section of the employment agreement confirms the rheumatologist's base salary, and explicitly explains how bonuses or incentive pay will be calculated. The agreement should contain provisions for salary adjustments each year and, at minimum, stipulate that salary will be adjusted according to inflation.

Many agreements provide for an incentive or bonus provision. Incentive pay is usually based on productivity, patient satisfaction, or serving on various committees that support the organization. Most bonus pay is given as a percentage of collections once the associate rheumatologist exceeds a certain threshold. It is important that the agreement is specific as to what is included in revenues that are counted and what period is used. Revenues can be based on collections, charges, relative value units (a monetary value assigned to an encounter based on a weight system of contributing tasks), profitability, or a combination of all. A sample calculation should be included in the agreement. Make certain that you will have the right to review financial statements to ensure that the bonus has been figured correctly. The agreement should be clear as to when the bonus is payable and whether the bonus will be paid on a pro-rata basis if the agreement is terminated without cause.⁷

**Fringe Benefits:** Fringe benefits typically include health insurance, malpractice insurance, professional dues, licensure, professional journal subscriptions, continuing medical education costs, retirement benefits, and paid time off. All benefits should be clearly outlined in the employment agreement or should make reference to an outside exhibit or manual that details the benefits provided. Be sure to review all benefits carefully before signing the agreement.

Health insurance is provided by almost all health care organizations and the agreement should be clear as to whether coverage is provided for the rheumatologist’s entire family or just the rheumatologist alone. It is also standard that malpractice coverage is provided by the organization. Malpractice coverage will be provided as either occurrence coverage, that covers the rheumatologist no matter when the claim is made, or claims made coverage, which covers the rheumatologist only as long as the policy is in place.

With claims made malpractice insurance, it is important to purchase tail coverage for that period when the policy is no longer active. Whether or not the organization purchases tail coverage varies. Many agreements state that tail coverage is the responsibility of the rheumatologist if he or she leaves voluntarily or if employment is terminated with cause, and the responsibility of the organization if they are at fault for the termination. Malpractice terms may also require that a rheumatologist share a portion of the premium if it exceeds a fixed amount or if it is a percentage above the standard paid by other rheumatologists. Regardless of where the responsibility falls, the agreement should be very clear as to the specifics of malpractice insurance.⁷

All dues, fees, and expenses associated with professional associations such as the American College of Rheumatology, licensure, and CME should be provided by the organization.

In addition, many organizations may provide a one-week supplement to paid vacation time to attend professional conferences such as the ACR/ARHP annual scientific meeting, so that physicians can stay up to date with advances in rheumatology. This should be clear in the contract.

Paid time off should be clearly stated. Paid time off can include personal days, sick days, and vacation days. You should know exactly how much time you receive, any restrictions of when it can or must be taken, and if there is an accrual system of hours or a time lag between starting the job and having access to paid time off. Many practices are moving to a system that combines all four into one lump paid time off. Take notice as to whether or not time off requires prior employer approval. Prior approval could ensure that days off are equally distributed as to not leave the practice in a bind or understaffed due to large employee absence.⁷

Typically an organization will match a portion of the rheumatologist’s contribution to his or her retirement plan. If this is applicable, make note of how much they have agreed to contribute in the fringe benefits to maximize your retirement plan utilization.
The organization may offer other miscellaneous benefits, such as relocation benefits, child care or educational assistance. These benefits should be clearly stated in the contract as well.

Often times, especially in the case of small groups, the employer will leave the description of benefits provided as loose as possible. With ever-changing managed care contracts resulting in lower reimbursement rates, small health care organizations want to have the ability to change and terminate fringe benefit plans as the financial means of their practice changes. As with any contract, wording is very important and any benefit that is not detailed is not guaranteed for the life of the contract.  

**Disability Provision:** The organization may or may not provide for disability insurance. If it is provided, clarify whether it is short-term disability (covering up to three months) or long-term disability (covering until the age of 65 or your retirement age under social security). The agreement must define what events initiate disability and the resulting compensation, and whether these provisions are tied to any applicable deductible period.

**Termination Provision:** The agreement will be in effect for the full length of the term, unless it is terminated as put forth in the termination provision. Generally, the agreement is terminated as “with cause” or immediate termination, or as “without cause” in which the termination is voluntary.

- “With cause” termination of the rheumatologist generally results from loss of medical licensure, abuse of drugs and alcohol, conviction of a felony, or some other misdemeanor charge.
- “With cause” termination by the rheumatologist can occur in the event of bankruptcy, insolvency, or failure to carry out certain responsibilities set forth in the agreement.

These contracts sometimes include a “material-breach” clause that covers unspecified material breaches like failure to perform duties or failure to abide by policies of the organization, as reason for immediate termination. The “material-breach” clause may be accompanied by a period for cure, which will require that the rheumatologist be notified of the breach and be given adequate time to fix the problem to the satisfaction of the employer.

Termination “without cause” allows for either party to end the agreement at any time without justification. This clause will typically include a statement that will require some advance notice ranging from 60 to 90 days before the contract formally ends. The contract may allow for the organization to immediately suspend active practice by the rheumatologist, but continue to pay salary and benefits until the end of the notice period.

**Restrictive Covenants:** Most contracts include a restrictive covenant or a non-solicitation clause that is intended to protect the business interests of the practice. These restrictive covenants establish a fixed time and distance in which the rheumatologist cannot establish a competing practice and prohibits the leaving rheumatologist from soliciting former employees or patients. You may want to include a provision that will override these terms if you are terminated without cause from the practice. The terms of these articles must be reasonable and the enforceability will vary from state to state. Your attorney should review these terms to determine if they are in keeping with the laws of your state. A contract may also include a buy-out clause which will override the above mentioned articles if the rheumatologist agrees to compensate the practice for a mutually agreed upon amount.

**Starting the Practice**

In order to be successful in a medical practice, today’s rheumatologist must learn to manage the multiple and varied medical partnerships that he or she will encounter. Working is more than just practicing medicine. Investing the time and energy into establishing mutually satisfying professional relationships will create a practice environment that allows for more efficient, effective and enjoyable work and will ultimately allow you to reap huge rewards professionally and personally.
Building a Referral Network

Referral relationships may be the most important relationship in practice. Referring physicians directly affect the bottom line of a practice, and without referrals a rheumatology practice can be destined for financial ruin. You must dedicate a substantial amount of time and energy to planning, developing, and cultivating positive referral relationships. This process begins with understanding the needs of the referring physician and developing a relationship that meets the need of both physicians and patients.

The first step to establishing a referral relationship is to make your services known. It is your responsibility to let all referring physicians know your area of interest (e.g., lupus, JIA, etc.) and what services the practice offers (e.g., infusions, in-house diagnostic services, etc.). Make it a point to visit the local hospitals and attend physician meetings and/or educational sessions to meet physicians and build professional association for referrals. Showing initiative by taking the time to visit these places will illustrate the determination to be involved and will increase the likelihood of other physicians referring their patients.

Do not make the mistake of thinking that once a referral is established, it is set in stone. A referral is a relationship between you and another physician, so it must be maintained in order for it to survive. Establish regular, open communication with all referring physicians to maintain trust and courtesy. As a rheumatologist, you are working as part of a care team with the common goal of improving the patient's health. Professional and social encounters are the best ways to maintain relationships with referrals. Holding CME seminars, roundtable discussions, and conferences and inviting referring physician partners are excellent ways to reach out.

Referring physicians also want, and expect, prompt and efficient communication regarding a patient’s care plan and status. Not all physicians like to receive communication the same way. It is advisable to build a list of referring physicians and their contact preferences and use the preferred method whenever possible.

Be sure to express gratitude to a referring physician each time you receive a new patient from the referring physician. Keep yourself abreast of the encounter with the referred patient, including any new developments, changes in treatment or medication, or diagnoses. The patient was first and foremost a patient of the referring physician and he or she deserves to be kept up to speed on the patient’s progress. The demands and time constraints placed on practices can make prompt communication difficult, but making it a priority and putting effective office systems in place can help to ensure that communication does not fall through the cracks. Prompt communication will not only help to build trust and respect with referring physicians, it also improves the quality of patient care.

Relating to Business Staff

Taking steps to promote healthy working relationships with and among support staff, such as office administrators, laboratory staff, X-ray technicians, and nurses, will produce a culture that is committed, passionate, and dedicated. It will encourage staff to succeed. Patients will in turn see the benefits in excellent customer service and quality of care.

Positive working relationships begin with hiring the right people. A medical office operates on teamwork and all members of the team should be on the same page. The practice support staff is an extension of the rheumatologist and of his or her philosophies regarding customer relations. Staff networking is equally as important as physician networking. Practice managers and schedulers should be given an opportunity to meet with staff from other referring offices to get to know each other better and to discuss scheduling techniques. Staff networking will increase a rheumatologist’s web of contacts in the medical arena and help him or her to spread awareness of his or her practice. You can contact the Association of Rheumatology Health Professionals for more staff networking opportunities at www.rheumatology.org.

Understand your role in setting the overall tone and practice culture as part of the operating team. This will allow you to effectively lead the support team by clearly articulating expectations and delegating responsibilities as appropriate. Because of the chronic, complicated nature of rheumatic diseases, it is crucial for the staff and the rheumatologist to act as a cohesive unit to coordinate all of the components of a patient’s treatment.
The practice manager, or administrator, is the staff member responsible for handling the business side of a medical practice. The practice manager's strengths lay in his or her multi-tasking and interpersonal abilities. The practice manager deals with payors, insurers, regulatory agencies, personnel, and financial issues on a daily basis so that the rheumatologist has the freedom to devote all time and energy to fulfilling the patients' needs. The relationship between a practice manager and a rheumatologist is much like a partnership, with the rheumatologist handling clinical functions and the manager overseeing clerical functions.

Establish a chain of command so that those staff members, whom the manager supervises, are under his or her authority for operational purposes. The practice manager needs to have a sense of autonomy to remain motivated, but also a clear understanding of day-to-day duties and tasks to avoid feeling overwhelmed. Building a partnership between yourself and your practice manager that is based on trust, and allows for a profitable working relationship, is a process that needs time to grow. Establish an open-door policy and hold regular informal staff meetings and one-on-one meetings with the practice manager to encourage open communication. It is crucial to emphasize that this relationship is a mutual one and neither party could function without the other.

**Conclusion**

From preparing to conduct a job search, finding the ideal fit to negotiating an employment agreement and joining a practice, this transition is both an exciting as well as a time-consuming one. If joining an existing practice isn't as appealing as starting your own, be sure to read the next chapter on what it takes to start a practice.

**References**

CHAPTER 3: STARTING A PRACTICE

Perhaps, instead of joining an existing practice, you would like to start one from the ground up. Starting a practice can be a long and extensive process, and should be completely understood before embarking on.

Understanding the major issues associated with starting a new business, creating a specific and detailed plan, and staying motivated while executing that plan are keys to establishing a successful practice that will grow and fulfill your professional needs. The U.S. Small Business Administration states that approximately 50 percent of small businesses fail within the first five years, with the primary reasons being lack of experience, insufficient capital, poor location, poor inventory management, over-investment in fixed assets, poor credit arrangements, personal use of business funds, and unexpected growth. However, armed with good organization and planning, you can make your practice a success.

Building an Advisory Team

The most important part of starting a medical practice, even before financing, is recruiting a trusted and skilled team of advisors to coach you through the process of developing and starting the practice. The right advisory team will ensure that every measure to set the practice up for success in the most efficient way possible has been evaluated. Advisors should be carefully credentialed to ensure that they are qualified in the given field, and also have experience and training directly related to health care.

The two key players on an advisory team are an attorney and an accountant. A good health care attorney will help set up the legal structure of the new business and will guide you through the various requirements for legally establishing the practice. It is important that the attorney has experience and understands health care law. Seek recommendations for a qualified health care attorney from peers or other health care professionals in the area. Interview multiple candidates and hire the one who fits the practice needs the best. Building a strong, long-term relationship with an attorney will help to understand how to use his or her services effectively.

An accountant will also prove to be a valuable resource and friend. The advice on setting up accounting processes and establishing internal controls for tracking cash flow, profit and loss statements, payroll withholdings, quarterly taxes, and an operating budget is critical. Due to the complexity and uncertainty associated with managed care organizations, it is important that the accountant have experience with health care organizations. The accountant can help to create the practice's business plan by providing sound financial projections. Other types of advisors to consider include a financial planner, practice management consultant, and an insurance broker. Keep a practice contract monitoring log while building the advisory team to track the contract commitments made by each advisor and their progress in fulfilling these commitments.

Personal Financial Data

Before starting to design the practice, your personal finances will need to be in order to determine the amount of business financing required for startup.

You will need to review your current resources, complete a personal financial analysis, and obtain a credit report, as this information will have to be provided when applying for financing or seeking potential investors.

When all personal finance information is accurate and up to date, prepare several packets that contain at least your previous two years of personal tax returns, personal financial statements, a personal budget, and a resume. Having this information in easy reach will save much-needed time in the pursuit of startup capital. Knowing where you stand financially will help you to fully understand financial needs and capabilities to map out a business plan accordingly. Below is an exercise to evaluate a physician business owner’s personal financial status.
# PERSONAL FINANCIAL STATEMENT

[Name]

[Date]

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<thead>
<tr>
<th>Assets</th>
<th>Amount in Dollars</th>
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</thead>
<tbody>
<tr>
<td>Cash – checking accounts</td>
<td>$</td>
</tr>
<tr>
<td>Cash – savings accounts</td>
<td>-</td>
</tr>
<tr>
<td>Certificates of deposit</td>
<td>-</td>
</tr>
<tr>
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</tr>
<tr>
<td>Notes &amp; contracts receivable</td>
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</tr>
<tr>
<td>Life insurance <em>(cash surrender value)</em></td>
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</tr>
<tr>
<td>Personal property <em>(autos, jewelry, etc.)</em></td>
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</tr>
<tr>
<td>Retirement Funds <em>(e.g., IRAs, 401k)</em></td>
<td>-</td>
</tr>
<tr>
<td>Real estate <em>(market value)</em></td>
<td>-</td>
</tr>
<tr>
<td>Other assets <em>(specify)</em></td>
<td>-</td>
</tr>
<tr>
<td>Other assets <em>(specify)</em></td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liabilities</th>
<th>Amount in Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Debt <em>(credit cards, accounts)</em></td>
<td>$</td>
</tr>
<tr>
<td>Notes payable <em>(describe below)</em></td>
<td>-</td>
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<td>Taxes payable</td>
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<tr>
<td>Real estate mortgages <em>(describe)</em></td>
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<tr>
<td>Notes &amp; contracts receivable</td>
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<tr>
<td>Other liabilities <em>(specify)</em></td>
<td>-</td>
</tr>
<tr>
<td>Other liabilities <em>(specify)</em></td>
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<tr>
<td>Retirement Funds <em>(e.g., IRAs, 401k)</em></td>
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</tr>
<tr>
<td>Real estate <em>(market value)</em></td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>$</strong></td>
</tr>
</tbody>
</table>

| Net Worth                                   | **$**             |

Signature:  
Date:
Mission and Goals

Before constructing a business plan, first craft the practice’s mission and goals. These will serve as a blueprint for the practice and ensure the business plan is cohesive with the overall view of the practice.

A goal setting process for an organization begins with the development of the mission and vision for the practice. These serve as the foundation of the strategic business plan, which is the overall strategy for the long-term growth and development of the business. The practice’s mission is derived from the culture of the practice and should communicate both the doctor’s purposes and the patients’ needs. The mission of the practice should be inspiring to the patients being treated. The mission and vision should be consistent with community needs and desires, so customers and providers will prefer this practice over other alternatives.

A mission statement describes the overall purpose and activities of a practice. The mission should be market-oriented and defined in terms of customer needs. It should be realistic, specific, fit the practice’s market environment and focused on the distinctive competencies and motivation. The mission and vision are what the practice aspires to become and what they hope for their patients to achieve. It is an ideal future target, not a current reality. The practice can begin forming its mission statement by answering the following questions:

- What is our business?
- Who is our customer?
- What do our customers value?
- How do we envision our business’ development over the next three to five years?

Once established, the mission statement is used to create detailed supporting goals and objectives for the practice.

A goal is a statement that clearly describes actions that need to be taken or tasks that must be accomplished for the mission to be realized, and, in turn, for the business to be a success. A goal must be very specific and measurable. The goals can be related to clinical performance, patient satisfaction, financial operation, or any other factor relating to success, as long as it defines how it will be measured. Goal setting establishes a measure for evaluating the success of the business, and helps to direct focus away from activities that do not fit with the goals and can drain the resources of the business.

In creating the goals, look at the mission statement and make a list of things that must happen to fulfill the mission. The mission goals should be task-oriented, specific and challenging. Articulate goals both in short-term (12 months) and long-term (three to five years). For each goal, establish a list of objectives that must be achieved in order to reach the final purpose. These objectives can then be assigned to an accountable party, given assessment measures, and if necessary, given an allotted budget. The mission needs to be reviewed each year and altered to fit changing goals, patients’ needs, etc.

Together, the mission, vision, goals and objectives form the foundation of the practice. Once the mission and vision have been created, the practice needs to commit to incorporating them into every aspect of work. All actions in developing the practice, from establishing startup capital to hiring staff, will be adhering to this foundation and will come together to create the ideal practice.

Business Plan

Business plans are critical for any new startup business. It will help to determine if the dream of owning and operating a practice is financially feasible and will outline what is involved in business startup and operation. It will guide you through establishing the goals of the business and developing a plan to accomplish them.

The business plan will be the key for getting people on board with the practice, which will be essential in raising startup capital. It is an outline for the business that details objectives, strategies, the current market situation and a financial forecast. A good business plan is the instruction guide for starting a business, and without it, there is a good possibility that the business will fail.
Business plan designs vary, but the essential components of the plan should remain the same, and flashy packaging does not make a successful business plan. Time should be devoted to developing solid and thorough content rather than design, and the content should emphasize three points: the description of the business, marketing plan, and financial projections. The business plan should be aimed at achieving efficient office operations, high quality of care, and financial stability.

The business plan should be informative, specific and visionary. It should state the goals of the practice and provide a strategy and plan to achieve those goals. The goals need to be specific, concrete and measurable. It will also detail the team of advisors and staff that will be vital to the success of the practice and used as a marketing tool to highlight the strengths of the business, disclose the weaknesses, and provide a plan for marketing initiatives. All financial information significant to the practice, including projected revenue, budgets, and a request for capital, should also be presented in the plan.

All business plans address the business type, where it will be going, and how it will get there. The outline below can be used to organize the plan, help to identify the needs of the practice, and develop specific strategies with measurable outcomes for achieving the goals. For additional help in the development of the business plan, you can find templates online, explore business planning software, and explore business development manuals in the community's local library. A detailed explanation of the parts of a business plan as well as a medical practice business plan example is provided in Appendix III.

**Parts of the Business Plan**

**Executive Summary:** The executive summary is a synopsis of the key points of the business plan, explaining the fundamentals of the business. It should be developed specifically for the intended audience and address the questions and issues of that audience. For example, if you will present the plan in order to secure a loan or backing from an investor, key financial points should be included that will be of interest. The language used in the business plan should also be taken into consideration, and concepts and terminology that may be foreign to a rheumatologist’s audience should be avoided.

Begin the summary with the practice’s statement of purpose, and then describe the business and services that will be offered. Highlight key points from each section of the business plan that are important to the reader such as the mission statement, management team, financing and service forecasts. Take care not to simply cut and paste parts of the plan into the summary. Write it in a way that excites the reader and entices him or her to read further into the plan. Conclude with the purpose of the plan and a statement requesting action from the reader.

In the pursuit of startup capital, the executive summary is often viewed as the most important part of the business plan. Many times, the executive summary is the only part of the plan that potential investors will read and use to decide whether to pursue or pass on the business. Write the entire business plan first and then go back to write the executive summary using major components addressed in the body of the plan. The executive summary should be brief, exciting and to the point. It is the sales pitch and should be presented with enthusiasm. If you don’t believe in the plan, no one else will.

**Ownership Structure and Financing Summary:** This section should briefly define the registered name and legal structure of the practice along with its tax structure. It will also describe who the owners are and how they are tied to the financial and operational aspects of the practice. This section will need to discuss required funds for startup, how equity will be divided, and an exit strategy. The exit strategy should include courses of action that will be taken should the owner decide to sell or dismantle the practice.

**Products and Services:** In this section, elaborate on the products and services summary that will be provided in the executive summary. This section should include all offerings of the practice, including any ancillary services.
Organizational Structure: Key leaders and advisors to the organization should be detailed here with a short biography describing their qualifications and role within the organization. Include any organizational charts you may have developed to show the hierarchy within the organization.

- Physician Information: Because the business is centered on the rheumatologist, it is only fitting to include a portion of the plan dedicated to the physicians. This subsection should provide professional information regarding education and licensure along with personal financial and budgeting data if necessary. In short, it will be a professional CV for all physicians involved in the practice.

- Practice Administration: This subsection should list all management and staff positions along with a chart showing proposed hierarchy within the office. Also outline any policies and procedures that will be implemented in the practice pertaining to employment and working environment.

Strategic and Marketing Analysis: This section should outline the market needs, trends and competitive environment in which the practice will be operating. An analysis of the economy, health care industry and rheumatology community in reference to your operations should be included. If you will be participating in Medicare or Medicaid program, analyze that population and legislative environment as well.

Marketing Plan: This will identify target markets and key strategies to capture those markets. Pricing as it relates to the market that is being served may also be included. This section is a marketing outline that will answer key questions the readers may have.

- Patient Demographic Profile: Use this subsection to describe your patient base and how it will affect the practice. This will greatly affect the payor mix and the needs of the practice.

Financial Projections: This section will present a detailed analysis of the funds required for startup, anticipated funding over the next three to five years, how these funds will be used, and a timeline of when funds will be received and depleted. More specifically, the financial section should include a break-even analysis that will show the point at which total revenue will equal total costs associated with providing services; a balance sheet that shows the breakdown of assets, liabilities and equity; a projected profit and loss statement that shows the amount of profit or loss expected for the business to generate in the future; and a projected cash flow statement that will detail monthly cash inflows and outflows.

Most investors and lenders will want to see a detailed startup and operations budget, along with a listing to show how much capital will be required to keep the business operating long-term. Free Excel templates are available on Microsoft’s website (http://office.microsoft.com/en-us/templates/) to help create statements and projections. The financial statements in this section should be well researched. They should show a clear picture of the realistic financial expectations of the business by planning and being prepared for the worst case scenario, you ensure your business can survive. If instead you plan only for the best-case scenario and encounter problems, lack of adequate funding can devastate the practice.

- Revenue Sources and Payor Mix: Include any information that the rheumatologist has on expected or target payor mix and revenue collected from these sources. Managed care contracts can also be described here. For more information on this topic, see Chapter 7.

- Fee Schedules: The business plan should include the fee schedules and highlight those procedures expected to perform most often or that will bring in greater revenue.

Startup Capital

A major question to answer is how much capital is required for the startup of a practice and where to find it. The first step should be to consult an attorney, accountant, or broker to analyze the financial statements and projections you have created. These experts can help map out the worst and best case financial scenarios. From here, it will be easier to identify the appropriate amount of capital. Beware of the danger of underestimating expenses or overestimating income. The easiest way for a
business to fail is by having too little financing. Many physicians who attempt to pull together financial estimates on their own get the big line items such as rent, salaries and malpractice insurance correct, but fail to list all the small items that add up to a substantial amount of your budget. Health care consultants and accountants can assist in developing budgets, anticipated costs and projected revenues based on the rheumatologist's past experiences in the field and the financial performances of other practices in the area.

A negative cash flow in the beginning is likely. Do not be taken aback by this; it is very common for any new business to experience this from its first few months through its first year. Take the negative cash flow along with the interest expense of borrowing money into account for the beginning stages of the practice, and back it up with enough capital to put the practice in firm standing until you get on your feet.

Very few rheumatologists will have the funds available to start a practice without the help of outside funding sources. Most will pool together all personal assets and still need to seek outside startup capital in the form of debt and equity financing. You should have a good grasp on where to find outside funding, exactly what you are getting into with lenders or investors, and the risks associated with various types of funding sources. All startup capital will be in the form of debt or equity capital. The goal is to find a mix of capital that suits you best given the resources that are available.

**Family and Friends**

The first source of funding for most budding entrepreneurs is the circle of family and friends. After all, this group of people might be supporters in the decision to open a practice, and may feel as involved in the new business venture as you. These are the people who believe you can do anything and won’t stop to consider the actual business plan. They will give you everything they can to support the business, but understand that they are supporting you, whereas other lenders and investors will be supporting the business.

Extreme caution should be exercised when borrowing funds from family and friends. Most times family and friends will spend more time considering how much money they will be able to part with, rather than the feasibility of the business they are investing in. Therefore, it is important to be upfront and honest about the money, how it will be used and what can be expected on the return of investment. Unlike experienced investors and bank lenders, this group of people might not understand the risks involved in the investment. Also, consider the relationship with the individuals loaning the capital and ask yourself these important questions:

- How would you feel if they experienced a sudden financial hardship and needed to pull their money out, to the detriment of the business?
- Are they really secured financially and can afford to lend the money or invest?
- How will they be involved in the business?
- How involved will the family members be in the business if they feel they have an actual interest in it?
- Will the personal relationship be bound by the money that was borrowed, or will you be able to continue a friendship or family relationship outside of the debt owed?

Even with the caution needed, borrowing from family and friends is a reasonable place to start. If the lender is financially able to part with the money and understands the risk involved, they can serve as a source of funding for low- or no-interest loans that allow for more flexibility of use than loans from banks, venture capitalists, or angel investors.

If family and friends are good candidates for lending, take the following steps to ensure:

- Provide a business plan explaining the business, industry, structure and all risks involved with the startup.
- Formalize all loans to protect and distinguish the personal relationship from the new business relationship.
- Get all loan agreements in writing and be sure to include the payment plan that is agreed upon and how the lender will be involved with the business.
• Sign and give the lender a promissory note. This process may sound a bit excessive if you are borrowing money from a parent, but it is important to voice all expectations and for both the borrower and the lender to have confidence in one another and the business.

It is never easy to turn down money, especially if the funds are needed to get the business off the ground. Still, remember that entering into an unstable financial arrangement with friends or family could crush the business before it ever gets off of the ground and damage personal relationships beyond repair. Planning is essential to making this type of arrangement successful.

**Investors**

Investors can be a fruitful source of startup capital. They come in many shapes and forms, including venture capitalists who make a living off investing in businesses or “angel investors” who are wealthy, retired people looking to invest in young entrepreneurs. When looking for an investor, try to find someone who has worked with a medical business before so they are familiar with the structure and operations.

While it may look attractive to enlist an investor, keep in mind that there are various types of investors and depending on the agreement that is reached, make sure it is ideal for your business plan.

**Bank Loans**

Startup capital can also be obtained through banks and credit unions if the financial institution determines the business to be low risk and the business plan to be sound. That means that to secure a bank loan you need to market the viability of the business and provide the numbers to back it up. The lender will be looking for firm answers to questions such as:

- How much money is needed?
- Where is the money going?
- When will the loan be repaid?
- What will be done if the loan does not get paid off?

It is important to have a firm grasp on the basics of a loan before setting out to obtain funds and signing all of the paperwork. You will be borrowing a large sum of money, for which you are solely responsible for repaying. This should not be entered into lightly.

The search for the right loan for the practice startup should begin with a good broker, someone who will help to navigate through the myriad loans and find the one that is right and realistic for the business. Retain a broker who has experience with health care lending, understands the risks and trends in the industry, and who will be able to coach through the process of securing the loan.

**Practice Structure**

The next step in developing the business is to establish the ownership structure. The structure of a practice not only determines who owns the business, but also who controls it, who assumes the liability for it, how profits are divided, and how the business will be taxed. Factors such as personal assets and liabilities, existing capital and need for outside investors, state licensing, statutes and tax requirements, as well as the size, scope and type of business, all play an important role in determining the structure. Make certain to understand the liabilities that each structure carries and how malpractice or creditor problems will affect the practice’s personal assets. Be aware of the requirements and restrictions for each entity before choosing one because each practice is unique. Consult with both a health care attorney and an accountant during this process to determine which structure, or combination, will best suit the needs of the practice.
Below is a brief outline of each business structure option as well as a matrix comparing the elements of each.

**Sole Proprietorship**
The most common business entity for physicians is the sole proprietorship. It is an unincorporated business owned by a single individual, and identifies the business and the owner as one in the same. Formation of a sole proprietorship follows all of the same guidelines in owning and operating any business. This type of entity gives the owner complete freedom in running the business and all income and losses must be filed on a Schedule C which is part of your personal income tax return.

However, sole proprietorship is not without a downside. Because the proprietor is the sole owner, unlimited personal liability and responsibility for the business is on the physician practice owner. There is no distinction between personal and business assets, so if the business assets are not enough to cover business obligations, the physician practice owner is legally obligated to use personal assets to cover any debt. Also, if you plan to expand or bring on partners, this is not the route to take as no one else can ever own a part of this entity.

**General Partnership**
A general partnership is a business owned by two or more partners. Partnerships are easy to form as there are no formal legal requirements; however, legal counsel should be involved. Much like a sole proprietorship, income is only taxed on the partners’ personal tax returns. General partnerships are easy and inexpensive to establish with many advantages. The partners have complete control over operations and can conduct business as they agree. They collectively own all assets and do not have to go through a bureaucratic process to make a decision. Unlike a sole proprietorship, partners are able to benefit from complementary skills that each offer to the business.

One key disadvantage of a general partnership is that the success of the partnership and, the business is linked directly with the success of the relationship between partners. All partners have the right to participate in the decision making process and action can be delayed if partners are deadlocked on what to do. Additionally, one partner is liable for the action of another, regardless of whether or not either agreed with action, so trust is a major concern within a partnership. Because the partners own all of the assets of the company, they are all personally liable and responsible for any debts the business incurs and is unable to pay.

**Limited Partnership**
Limited partnerships are similar to regular partnerships except that there are two types of partners involved who have differing levels of control and liability in the company. To form a limited partnership there must be at least one general partner and one limited partner.

- **General Partner:** The general partner in a limited partnership has the same characteristics of a partner in a standard partnership. He or she has an equal share of control, income, and personal liability as other general partners within the firm.
- **Limited Partner:** On the other hand, the limited partner is not involved in the management of the organization and does not share in the personal liability for debts or losses and can only lose the amount of capital invested. The limited partner invests assets into the business at his own risk, and functions much as a shareholder in a corporation. General partners give limited partners a return on their investment into the company.

Limited partnerships are relatively easy to establish and may require as little as filing a certificate of limited partnership with the Secretary of State’s office in the operating state. Financing is usually easier to obtain in limited partnerships than a general partnership, but they are more expensive to establish due to the required documentation that must be filed and the more complex partnership agreement that must be developed.

**Corporation**
A corporation exists as a separate legal entity from its owners, or stockholders. It can be viewed as an individual with legal rights and duties with a definite beginning and a legal residence. The corporation’s life begins when the Articles of Incorporation
are filed with the state and necessary fees are paid. This can be a long and complicated process deterring entrepreneurs from using this structure.

A corporation's liabilities are distinct from its owners' which releases its owners from any personal responsibility of business debt. A corporation is owned by stockholders who own one or more shares of stock in the company and vote on issues presented at a stockholders meeting, which must be held at least once per year. Shareholders will have to elect a board of directors that manages and supervises the day-to-day operations of the company. The members of the board should always act in the best interest of all shareholders. A major disadvantage of corporations is that any income generated undergoes double taxation. It is taxed initially as business income and also on personal income tax of each shareholder. A corporation can either be formed as a C-Corp, the standard form described above, or an S-Corp.

**S-Corp**

To be considered an S-Corp, one must elect the classification upon filing for incorporation status. Several restrictions apply to S-Corp status, including limitations regarding the number and citizenship of shareholders. The primary advantage to incorporating as an S-Corp is the allowance for a pass-through tax advantage, which keeps the profits of the corporation from being taxed twice.5

**Limited Liability Partnership**

A limited liability partnership has characteristics of both a general partnership and a corporation. Partners in an LLP investment, are taxed, and operate as a general partnership, but have no personal liability for the consequences resulting from the conduct of the other partners. In general, partners in an LLP are immune to liability from negligence, malpractice, the intentional acts, and misconduct of partners or of employees supervised by partners. The limit to which partners are liable for business debts varies from state to state. This is a very viable business structure option for rheumatologists, given the protection from negligence and malpractice of other partners.

Limited liability partnerships are formed in the same way as a general partnership with a formal or informal partnership agreement, and registered as a limited liability partnership with the office of the Secretary of State, in the state in which the business operates. Once registered, the name of the business must include the words “limited liability partnership” or end with the letters LLP.

**Limited Liability Company**

A limited liability company is a hybrid of a partnership and a corporation. It is a legal form created by statute that offers limited liability protection to its owners much like a corporation and single taxation much like a partnership. The LLC exists as a separate legal entity from its owners, called members, and the owners cannot be held responsible for debts and liabilities of the company. However, LLCs also provide pass-through taxation that allows for the profits or losses of the company to be passed through for the owners to report on personal tax returns, rather than taxing at the business entity level.

There are more costs associated with forming an LLC than a partnership, but the lack of personal liability associated with an LLC may make the costs seem minimal. A limited liability company requires much less administrative paperwork and record keeping than a corporation but ownership is harder to transfer.

**Professional Limited Liability Company**

Professional corporations and professional limited liability companies are formed for the purpose of providing professional services and are limited to professions that require a license, such as the medical or legal profession. They are formed in much the same way as standard corporations and LLCs and must be registered by the professional filing the articles of incorporation or the articles of organization. Depending on the state in which the articles are filed, approval maybe required by the professional licensure board of the professional. These companies provide the same advantages and disadvantages as the Standard Corporation or LLC.
Business Structure Matrix

Below is a business structure sample to compare aspects of the different business types. Double click the image to view a larger version in PDF.

<table>
<thead>
<tr>
<th>Type of Business</th>
<th>Sole Proprietor</th>
<th>General Partner</th>
<th>Limited Partner</th>
<th>C-corp</th>
<th>S-corp</th>
<th>Limited Liability Company</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>A business owned and operated by one person for profit.</td>
<td>Two or more people who jointly own and operate a business.</td>
<td>One or more partners have limited liability and no rights of management.</td>
<td>Formed under State and Federal Law. An artificial entity separate from its owners.</td>
<td>Structured like a corporation but taxed like a partnership.</td>
<td>Business entity created by statute. Owners called members. Taxed like S-Corp or partnership. Has limited Liability like a corporation</td>
</tr>
<tr>
<td><strong>Ease of formation</strong></td>
<td>Easiest form of business to set up. Permits licenses, taxpayer ID still may be required.</td>
<td>Easy to form and operate. A written partnership agreement is recommended.</td>
<td>File certificate of Limited Partnership with the Secretary of State. Name must show that business is a limited partnership. Need written agreement and must maintain minutes.</td>
<td>File articles of incorporation with Secretary of State. Prepare bylaws and follow corporate formalities.</td>
<td>File articles of organization with the Sec/State. Adopt operating agreement, and file necessary reports with the Sec/State. LLC must be in the name.</td>
<td></td>
</tr>
<tr>
<td><strong>Period of Existence</strong></td>
<td>Terminates at will or on the death of the owner.</td>
<td>Terminates by agreement, or by death or withdrawal of partner, unless there is a partnership agreement to the contrary.</td>
<td>Same as General Partnership.</td>
<td>Formal dissolution. Most stable form of business. Not affected by death or dissatisfaction of shareholder.</td>
<td>Same as C-Corp.</td>
<td>Terminate by agreement or withdrawal of member. Depending on the operating agreement.</td>
</tr>
<tr>
<td><strong>Taxes</strong></td>
<td>Profits taxed once. Proft and loss are reported on individuals State and Federal tax returns.</td>
<td>Profits taxed once. Each partner reports his or her share of the profit and federal income tax returns. Partnership files an information return.</td>
<td>Same as General Partnership.</td>
<td>Subject to double taxation. Once at the corporate level and again at the shareholder level.</td>
<td>Taxes once. Each shareholder reports individual profit or loss on individual tax returns. S-Corp does not pay taxes.</td>
<td>Each member reports individual share of profit and loss on their individual income tax returns. Taxed like a partnership or S-Corp. If not structured properly LLC can be taxed as C-Corp.</td>
</tr>
<tr>
<td><strong>Liability</strong></td>
<td>The owners personal assets are at risk.</td>
<td>Each partner’s personal assets are at risk. Limited partners personal assets are at risk.</td>
<td>General partners personal assets are at risk. Limited partner is liable only to the extent of his or her investment.</td>
<td>Limited to corporate assets, except: 1. Personally guaranteed business debts. 2. Personal negligence or fault. Corporate form is found to be a sham.</td>
<td>Same as C-Corp.</td>
<td>Similar to rules for Corporations.</td>
</tr>
<tr>
<td><strong>Dissolution</strong></td>
<td>Easiest to dissolve. Pay debts, taxes, and claims against the business.</td>
<td>Pay debts, taxes, and claims against business, settle partnership accounts.</td>
<td>Same as General Partnership plus. File cancellation of Certificate with the Secretary of State.</td>
<td>Shareholders must vote to approve dissolution. File intent with Sec/State. Pay all debts, taxes and distribute corporate assets to shareholders.</td>
<td>Same as C-Corp.</td>
<td>Pay debt, taxes and claims against LLC. Distribute remaining assets to members. File articles of dissolution with the Sec/State.</td>
</tr>
</tbody>
</table>

Practice Location, Layout and Design

Securing appropriate office space, location, layout and design is critical to the success of a practice.

**Location:** Choose a commercial broker who has experience with medical offices and who understands the needs of a practice in terms of construction, parking, zoning ordinances and requirements as outlined by the Americans with Disabilities Act. The broker should put together a comparison list of target locations that includes information on traffic count, photos, locations of competitors, environmental reports and details on leases and/or purchase options.²

Look for an area that will not only be personally convenient, but also fitting for future patients. Access to main highways and other medical facilities, such as labs and imaging centers, are key areas to look at for a possible practice location. Be sure to check out a prospective location at different times of the day to assess any potential issues like heavy traffic or difficulty parking. If you find a location that seems perfect but feel that the rent is too high, don’t cross it off of the list, as there may be room to negotiate.

Property can be purchased or leased, and can range from a stand-alone practice to a suite in an office building. As different property types are considered, walk the path of the future patient and evaluate the distance from the parking lot, availability of stairs and elevators and in proximity to the office, foot traffic outside of the office, and overall impression of the property. Check to see how soundproof the exam rooms are to ensure that all patients have confidentiality during their visit and guarantee the Health Insurance Portability and Accountability Act is not violated.
Layout and Design: The layout and design of the office can greatly contribute to its success or failure. Current trends in managed care call for higher quality in spite of ever decreasing reimbursement rates. As a result, practice efficiency becomes the key to financial success. A well-structured and organized office layout can contribute to the effectiveness of the practice, whereas an office that is carelessly thrown together will bring about chaos and work inefficiency, particularly in patient flow. Even a small office space can be designed for success. Consider visiting other practices to determine likes and dislikes as the practice is established.

The office will support three primary functions: administration, patient care, and support services. Administration covers the waiting and reception areas, business office, and the area where medical records are kept. Patient care consists of the examination rooms, treatment room, and a consultation room, but this will vary according to the in-office services the practice provides and the needs of the staff. Support service rooms will mostly consist of a nursing station, laboratory, an X-ray or dark room, storage, and a staff lounge.

Consider retaining a professional contractor and/or health care design consultant to work on determining the exact square footage that is needed. Be aware that designers can outfit the entire clinic, but usually add a substantial markup on furnishings. When contracting, know what the proposed markup is and be ready to negotiate. If you are not ready to commit to hiring a contractor or design consultant, check out books on medical space planning and design from the local library. There are a number of books available that explore not only structural planning and applicable regulations, but also the psychological theories of designing for maximum efficiency, positive work environment, and contributing to patient well-being. These guides also contain sample architectural sketches that will give an idea of the square footage needed, and can guide you when scouting locations. Be aware that every inch added will increase price, so use space wisely.

Ensure that the office space will allow for adequate and safe storage of supplies and medical records that adhere to HIPAA guidelines. If maintenance or janitorial staff will have access to the practice, ensure that they understand and follow regulations associated with confidentiality.

Whether the practice is owned or leased, the office space, the furnisher and equipment that go along with it will be a great expense. Keeping overhead expenses low is a must for every new practice; but for startups, even the bare minimum of equipment is very expensive. Developing what will become the physical representation of the practice is an enormous task and should not be taken lightly. It’s important to be involved in every aspect of development and design the clinical environment to fit the practice style and the needs of the patients and staff. Keep detailed records with pricing quotes during the planning process in order to yield an accurate projection of the startup capital for the development of the facility.

Overall, office layout should be designed to expected patient flow to reduce unnecessary traffic. Patients should be able to proceed from the waiting area to the exam room, to the checkout station, and exit the office as directly as possible. Below are suggestions on how to design the individual areas in the office.

Reception Area/Check-in Area: Patients should be able to access the receptionist desk or check-in area easily without stepping over other patients in the waiting area. There should be enough room for staff to complete the tasks of greeting patients, having them sign in, gathering information for billing purposes and to check out the patient at the end of the visit.

Patient Waiting Area: Don’t underestimate the importance of the waiting area. A patient’s first impression of the practice and the rheumatologist is often based on the reception and waiting areas. Studies show that a patient’s perception of quality and overall health care experience is not based solely on their interaction with the physician and health outcomes. Attractive waiting areas are associated with the quality and overall health care experience. Purchase quality, sturdy chairs for the waiting room area. Especially chairs with a strong arm rest to assist elderly patients who need to push themselves to stand, and armless chairs for overweight patients who will not be comfortable in a chair with restrictive arm rests. A common formula used to determine the space necessary for a patient waiting area is to take the number of patients expected to be scheduled at the busiest hour, multiply by two and a half to account for guests that accompany patients, and subtract the number of
exam rooms the practice has. This calculation will yield the number of chairs needed in the waiting area. Then multiply the number of chairs by twenty feet to give an estimate of the square footage needed in the waiting area.

Work stations: The work stations should have easy access to task-related materials and storage areas for efficiency. This area needs enough space to allow for bookkeeping, billing, and other managerial duties. Storage areas for patient records or computer terminals need to be secluded and meet HIPAA privacy guidelines.

Exam rooms: A patient should feel completely comfortable in an exam room. The rooms should have discreet access and be secluded from other areas of the office. For convenience and efficiency, the exam rooms should be near a central work station for nursing staff (depending on the size of the practice). You will also be able to use this central work station to review charts and make phone calls in between patient exams.

Laboratory/X-ray Room: The lab should have convenient access to the waiting area so patients can easily exit after having tests done. It should also be somewhere private so patients feel comfortable while they are having tests and X-rays.

Employee Break Room: Staff should have a place to take a break and eat meals. The staff lounge should have a table, chairs, refrigerator, and microwave for staff to utilize during their breaks. Providing an employee break room can help to keep overall morale high. The break room should be segregated from patient flow.

Once the office is fitted with the necessary furnishings, it’s time to stock the cabinets with medical and business supplies. Listing all of the items needed is a huge undertaking; luckily, it does not have to be done alone. The best way to purchase and stock inventory is to simply ask a colleague for a copy of a working inventory list or find an inventory template online. A pre-generated list can easily be customized to fit the rheumatologist’s needs and will help to ensure a practice does not open without the necessary supplies, like needles to draw blood. Outsourcing inventory needs to a medical inventory management software system will keep an automated inventory list and help to ensure supplies are received when needed, but this should only be considered if it is within budget.

To Own or to Lease?
Deciding whether to buy or lease a medical office is not an easy decision. Both options have advantages and disadvantages. It is important to evaluate the current situation as well as the future projections of the practice when making the decision of leasing or buying office space.

Owning
The benefits of ownership include cost control, tax benefits and the opportunity to build equity, and not having to worry about market conditions driving up occupancy costs. Ownership definitely has its payoffs in tax breaks for mortgage interest and depreciation—which are both deductible—and equity in the real estate can provide for a sizable payoff at retirement. But for

WHAT SUBLIMINAL CUES ARE LURKING IN THE OFFICE?

Out of date furniture, worn upholstery, or grimy spots on the wall may send patients a message that the doctor does not care about patient comfort, or that the doctor is reluctant to replace things when they are worn out. It may also suggest that the doctor is outdated on medical matters as well, which can lead to a lack of confidence and breed patient anxiety.

Plastic plants suggest that live plants probably could not survive the environment, and the patient may fare no better. Healthy, lustrous green plants promote a feeling of well-being.

A poorly illuminated room suggests to patients that the staff is trying to hide something—perhaps poor housekeeping.

Burned out light bulbs suggest inattention to detail.

A closed sliding glass window with a buzzer for service tells patients that they are not really welcome, and that they are intruding on the staff’s privacy.
every benefit, there is an additional cost. Purchase of a practice always leads to extra and unexpected construction costs for inspections, zoning issues, safety code regulation, and after opening the practice, additional repairs, taxes and other costs will still increase.\textsuperscript{13} Owning an office requires more startup capital, but by building equity in the building, the practice may be able to better control long-term costs.

Practice ownership also opens the door for increased liability. In addition to holding the appropriate insurance policies, most often the real estate is not owned by the medical practice as a corporation, but instead is owned by a separate partnership or LLC. This setup will help to protect both corporate assets and the personal wealth of the rheumatologist, in the case of a drop in the number of patients. The holding of real estate by a separate entity allows tax attributes of the property to flow directly through the owners, protecting the medical practice from double taxation that may occur if the medical practice as a corporation owns the real estate.\textsuperscript{13}

Ownership may cause further issues if a partner retires or separates from the other partners. In this case, the partnership must come up with the cash to pay out the departing party and may be subjected to cash flow issues. This problem can be mitigated by including details regarding what will happen in the case of disability, death, retirement, or split-up in the practice group agreements. The possibility of potential mergers must also be taken into account when considering whether to lease or buy a practice. Building ownership can lock up equity and result in unwanted assets and can make a potential merger unattractive.\textsuperscript{13} Owning office space also limits mobility of a practice if it outgrows its space.

**Leasing**

Leasing a building or office space for a practice is an option for consideration. Leasing a medical office is a much more complex process than leasing an apartment. The practice space will be subject to many requirements unique to medical office buildings, and you should consider consulting a professional lease broker who is familiar with these requirements and the leasing process. A broker may also be aware of current leasing opportunities that will specifically fit your needs, saving much of the time and energy required when scouting sites.

Ensure the office will be an approved facility that follows the Americans with Disabilities Act, Occupational Safety and Health Administration and Medicare guidelines. According to the Center for Medicare and Medicaid Services facilities must “meet the minimum standards to ensure the safety of beneficiaries” being treated in the physician practice. The property should produce an official document showing that the facility meets the required standards.

Converting an office space to be handicapped-accessible can be a very expensive process. It is important to know who will be responsible for the bill if improvements are necessary. Rheumatology practices should be accessible to all patients, and OSHA and ADA compliance standards should be carefully reviewed to ensure that the facility is up to code. If the landlord takes responsibility for maintenance of these standards, it is important to know that the necessary repairs will be completed effectively and quickly.

**Lease Negotiation Strategies**

Once prospective offices have been narrowed down, the negotiation of leasing terms begins. It is advisable to openly negotiate with multiple locations at the same time. This allows you to compare leasing terms and incentives, and there will be backup locations if the first choice falls through. Openly negotiating with multiple locations can also generate a sense of competition among landlords, and could provide increased negotiating power.

When negotiating, there are several types of leasing agreements to consider. Each will vary in base rent, utilities, maintenance and insurance to determine who is responsible for what. Consider seeking legal advice prior to signing a lease since it is a binding document. Listed below are some common leasing agreement forms.

**Gross Lease:** The gross lease is an agreement in which a tenant pays a fixed rate that includes base rent plus an estimation of utilities and is not responsible for any additional fees associated with ownership or upkeep of the property. The landlord is responsible for paying all expenses outside of rent including utilities, maintenance, building insurance, and estate taxes.
Graduated Gross Lease: A graduated gross lease is a long-term gross lease in which the rent slightly increases each year. The total amount the tenant pays over the course of the lease is agreed upon at the time of signing and is allocated differently over the years. If it is a new practice with limited financial resources, this may be an attractive option to control costs in the beginning.

Adjusted Gross Lease: This lease structure operates the same as a gross lease with one exception: the utilities are charged based on individual tenant utilization as opposed to equal distribution among tenants. With this type of lease, the rheumatologist will only be paying for utilities used, which could hurt or help finances depending on the fellow tenants.

Double Net Lease: A double net lease agreement requires a tenant to pay for real estate taxes and building insurance in addition to base rent and utilities. The landlord is responsible for maintenance and any structural costs.

Triple Net Lease: A triple net lease is similar to a double net lease with one exception: the tenant must pay maintenance fees in addition to the costs associated with a double net lease. The maintenance responsibilities of a tenant can include common areas such as a lobby in an office building.

Many leases require a personal guarantee to pay out the life of the lease in the event that the practice is unsuccessful and unable to pay rental obligations, including in the case of the rheumatologist’s death. If possible, do not sign a personal guarantee. If you negotiate to sign a “limit-declining personal guarantee,” which will reduce the payments each year after default of the practice, make sure there is a provision included that you will be released from the lease upon dying.

This would also be a good time to review the subletting provisions. In the event that the practice needs to move before the lease is up, you should know and understand if there is an option to sublet the space. Most leases provide that a tenant will only be able to sublet with the approval of the landlord. Make certain that this statement includes a provision to state that the landlord’s consent will not be unreasonably withheld or delayed. Also, know if the landlord’s consent is required to sell or merge the practice with another. The lease should be specific and detailed, not only in your right to make improvements to the facility, but also in who owns those improvements.

Most medical office leases usually contain a “duty to remove improvements” provision. The provision requires that the space being leased be in the same condition when you leave as it was when first moved in. This means that any changes made to the office while utilizing it will have to be removed at the end of the lease. This provision should be negotiated as it can be a major hold up at the end of a lease. Consider discussing possible transfer of ownership to the landlord for any modification that is made. Usually a modification made in the office will benefit the landlord by increasing the value of the space. If this is the case, the landlord should be open to a transfer of ownership, and both parties will benefit.

Many times the ability to move into a space and begin a practice is determined if financing can be obtained. If financing has not been secured, insist that the lease include an option for termination if financing is not secured within a stated amount of time. The following is an example of such a stipulation:

“This lease is subject to Tenant obtaining a written commitment within (number) days of the date hereof for a loan in the principal amount of ______________ at an initial rate of interest not to exceed ______ percent for a term of _______ years. Tenant will make application therefore within five days from the date hereof and use reasonable diligence to obtain the loan commitment and to satisfy the terms and conditions of the commitment and to close the loan. If the Tenant fails to obtain the commitment or fails to waive Tenant’s rights hereunder or after diligent efforts fails to meet the terms and conditions of the commitment then either party may by written notice to the other cancel this lease and tenant shall be refunded his deposit.”

Licenses/Permits/Registrations

Having the ideal practice with the necessary furnishings is part of the journey to open and treat patients, but before that can happen, you need to secure all required business and medical licensures to legally practice.

Physician credentialing is a process that must be done for both Medicare and managed care organizations to review and verify
the information of a health care provider who is interested in participating. The review and verification process includes current professional license, current Drug Enforcement Administration and controlled drug substance certificates, verification of education, post-graduate training, hospital staff privileges and levels of liability insurance. The credentialing process also includes review of a physician's office to verify that all the necessary permits and licensures are in place. Compliance standards as outlined by individual MCOs, will have to be substantiated before final approval can be given. Credentialing of a physician and a practice should not be underestimated as it takes a substantial amount of time to complete and finalize. A physician will not be able to receive reimbursement from payors if he or she is not credentialed.

With this in mind, the credentialing process should begin when the decision is made to open a practice. In most cases, you will be able to list a temporary address if the physical address of the potential practice has not been secured. Payors will require tax identification and National Provider Identifier numbers, so obtaining these should take precedence. Check into securing the following licensure as early in the process of starting the practice as possible.

**Medical License**
As soon as you decide on a location, the process of obtaining a license to practice medicine in that state should begin, as no other licensure or registration can be obtained without it.

Medical licenses are state specific and requirements will vary. Most states require a written exam, graduation from an accredited medical school, and completion of postgraduate training. Beyond this, requirements for further examinations vary from state to state. There are specific state requirements, which are available from the American Medical Association's State Medical Licensure Requirements and Statistics at [https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod1500002](https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod1500002).

Licensing information and applications can be obtained from the state board's website. The Federation of State Medical Board's website ([www.fsmb.org](http://www.fsmb.org)) has a state-by-state directory with links to each state board's website.

**Drug Enforcement Administration Registration**
A Drug Enforcement Administration permit is required to prescribe controlled substances in a rheumatology practice. If you already have a DEA permit, you will need to submit a change of address form for the new practice location. Some states require a narcotics license in addition to DEA registration; this should be verified if you are practicing in one of these states.

To download an application or a change of address form, go to [www.usdoj.gov/dea](http://www.usdoj.gov/dea) and click on DEA Registration and Renewal or call (800) 882-9539 for more information. Registration renewal for a DEA permit is required every three years and current registration fees can be located on the DEA website.

**Clinical Laboratory Improvement Amendments Certificate**
Medical practices where one or more laboratory procedures are performed on specific patient specimens require appropriate licensing and certification from CLIA, even if it is only one procedure, done once per year. To download an application to certify a practice, visit [www.cdc.gov/clia/reggs/subpart_c.aspx#493.43](http://www.cdc.gov/clia/reggs/subpart_c.aspx#493.43). A listing of state agencies can also be found on the Centers for Medicare and Medicaid Services website at [www.cms.hhs.gov](http://www.cms.hhs.gov), or call (887) 267-2323. The cost of the license and certificate is based on the types of tests that the rheumatology practice performs as well as the number of tests performed each year.

If a rheumatology practice does not want to apply for an in-house lab and prefers to avoid CLIA licensure, the practice may consider contracting with off-site laboratories to refer patients. Keep in mind that insurance companies have to approve the off-site laboratory and different carriers may contract with different off-site facilities causing some complication in knowing where to send a patient for lab tests. To view the list of CLIA waived laboratory tests and CPT codes, visit [www.doh.wa.gov/hsqa/fsl/Documents/LQA_Docs/Waivedtests.pdf](http://www.doh.wa.gov/hsqa/fsl/Documents/LQA_Docs/Waivedtests.pdf).

**Employer Identification Number**
An employer identification number, also known as a federal tax identification number, is used to identify a business entity. To obtain an EIN, you will need to provide information such as the legal name and location of the business, the structure of the
business, number of expected employees in the coming year and principal activity of the business. The EIN can be applied for on the IRS website at www.irs.gov/businesses. The IRS assistors will also provide an EIN via phone at (800) 829-4933. To view the SS-4 form for EIN application, visit www.irs.gov/pub/irs-pdf/fss4.pdf. Completed forms should be faxed to (859) 669-5760 for businesses operated within the United States, and (215) 516-1040 for international businesses.

**State Tax Identification Number**

Not all states require a separate state identification number; contact the state controller’s office to determine if one is required or hire an accountant. Visit the state’s website to verify the tax requirements.

**Medicare Provider Number**

Physicians have three contractual options for Medicare: engage in a participating agreement; a non-participating agreement; or opt-out entirely by becoming a private contracting rheumatologist.

**PAR:** A participating rheumatologist agrees to accept predetermined, approved Medicare charges as payment in full for any Medicare patient they treat. In this scenario, Medicare pays eighty percent of the charge and the patient must cover the additional twenty percent. This agreement does not allow rheumatologists to charge patients anything over the amount determined by Medicare, but rheumatologists are not required to treat every Medicare patient that approaches them. There are various incentives for rheumatologists to enter into PAR agreements including:

- PAR physicians receive a five percent higher rate of payment from Medicare than non-PAR physicians.
- Contact information for PAR physicians is published in directories and disbursed to various groups and individuals who utilize Medicare.
- Claims for PAR physicians are processed more quickly, due to toll-free claims processing lines provided by carriers.

**Non-PAR:** Non-participating rheumatologists have the ability to determine a billing amount that varies case-by-case and can charge more than the amount that has been allotted by Medicare if the claim is unassigned—up to 109.25 percent of the Medicare cost. However, non-PAR physicians receive only 95 percent of the approved amount set by Medicare for assigned claims.

Below is an illustration from the American Academy of Family Physicians on the difference between PAR and non-PAR Medicare reimbursement. It shows a Medicare encounter with a Medicare fee amount that equals $100. The table shows the different payment amounts a physician will receive from Medicare and from the patient in question, depending on which contractual option for Medicare they have chosen.

### Example: A Service for which Medicare Fee Schedule Amount is $100

<table>
<thead>
<tr>
<th>Payment Arrangement</th>
<th>Total Payment Rate</th>
<th>Payment Amount from Medicare</th>
<th>Payment Amount from Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAR physician</td>
<td>100% Medicare fee schedule = $100</td>
<td>$80 (80%) carrier direct to physician</td>
<td>$20 (20%) paid by patient or supplemental insurance (e.g., Medigap)</td>
</tr>
<tr>
<td>Non-PAR/assigned claim</td>
<td>95% Medicare fee schedule = $95</td>
<td>$76 (80%) carrier direct to physician</td>
<td>$19 (20%) paid by patient or supplemental insurance (e.g., Medigap)</td>
</tr>
<tr>
<td>Non-PAR/unassigned claim</td>
<td>Limiting charge/109.25% Medicare fee schedule = $109.25</td>
<td>$0</td>
<td>$76 (80%) paid by carrier to patient+ $19 (20%) paid by patient or supplemental insurance+ $14.25 balance bill paid by patient</td>
</tr>
</tbody>
</table>

Source: www.aafp.org/online/en/home/practicemgt/mcareoptions.html
**Private Contracting:** A rheumatologist can opt-out of Medicare entirely and instead bill patients directly for payment. A contract will have to be signed by both the physician and the Medicare beneficiary, agreeing not to submit any claims to the Medicare contractor. A decision to become a private contractor means foregoing the option to submit a claim to Medicare for no less than two years. However, Medicare will cover a service that is medically necessary for the beneficiary, such as an off-site lab test, as long as the private contracting physician receives no compensation. To learn more about opting out of Medicare, go to [http://www.aapsonline.org/medicare/optout.htm](http://www.aapsonline.org/medicare/optout.htm).

Medicare will not reimburse for services provided to a Medicare beneficiary unless the provider has a provider number. To become a Medicare provider, request an application form directly from the Medicare carrier. The local carrier will review the application, and will issue a provider number if all the requirements are met. The process takes approximately six weeks for completion, but any errors or incomplete information on the application will cause delays. Call (877) 267-2323, or visit [https://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage](https://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage) for enrollment information.

**Medicaid Provider Number**

As with any social program, there are advantages and disadvantages to accepting Medicaid. An advantage of being a Medicaid provider is that it guarantees a consistent source of income for physicians and a steady flow of patients. The government commits to paying Medicaid bills, so there is very little risk associated with collection of money. Also, there is a large base of Medicaid patients in the U.S. who receive information on doctors who participate in Medicaid. Medicaid offers various incentive programs and bonuses for physicians who participate in the program.

Some of the disadvantages to participating in the Medicaid program range from a lack of coverage for some aspect of treatment to lower reimbursements. A patient with a rheumatic disease typically has to undergo various steps in a treatment plan involving different procedures. If Medicaid deems a treatment or procedure unnecessary, no reimbursement will be paid out and this can create a roadblock in a patient’s treatment plan. Visit [www.cms.gov/home/medicaid.asp](http://www.cms.gov/home/medicaid.asp) for a list of state provider enrollment links and telephone numbers.

**Conclusion**

Starting a medical practice can be a very extensive process. Forming a plan, obtaining financial backing, securing an office, and applying for necessary licensure are just a few of the necessary steps to take when deciding to open a practice. In the next several chapters, we’ll discuss taking this practice foundation and building upon it by adding and managing staff, creating operational systems, marketing the practice to get patients in the door, outfitting the practice with Health Information Technology, securing managed care contracts, and getting reimbursed for the work performed.

**References**


As a business owner, you are in charge of overseeing the responsibilities associated with human resources management. This includes employment and labor laws, government compliance issues, employee-related costs, and the ever-present threat of employee litigation.

The central components of human resources management includes staffing the practice, the legal environment of human resources, developing a compensation structure, creating an employee handbook, and procedures for recruiting, hiring, discipline and termination—and much more.

**Staffing the Practice**

Structuring the staff to best fit the needs, size, and culture of the practice is an important task. It will dictate how well the practice runs on a daily basis and how satisfied patients will be during encounters. As you create the staffing structure, understand the quality of care provided will be largely dependent on the skills and proficiency of the staff.

According to the Medical Group Management Association, practices do not operate at efficient and optimum financial performance when they are under or overstaffed. Low staff levels constrain productivity and require employees and the physician-owner to perform tasks that are outside of their areas of expertise and are an ineffective use of time. This may lead to problems in patient access and poor staff morale. Likewise, having too much staff produces higher staffing costs and often leads to confusion as to which employee performs what task. Finding the optimal staffing level is called rightsizing.

Rightsizing is defined as the systematic review of staffing levels, tasks and work processes to determine the appropriate number and mix of staff needed to meet business goals. Rightsizing answers the questions: do you have the right staff and are they doing the right things? It seeks maximum efficiency by matching the employee’s skill set to the work that needs to be performed. The number of employees needed and the positions that they fill depends upon the type of professional and ancillary services provided and what the physician prefers.

**Perform a Job Analysis**

A staffing structure should always begin with a job analysis. This is a process that identifies the task an employee performs, the situation in which it is performed, and the qualities necessary to perform it. This information will then be used to recruit for the position, identify who to hire, and set an appropriate and fair level of compensation. A job analysis consists of:

**Work Activities:**
- Use -ing words indicating activities performed

**Equipment, Machines and Tools Used:**
- What is used by the employee to perform the -ing word

**Work Performance:**
- Time taken to perform activities, standards for work and expectation levels

**Job Context:**
- Physical work conditions, work schedule, organizational context (e.g., culture, climate, etc.), incentives and rewards

**Personnel Requirements:**
- KSAs (Knowledge, Skills, and Abilities) or KSOs (Knowledge, Skills, and Other) the employee needs to do the job
- Knowledge – facts and principles
• Skills – well learned proficiencies acquired through practice
• Abilities – more stable traits or capabilities of a person
• Other – things not covered by the K, S or A that are required (e.g., licensure, permit, education, etc.)

Various methods are used to collect information for a job analysis. Interviews, direct observation, diaries, and structured questionnaires are all helpful, but the best resources for the purposes of staffing a small medical practice are the ONET Resource Center and the U.S. Department of Labor’s Occupational Outlook Handbook.

ONET is a collection of job analyses compiled by the Department of Labor. You can access these analyses at http://online.onetcenter.org. The job analyses located on this site are a great place to start, and can be used as a template that can be further developed and customized to fit what is needed at the practice. The Occupational Outlook Handbook can be accessed through the U.S. Department of Labor’s Bureau of Labor Statistics at http://www.bls.gov/oco/home.htm. Much like ONET, the handbook gives the training and education requirements, required earnings, description of typical job duties and working environments for hundreds of different types of jobs. The end process of a job analysis is a written job description. The job description is a one to two page description of the employee that can be used in a compensation system, performance appraisal and selection system.

Legal Environment of Human Resources Management

You do not need to have the employment law background of an attorney, but there are some basic legal issues that anyone who will be hiring and managing employees should know. Having a good grasp on the basics of employment laws will also protect you and your practice.

Most hiring rheumatologists know that it is illegal to discriminate on the basis of race, color, religion, gender, and national origin in any aspect of employment. However, there are lesser known employment regulations that employers will have to adhere to, such as the Fair Labor Standards Act, which require employers to pay employees the required minimum hourly wage rate and overtime for hours worked in excess of 40 hours in a work week.

Also, it is necessary for rheumatology practices to comply with Occupational Safety and Health Administration standards, but what exactly do those standards entail? You know that you will have to give employees leave for medical emergencies or serious health conditions, but how much time is required?

Familiarity with the regulatory environment in regards to employment can save you a lot of trouble down the road. Key legal issues relating to employment are listed and described in Appendix IV.

It is important to seek advice from a qualified legal professional regarding employment law when appropriate. For more information on the legal environment of human resources management, go to the U.S. Department of Labor website at www.dol.gov/ which offers help in navigating employment related laws and regulations.

Disclaimer: Most labor laws generally apply nationwide except for the state of California. For rheumatologists practicing in California, please refer to the California Labor & Workforce website at http://www.labor.ca.gov/laborlawreg.htm.

Salary and Benefits

There are many different methods for determining the salary for medical practice staff, such as reviewing existing comparable job openings and assessing the range of salaries or accessing online tools such as mysalary.com where employers can find the average base salary, bonuses, and benefits offered for jobs by region.

Pay and benefits should fall within the benchmarked data from other medical practices in order to attract well-qualified applicants. It is sometimes possible to offset a pay scale that is slightly lower than competing practices with a benefits package that makes up for the difference.
A formal benefits package may consist of a retirement plan, health plan, paid time off, life insurance, paid sick leave and many others benefits. The benefits package must offer employees time off to vote, serve on a jury, and perform military service; it should also comply with all requirements of worker’s compensation, withholdings for federal tax obligations, and contribution to state disability programs in states where such programs exist.

Offering an extended benefits package allows you and your employees the opportunity to take advantage of a variety of benefits, often at a lower rate and with tax benefits. Benefits you may want to consider offering include:

- **Health plans**: Health insurance is a very attractive benefit to employees and may greatly increase the chances of attracting and hiring highly skilled and qualified employees. Offering insurance to employees will also allow you to take advantage of less expensive health insurance for staff as well as their family, and will give some tax breaks for contributions by the business. Look for vendors online, in the phone book, through independent insurance agents and consultants, or through other employers in the area. Contact these vendors and request a quote on group monthly premiums and be prepared to negotiate on this price.

Due to the Patient Protection and Affordable Care Act passed by Congress on March 23, 2010, starting in 2014, employers with over 50 full-time employees (working an average of 30 or more hours per week) must offer those employees medical coverage of at least 60 percent of benefits covered by the plan. Employee contribution for this plan must be less than 9.8 percent of household income for that employee. If an employer fails to meet these requirements, the physician will be forced to pay a considerable fine. State legislation will also attempt to reduce the number of uninsured citizens and may require a practice to offer some form of insurance and financial backing for employees. Check with the local and state medical societies to verify those laws that apply in the state.

- **Dental plans**: Dental plans are sometimes purchased in addition to basic medical care or through a separate policy from a separate provider. They are available in the form of an HMO plan or an indemnity plan and usually cover only basic dentistry services.

- **Vision care**: Vision care is often offered as an additional feature with HMO or PPO plans, but can be purchased separately as well.

- **Retirement plans**: Retirement plans are attractive options for employees who want to begin planning for their future and will allow them to enjoy some tax advantages while they do it. If you are considering offering retirement planning options, consult an attorney. Pension rules can be very complex and can also include confusing tax requirements.

- **Life insurance**: Life insurance is one of the most commonly offered benefits. It creates many of the same issues as health insurance, including determining who will be eligible to receive benefits.

- **Paid vacations**: You are not legally required to provide paid vacation time. The decision whether or not to offer paid vacation time becomes especially difficult for small businesses with minimal staff. If you decide to offer paid vacations, implement rules regarding the pre-approval of vacation time from supervisors.

- **Paid holidays**: You are not required to give employees paid time off for federal and state holidays, although most employers do so. Typical paid holidays for medical offices include New Years’ Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas. Whether or not you pay your employees for these days is up to you. You have the option of allowing the employees to use vacation time during holidays if you choose not to pay for the days the office is closed as long as it is specified in the initial agreement.

- **Paid sick leave**: Paid sick leave is not required by law, but the practice may be subject to unpaid sick leave under the Family and Medical Leave Act. Offering sick leave when combined with health insurance can attract and keep skilled employees at your practice.
Continuing Medical Education

Continuing medical education is not only an important part of a well-run practice, it is mandatory for maintaining licenses and/or certifications for many of the staff. Continuing education can serve as an effective and efficient tool to increase the quality of care in the practice not only through acquisition of new skills, but also as a motivational tool.

Before mapping out salary and benefits, determine if you will pay for staff to participate in CME and if so, how they will be compensated. Consider providing additional salary to an employee to account for CME expenditures, or allotting each employee a specific amount to spend per year on continuing education. While you are not required to cover the cost of continuing education programs nor required to pay for time off during which an employee undergoes continuing education, reimbursement can be an added value benefit that will place the practice in a competitive position when recruiting.

Office policy should be set regarding the process for approval of and participation in continuing education programs that are directly related to an employee’s position. Continuing education is directly related to an employee’s position if it is designed to enable the employee to handle the job more effectively. If the training teaches the employee how to do a new job, teaches a new skill that would NOT improve the handling of the present job, or upgrades the employee to a higher skill but isn’t intended to make the employee more efficient in the present job, it is not considered directly related.

If you decide to offer continuing education in employee benefits, reimbursement of the approved program should include some combination of the following:

- Cost to attend the program
- Time for attending program
- Time traveling to and from program
- Travel expenses associated with the program

To see an example of an organization’s CME reimbursement protocol, view the New York Medical Alliance’s “Policy and Procedure” document at www.nymedicalalliance.org/nyma/docs/pandp/P&P_travel_and-or_reimbursement_policy3-10-10.pdf. To prevent misunderstandings, be certain to discuss all expenses before seminar attendance and have written, signed agreements as to exactly what the rheumatologist will be paying for. Employers may request a copy of certificates and units earned which will then be placed in the employee’s file.

Employee Travel

The following guidelines should be used if and when handling training or job-related travel.

One Day Travel

Travel time for the purposes of attending a meeting, seminar or other types of training during or outside of the normal work hours is considered time worked and must be paid. The usual meal time during which no work activities take place may be deducted. When traveling is a part of an employee’s regular work assignment, (e.g., when traveling from one job site to another during work hours) the travel time must be paid.

The time spent traveling between the office and the terminal of a common carrier is considered time worked. The usual meal time may be deducted. The time spent traveling between home and the terminal of a common carrier need not be counted as travel time or as time worked. We recommend the employer pay for the travel time to the common carrier less the normal travel time from home to the office.

Overnight Travel

The Fair Labor Standards Act states that travel time as a passenger on a public conveyance outside the normal work hours is not paid time provided that no work related functions are performed during that time. State laws can be stricter. Time spent as the driver going to or from an event is often considered paid time. Be certain to check the state’s regulations.
Most practices will take care of all air, train or bus travel and lodging. When it comes to meals that are not included in the seminar, the choice is up to you to pay for all, some or no meals. Many practices establish a per diem rate for meals each day that employees may spend at their own discretion. With this plan, you do not need to worry whether the staff eats at McDonald’s or the Four Seasons. Again, individual state laws can vary significantly, so check your state’s regulations.

**Payroll Obligations**

As a physician practice owner, you are subject to the same payroll obligations as any other small business and must report income paid to the IRS. You will be responsible for withholding a predetermined amount of each employee’s taxable income and submitting that amount, along with the contributions, to the IRS. There are three components of federal payroll taxes: federal income tax, the employee share of the Federal Insurance Contributions Act taxes (also called social security), and the employers matching share of FICA taxes. Work with an accountant to determine appropriate taxation practices.

You can either decide to handle the responsibility of payroll on site or contract with an outside vendor. Accounting software, such as QuickBooks by Intuit, makes it easy and inexpensive for office administrators to manage payroll within the practice. It is also common to contract with a company to outsource payroll responsibilities. Typically, a small fee per payroll check is charged for the service.

**Recruiting and Selection**

Now that job descriptions, salary and employee benefits packages have been created, it is time to begin recruiting for open positions in your practice. A recruiting plan will help to establish the organization’s present and future needs, increase the success of the selection process, reduce costly employee turnover, and meet affirmative action responsibilities. For a new practice, recruitment methods are limited to external recruiting sources.

Recruiting is an ongoing process and should be evaluated often to ensure the efficiency and effectiveness of each source used. For each source, evaluate the number of overall applicants, the number of applicants from protected groups, the time taken to get resumes from sources, the number of qualified applicants, and the cost of each recruiting source.

Once you have acquired a qualified pool of applicants, the selection process should begin. The two primary goals in any selection process are to hire the best candidate and to carry out a fair selection process so as to uphold legal standards. There are several selection techniques that can be utilized when selecting from a pool of applicants. No one method is perfect, but using a combined technique can deliver solid data and lead to hire of the best candidate.

**Analyzing Resumes and Cover Letters**

When first looking at a cover letter and resume, note the effort that has been put into the content as well as the format.
amount of time poured into a resume can be very telling of a person’s drive and motivation to excel. Any careless mistakes, such as a typing error, could indicate an applicant’s lack of regard for details.

As you evaluate candidates, make sure that education and job experience matches or exceeds the minimum requirements for the position. Compare resumes to the previously established job description and prioritize candidates according to how closely skills and education match the criteria. The resumes and cover letters that stand out from others and are able to hold your attention should be given extra consideration as this illustrates a candidate’s ability to prioritize and communicate effectively. Once the screening process is completed, an interview should be conducted to further evaluate the skills and experience relayed in the resume and cover letter.

**Interviews**

Interviews are the most frequently used hiring selection method in the U.S. It gives the hiring party a chance to meet the candidate face-to-face. Interviews are also low cost and easy to conduct. Take advantage of these benefits by interviewing a good number of candidates for a position. Remember that just as you are considering multiple prospects for a job, an interviewee is likely exploring other opportunities. You may consider having an applicant take a relevant test prior to or during the interview to help to accurately evaluate the capabilities that are required for the position. The effectiveness of an interview depends on the skill of the interviewer, the purpose of the interview, and how structured the interview is.

Unstructured interviews are easy to muddle up, have low reliability and are generally unsound. The unstructured interview has no set procedure, no rating form, and the goal is to assess an applicant. The interviewer might pick the first question from the resume and base the second question on the answer to the first. Although easy and low stress, this style of interview should be avoided.

A structured interview uses a predetermined set of questions that is asked to everyone. This interview approach provides an accurate evaluation of each candidate’s knowledge, skills, and abilities directly related to the job. There are two major types of structured interviews: the behavioral description interview, which asks standardized questions about past employment and experiences in order to predict future behavior; and, the situational interview, which creates a situation and asks the candidate to respond. All interview questions should be based on the job analysis and responses should be rated or scored.

Examples of interview questions include:

- Why did you choose rheumatology?
- Why do you want to work here?
- What are your career goals?
- Where do you see yourself in five years? 10 years?
- What are your strengths and weaknesses?
- Why are you a good fit for this position?
- What can you offer our practice that other applicants cannot?
- How would your previous boss/co-workers describe you?
- What was your biggest challenge at your last job? How did you handle it?
- Tell me about a situation you wish that you had handled differently based on the outcome. What was the situation? What would you change when faced with a similar situation?

Certain topics should be avoided during an interview. These topics include anything that could offend or embarrass an interviewee such as marital status, age, religion, living situation, physical appearance including possible pregnancy, or anything that might indicate discrimination. No matter what type of interview is conducted, be sensitive to rating errors that typically
occur and legal issues associated with hiring. Interviews are notorious for common errors including:

- **Primacy/Recency effect**: Interviewers pay more attention to the information that emerges early in the interview rather than later.
- **Halo error**: Interviewers classify interviews as either good or bad, which makes differentiating between really good or really bad more difficult later.
- **Contrast error**: Interviewer’s rating of the current candidate is influenced by the previous interview.
- **Impression management**: A natural tendency is to judge a candidate immediately and then spend the remaining portion of the interview trying to support your first impression.

Demographic variables such as gender, race, age, disability, or attractiveness all affect interview ratings. You should be aware of this and be very careful that the final selection is not influenced by these variables. Legal issues are also very important when interviewing. The law sees an interview no differently than a test; and, therefore, interviews are subject to the Griggs Burden, which prohibits employment tests that are not a reasonable measure of job performance, regardless of the absence of actual intent to discriminate. Despite these drawbacks, the structured interview is a highly valued hiring tool with great potential to find the best hire for the job. Just remember that all questions should be based on the job requirements and created from the job analysis.

**References**

Interviewing references is preferable to the traditional letter of reference. Calling references allows you to ask specific questions related to the job analysis, fill in any details missing in the resume, and offers the opportunity to read between the lines. When speaking with references, be sure to only ask questions relevant to the job, and ask the same questions for everyone.

Examples of questions to ask a reference:

- Did the applicant get along well with co-workers, superiors, etc.?
- Did the applicant supervise other employees? If so, how effective was her management style?
- Is the applicant a team player?
- What are strengths and weaknesses of the applicant?
- Is this individual a self-starter?
- Would you describe the applicant as honest and morally sound?
- How would you describe the applicant’s work ethic?
- How advanced are the individual’s communication skills?
- Do you think the individual is a good fit for this position, given the job description? Why or why not?
- Is there anything you would like to add outside of the questions I have asked?

Have a list of extra questions to ask in the event that the reference neglects to respond to a question or provides a very basic answer. When asking a question that could be answered with a simple ‘yes’ or ‘no’, always invite the reference to elaborate or provide specific examples. The goal is to engage in a dialogue with the reference instead of simply reading off a list of questions. It is important to obtain written permission before contacting references.

**Develop Personnel Policies, Procedures and an Employee Handbook**

The thought of creating written company policies and an employee handbook can be intimidating, but do not be discouraged. An abundance of HR policy resources are available online and some even provide sample policies or handbooks that can be modified to fit the needs of the organization. A sample handbook is provided in Appendix IV of this guide.
An employee handbook is a collection of the company’s policies and other employment information that is used to guide the employee through the organization and help he/she understand their role. The handbook will clarify organizational policies, procedures and expectations, and ensure uniformity in the way certain matters are handled in conducting the business of the organization. The handbook is meant to simply be a guide—not a contract—and therefore should be unilateral and appropriate for the entire organization, not specific to any one position or department.

The employee handbook has many purposes. It will provide consistent answers to employment questions and evidence of formal policies which may be needed. It is also a vehicle to communicate the history, ethics and goals of the organization. Most importantly, a handbook will convey policies to ensure compliance with various government regulations relating to safety and employment.

Remember, as the physician practice owner, you are solely responsible for all policies and statements contained in the handbook, regardless of where it came from or who authored the book. An attorney should look over the book for appropriate wording and legal implications before distribution.

Some employment policies are mandated by law and must be physically posted where employees can easily view them. The U.S. Department of Labor provides a user friendly guide on its website at www.dol.gov/elaws/posters.htm. The guide offers employers a list that asks a series of questions to determine which laws apply to the business, and then provides a customized list of posters that are required. The DOL will then provide the poster to employers at no cost.

Determining other policies that should be developed and listed in the handbook can be a bit more challenging. There is no single policy list or guide. The policies that should be developed depend on both the size and nature of the organization, including written policies relating to conduct. These policies should be universal and followed without exception. If you need to begin making exceptions, then the policy should be amended.

In an article posted on the About.com Human Resources website, Susan Heathfield provides a list of six statements that will help to identify if a policy is needed, along with examples of how each statement can apply. She says to develop policies if:

1. The actions of employees indicate confusion about the most appropriate way to behave (e.g., dress code, email and Internet policies, cell phone use, etc.).
2. Guidance is needed about the most suitable way to handle various situations (e.g., standards of conduct, travel expenditures, purchase of company merchandise, etc.).
3. Needed to protect the company legally (e.g., consistent investigation of charges of harassment, non-discriminatory hiring and promotion).
4. The company must be in compliance with government policies and laws (e.g., FMLA, ADA, EEOC, minimum wage).
5. You must establish consistent work standards, rules, and regulations (e.g., progressive discipline, safety rules, break rules, smoking rules).
6. You must demonstrate consistent and fair treatment for employees (e.g., benefit eligibility, paid time off, tuition assistance, bereavement time, and jury duty).

If help is needed in writing the policy, online research can provide samples that can be molded to fit specific needs. The policy statements must be direct and clear, and apply to all staff members. The policy statements will also need to be reviewed by a legal advisor before publishing the employee handbook.

Once the policies are decided, drafting an employee handbook is the next step. Organization of an employee handbook is standard. The outline below can be used as a basic framework, and the content within can be tailored to any medical practice organization.

Table of contents: Every handbook should include a table of contents, regardless of length. A table of contents will help the employees quickly find the information for which they are searching.
Introduction: This should include a short welcome to the company and a brief overview of the company history, emphasizing accomplishments and goals. The introduction is also a good place to introduce the company philosophy, mission statement, and code of ethics, which define the “personality” of the company. Do not make statements that link the company to any specific religious beliefs, cultural, or ethnic values as they could be used as a basis for a claim of discrimination.

At will: If a practice follows the policy “at will”, as most do, then the practice should prepare a statement that clearly affirms that the employee handbook is not a contract and that all employees are “at will” employees. Include a brief statement that is to be signed by the employee acknowledging they received a copy of the handbook and it is not a contract for employment. Also, a signed document indicates that the employee understands that he or she is an “at will” employee.

Policies in response to law: Several policies must be established as required by law. These may include, but are not limited to:

- Statement of nondiscrimination: A brief statement that the employer does not engage in any discriminatory practice and will not tolerate any discriminatory practices, actions or conduct from anyone.
- Anti harassment policy: A brief statement that the employer will not allow harassment of employees, how harassment is to be reported, and how the employer will handle harassment.
- Reasonable accommodation policy: A statement that the employer will not discriminate on the basis of disability and that reasonable accommodation will be made.
- Family Medical Leave Act Policy: This policy may or may not apply to the employer. If it does, this statement should identify how an employee can take advantage of this act.
- Workplace safety: A statement that the employer complies with applicable workplace safety rules, that outlines employee rights and obligations, and which describes how an injury or illness is to be reported and handled.
- Drug-Free workplace policy: If this act applies, the employer must state how the practice intends to comply.

Wages and benefits: This section should include wage scales, paydays, details regarding overtime pay, and benefits information.

Property: Describe in detail how employees may and may not use company assets. This includes policies regarding the use of telephone lines, fax machines, e-mail, the Internet and other property that the employees will potentially be using. Don’t forget to add any policies regarding property of the employee and what they may and may not bring to work. Include a statement that explains the employer is not liable for any damage that occurs to personal property.

Discipline and termination: Use this section to explain any discipline policies that the practice may have and how termination will be carried out. Be careful how this section is worded. Do not commit to using any form of progressive discipline and turn the intended policy statement into a contract statement. Have employees read the company policies and sign an acknowledgement stating that they agree with the policy and understand that failure to follow will lead to discipline and possible termination.

Other policies: This section will be used to detail any other policies that the organization might have. This may include policies regarding hiring procedures, break and meal hours, expense accounts, travel policies, dress code, confidentiality and other organization specific policies.

Wording of policies and procedures is of utmost importance in the development of organizational policies and procedures. Bear in mind that a handbook is being created and not a contract, and one error in how a policy is worded can create a contractual statement and could cause lose to the “at will” employment status.

Writing policies that are unilateral for all employees and using the handbook to describe how business is to be conducted will usually keep a practice on track, but always review the policies and only include those that you are necessary to observe by a court.

It is important to keep the medical practice’s policies at the forefront as court cases and new legislation change workplace protocols. When a policy changes, a practice statement should be issued to each employee for their review and signature. The policy then becomes an amendment of the original handbook which needs to be updated every few years to incorporate these changes.
Employee Files

Employment law requires that an employee file be kept for all employees, regardless of hours worked or length of employment. Employers are responsible for the implementation of an organized system of maintaining employee records, and must be able to produce records on demand for employees, union representatives or government agencies. These files can be kept electronically, in file folders, or other format, as long as you follow guidelines regarding standard information that is required and the confidentiality of employee information.

Employee files are confidential documents and must be kept in a secure location where access is controlled by the employer. Access should only be granted to those whose job responsibility includes maintenance of the employee file, supervisory personnel of the employee and the employee. All parties should understand the importance of maintaining confidentiality of records. No information should ever be released without written consent of the employee or without a court order. Failure to keep an employee’s file confidential can result in a lawsuit against the employer for invasion of privacy. Generally, an employee record should contain all important information relating to the employee or the job that they perform.

WHAT TO KEEP IN AN EMPLOYEE MASTER FILE

PERSONNEL FILE:

- **Application documents**: Application, resume, records of reference checks, and interview notes if a standardized set of interview questions was used. If the notes are the result of a random set of questions for the candidate, it is better to keep the notes in the maker’s “hiring” file. It should also include interview notes for candidates not hired which are kept for no less than one year and longer if covered by laws requiring a longer retention period.

- **All applicable job descriptions**

- **New hire paperwork**: Direct deposit, authorization for a deduction or withholding of pay, records reflecting name, address and emergency contacts, offer letter or employment contract, employee handbook acknowledgement, harassment policy acknowledgement, signed confidentiality policy, and any records of property assigned to the employee.

- **Performance records**: Memos, notes, and letters relating to performance (both good and bad), performance evaluations, training records (record of continuing education courses, public speaking engagements and current licensure as required), and disciplinary documentation (including, but not limited to, documentation of oral warnings, copies of written warnings, and termination records).

- **Attendance records**: Documentation regarding dates and reasons for leaves of absence, vacation/paid time off, other personal time off, sick leave and leave under the Family and Medical Leave Act, but no medical records or medical information pertaining to the above because of privacy laws.

- **Employment history**: Documentation showing date of hire, dates of job changes (promotions, demotions, transfers, and layoff), and all pay changes with effective dates and reason, and general fringe benefit information.

MEDICAL/BENEFITS FILE:

- **Insurance (e.g., health, dental, life, disability) and benefit (e.g., 401(k), pension, profit sharing) enrollment forms and claims information.**

- **Any medical exam information for new hires and/or current employees**

- **Drug and/or alcohol testing-related documents.**

- **Worker’s compensation records.**

- **Medical documentation for FMLA leave and other types of leave related to an employee’s medical condition (actual dates of the leave such as attendance records should also be kept in the personnel file).**

- **Records relating to return to work medical evaluations, medical work restrictions, and reasonable accommodation.**

PAYROLL:

- **Paperwork related to garnishments, loans or advances from the company.**

- **Employee time cards/sheets.**

- **Records that include name, address, date of birth, job title, and pay rate and the dates of applicable pay changes.**

- **Work schedules.**

- **Documentation identifying race, ethnicity, or veteran’s status. The employer must maintain these for purposes of completion of the annual EEO-1 form for all employers with 100 or more employees as well as all federal affirmative action employers, the Vets 100 form, employers with a federal contract, or federal or state affirmative action programs.**

I-9 FORMS:

- **I-9 forms for all employees.**
Employee data can be divided into four filing categories:

**I-9 forms:** An employer is required to submit an I-9 form for all employees to verify eligibility to work in the United States. All I-9 forms should be kept in one file separate from individual employee files. To view the Employment Eligibility Verification I-9 form on the U.S. Citizenship and Immigration Services website, go to [http://www.uscis.gov/files/form/i-9.pdf](http://www.uscis.gov/files/form/i-9.pdf).

**Personnel file:** The personnel file holds every important document related to the job. This file should include all applicable job descriptions, application documents, new hire paperwork, performance records, attendance records, and employment history. Additions to the personnel file can be made at the employer’s discretion. A personnel file should always be complete and up to date, but keep in mind that depending on the state the rheumatologist practises in, the employee may have the right to view this file at any time, so any sensitive information should be kept in a separate file. Sensitive information includes tax records and insurance claims revealing a medical condition, and any other confidential information that an employee feels reflects badly on him or her.

**Medical/benefits file:** Employers are required to maintain an employee’s medical file separate from all other files and with limited access. This file should contain all documents relating to insurance, medical information, drug and alcohol testing, workers’ compensation, medical conditions, medical work restrictions and reasonable accommodations due to these issues.

**Payroll:** The payroll file should hold a record of the employee’s name, address, date of birth, job title, and pay rate. It should also include the dates of applicable pay changes along with documentation of employment wage per hour data, tax and payroll data, garnishments, wages earned and taxes paid for each pay period as well as the full calendar year.

Each of these files should be kept and maintained so that they are easily identifiable and contain all materials required by law and company policy. Just as the rheumatologist and practice will need to follow HIPAA guidelines in storing medical records, the rheumatologist and the practice will need to be legally compliant with employee record retention as well. You may want to seek legal advice to be certain you are fully compliant.

To view a list of record retention guidelines go to [www.organize-u.com/Employer_Records_Retention.pdf](http://www.organize-u.com/Employer_Records_Retention.pdf). Periodically review the files to ensure that they are current, accurate and complete. Employee files should not be considered just a task required by law, but viewed as a valuable source that might be necessary to back up an employer’s decision regarding employees. The information contained can verify whether the employee is qualified for a new project, a promotion, or for determining whether termination is warranted.

**Performance Appraisal**

Now that the practice staff has successfully been recruited, it is important to establish an objective performance, or appraisal, review system. A performance appraisal is the systematic description and evaluation of a worker’s relevant job strengths and weaknesses.

In addition to establishing the success of employees, the performance appraisal is used to award merit increases and bonuses, provide for feedback and development of employees, award promotion or support termination of employment, identify training needs, determine the success of the supervisors, and to develop organizational goals. Performance reviews should be conducted at least annually to maintain alignment of goals and expectations between you and your employees. These appraisals allow employees to be commended for areas of high performance and informed of areas that need improvement.

Employees can be evaluated on hard and soft data. Hard data includes a quantitative description of employee actions, such as absences, tardiness, accidents, and disciplinary write-ups. Hard data is useful in some positions, but overall, it is up to each organization to decide how important it is related to job performance. Soft data, on the other hand, is subjective. It is one person’s opinion of a worker’s performance, and if assessed correctly, soft data can also review qualities like motivation and loyalty.

An employee can be rated by immediate supervisor, peers, subordinates, patients, or by all of these in a 360 degree feedback. Most performance appraisals are conducted by the supervisor only, but a 360 degree feedback is growing in popularity as it identifies discrepancies between raters. Whoever conducts the appraisals, the rheumatologist must hold them accountable for...
their ratings and they must have the capacity to give rewards based on the outcome, otherwise it is useless. If the review is conducted by someone other than a direct supervisor, the supervisor should be briefed on the outcome and available for the employee to discuss it with them.

The job analysis should logically lead to the performance appraisal. Multiple dimensions should be rated including job specific task proficiency, non job specific task proficiency, written and oral communication, demonstrated effort, maintaining personal discipline, and facilitating peer and team performance. These dimensions can be further broken into categories relating to each job related task, and then assigned a rating based on the behavior that you observe. To download medical performance review templates for various positions within the practice, go to www.medicalperformancereviews.com.

There are several relevant laws that should be taken into consideration when developing a performance analysis. First and foremost, discrimination is just as illegal in performance analysis as it is in recruiting and selection. Be careful to avoid any evaluation technique that may be construed as discriminatory. The evaluation should be based on the specific job description, but all employees need to be rated on the same scale and system.

It is important for the employee to be an active participant in his or her own appraisal. To ensure this, the employee should provide feedback on their own performance. Having an employee fill out a self-evaluation prior to the review will help you know what areas of high or low performance to focus on based on the employee acknowledgment. You can use this self-evaluation to address gaps in performance perception. In addition, the employee should evaluate the organization as a whole, including the chain of command. This will help you know if the command structure is effective and also target improvement areas of managerial skills.

The performance appraisal is used to provide feedback to the employee. Feedback helps the employee know what areas need improvement and what can be done to grow in that area. Feedback should be based on the things that the employee can control. Describe behavior and expectations in specific terms, provide for a two-way conversation, allow negotiation and be constructive.

**Ending Employment**

There are two types of employee termination: voluntary and involuntary.

**Voluntary Termination**

Voluntary termination is usually an employee’s resignation due to promotion, relocation or retirement. In this case, termination is usually an amicable separation. With voluntary termination, it is common to conduct an exit interview. The goal of these interviews is to figure out why a person is leaving the practice and how the organization could improve its employee retention in the future. There are many categories of questions you can ask a departing employee depending on the job function they served.

Examples of these categories include:

- Resources, Job Information, and Training
- Job Challenge and Opportunity for Advancement
- Relations with Supervisors, Coworkers, and Other Departments
- Comfort and Working Conditions
- Financial
- Organization Policies

Most departing employees are smart enough to not want to burn bridges, and may not be as honest as they would like to be. It is not a bad idea to ask separating employees if they would be willing to provide feedback about their employment experience after they have left, and follow up with them over the phone, rather than in person. They may be more willing to provide honest feedback if they are not sitting in the office or company conference room.
Involuntary Termination

Involuntary terminations can occur because of poor performance, insubordination or economic hardship. Termination of an employee is not easy, but through preparation, you can move the process quickly and ease some of the associated anxiety. The decision to end the employment relationship is often related to not performing as expected, not getting along well with colleagues, or insubordination. No employer brings on a new hire expecting that the employee will be fired later, so it is important to implement good practices that will lay the foundation for an efficient termination procedure. Good practices will also help you avoid many common mistakes that allow a bad employee to stay too long or land the employer in litigation.

The first step is to review the company policies, handbooks, and employment offer letters to ensure that they make no promise of employment or indicate that employment is guaranteed with satisfactory performance. Documentation is critical in termination, especially if the pending termination is due to poor performance or other causes that are justifiable. Make a habit of documenting performance deficiencies as they happen, even if the behavior has not been discussed with the employee. Sufficient documentation of the adverse behavior, along with any correspondence to or from the employee, will later demonstrate fair handling if termination must be pursued. If you issue any warnings or statements that employment is in jeopardy, have the employee sign the statement acknowledging receipt.

Once the decision to pursue termination has been made the process should begin immediately. Never procrastinate or try to avoid the situation because delaying action will only worsen the situation for all involved. The actual termination process begins before the employee is notified. Conduct an analysis of risk before notifying the employee, carefully review the personnel file and examine all circumstances surrounding the termination; ensure that all valid complaints raised by the employee have been investigated; examine the employee's status as a member of a protected group.

The second step is to begin gathering information and documentation that supports the decision to pursue termination. A written job description, establishing what has been expected of the employee and performance appraisals detailing the level of employee performance can provide proof of poor job performance. Review the employee's file for other documented incidences of misconduct. Statements given by the employee's direct supervisor or manager regarding the circumstances leading to termination can also be helpful.

Preparation is also important. Before carrying out the termination, have all documents prepared and have answers for the common questions asked by employees. Prepare and have ready any paperwork that needs to be signed, a list of all company assets that must be returned, and the final paycheck and benefits materials. You are not required by federal law to give former employees their final paycheck immediately, although some states do require this. For more information on final paycheck requirements, contact the wage and hour division of your local Department of Labor. Due to the Consolidated Omnibus Budget Reconciliation Act, some employees and their families have the right to choose to continue group health benefits provided by their group health plan for a limited period of time after termination (involuntary and voluntary). Under COBRA, companies with twenty or more employees must offer health coverage to terminated employees for up to eighteen months after termination. An exception to this rule is if an employee is terminated for “gross misconduct.” Have all information and paperwork regarding available health benefits on hand for the departing employee. Learn more at www.dol.gov/eb/-faqs/faq_consumer_cobra.html.

When carrying out the termination meeting, be direct, honest and professional. Arrange for the meeting in a private location away from the employee's normal work station. The meeting should be as brief as possible while covering key points. You should not be engaged by the employee, and never make statements that could be interpreted as attacking the employee's personal character. Simply advise the employee that he or she will no longer be working with the company and provide a reason for the decision. Inform the employee that the decision is final. Give the employee a written termination notice and information concerning any benefits that will be available. If the rheumatologist feels uncomfortable conducting the meeting, or if the employee is at high risk for taking legal action, it is acceptable to prepare a written statement beforehand and read it verbatim to the employee.

Termination is never pleasant, and employee reactions to being terminated range from shock and weeping to extreme anger. Never argue with an employee and affirm that the decision is final.
Conclusion

Conduct annual reviews or audits of the practice’s human resources processes to confirm that they are all in line with ethical and legal rules and regulations. The audit should be a comprehensive review of all areas including management, recruitment and retention, policies and procedures, compensation and benefits, legal compliance, and training. The practice can do a self audit, or contract with an outside vendor to audit the human resource functions at the practice. The audit will identify problems or flaws in the HR processes before it becomes the subject of legal action.

In the end, annual audits will ensure legal compliance with both state and federal regulations, minimize risk and exposure to employee litigation, and increase overall department or practice function, efficiency and effectiveness. To learn more about human resource management including interview questions, legal issues, and employee relations visit the Society for Human Resource Management website at www.shrm.org.

References


Managing a medical practice consists of many obligations and commitments. As the owner of a practice, you have four primary management functions: planning, organizing, leading and controlling. You plan during the development of goals and strategies; organize by making and finalizing decisions about where, when and by whom each job that will be performed; lead by keeping your staff motivated, supporting your staffs’ ideas, and giving clear directions and expectations to staff; and, control by observing and keeping track of all progress towards their practice and staff’s goals, striving for performance improvement and making positive changes where necessary.

Managing a practice involves implementing and analyzing policies and processes within the practice and continuously finding ways to improve them. Responsibilities also include managing the staff, overseeing day-to-day activities of the practice, managing efficiency and quality standards, and most importantly, operating the daily clinical and business operations of the practice.

The role you play as the practice’s owner and overall manager may sound overwhelming, but you will not be managing and working alone unless you run a micro practice. You should work closely with the staff and practice manager to structure the workflow and to delegate as many clinical and administrative tasks as possible without impairing your understanding of how the practice runs. Even with a good staff support, you should be well-versed on reviewing and analyzing practice management and financial reports and should use these summaries to develop future goals and strategies.

It is important to schedule regular monthly business meetings with the office staff to stay informed of human resource and operational issues, overhead expense, capital needs and accounts receivable management. As the practice owner and overall manager, you are ultimately held responsible for clinic operations, but this does not mean that you need to be involved in every area of the practice every day. With effective and efficient operating systems, as well as well trained staff, you should be able to keep up with how the practice is working.

Creating business and clinical processes

Medical practices run many processes that direct its business and clinical operations. All operations within a practice should have a documented process. Practice managers can avoid major process malfunctions by creating and maintaining official, written processes that will develop and differentiate the practice. These processes act as guidelines that a new or improving practice can use to respond effortlessly to attract new patients, better existing relationships, and provide consistent high quality services. As the practice owner, you can set standards and communicate properly with staff in order to keep the practice running smoothly with the use of the established processes.

Key categories of processes that form a medical practice include, but are not limited to:

- Personnel
- Medical Records
- Ancillary Test Reporting
- Financial Management
- Appointment Scheduling
- Patient Clinical Care
- Risk Management & Quality Improvement
• Materials Management
• Registration
• Patient Check-Out
• Referrals
• Information Systems
• Compliance
• Patient Communication & Access
• Medical Staff Management
• Office Management
• Central Billing Office/Billing & Collections Department
• Facilities or Satellite Offices (if the practice has more than one)
• Janitorial & Building Management
• Marketing Management

The first step for developing a process is to identify, keep track of, and document each task performed in the practice and what it takes to accomplish each one. It is a good idea to generate a description of everything that is done on a monthly, weekly and daily basis, with the help of your staff. New practices have a good opportunity to streamline the processes for each task from the start. However, as the practice grows, you may have to consider changing processes to make the practice more efficient.

Ensure each key process term or task has a specific definition so that everyone in the practice can comprehend it. Defining tasks are important in order to prevent conflicting perceptions. After a description of every single task has been generated and determined, map out the process of each task. Creating flowcharts to map out processes assists staff in following trails of information, observing clinical steps and looking for recurrent problems. Flowcharts give staff a universal understanding of a process in a more visual way. They can help practices find any errors or delays within a process or system.

Using flow charts will establish agreement on the practice’s current procedures and what the best current processes should be, and the need to collect data to monitor improvement on effectiveness and efficiency. There are three basic flowcharts that can be used to demonstrate processes and systems: top down flowchart, detailed flowchart, and deployment flowchart (see Figure 1 on page 56).

The top down flowchart is the simplest flowchart that shows a view for basic processes. It is used for illustrating just the major steps in a process. It can also be referred to as a high-level or first-level flowchart. It is good for identifying any changes taking place within a process.

The detailed flowchart provides a more detailed view of the process. It shows an outline of all the steps included in the process. This type of flowchart is valuable when rheumatologists are looking for areas of inefficiency in the practice. It shows the delays of a process when an employee is not performing efficiently or is not available.

The deployment flowchart specifically shows who is performing the steps in the process. It shows the flow of steps that each individual involved in the process is performing. It is commonly used for identifying who provides what services to whom. It can also help a practice when trying to indicate the length of time a patient is actually in the practice.
FIGURE 1

TOP DOWN FLOW CHART

Patient Arrives at Medical Practice

→

Patient's Records are Pulled

→

Patient is Seen by Physician

→

Patient Pays & Schedules a Follow-up Appointment

→

Patient Leaves the Medical Practice

DETAILED FLOW CHART

Patient Arrives at Medical Practice

→

Patient's Records are Pulled

→

Physician is Ready to See Patient

→

Receptionist is Ready for Patient to Pay & Schedule a Follow-up Appointment

→

Patient Leaves the Medical Practice

DEPLOYMENT FLOW CHART

Patient

→

Nursing Staff

→

Physician

→

Receptionist

Arrives at Medical Practice

→

Pulls Patient's Records

→

Sees Patient

→

Orders Infusion

→

Documents Infusion in Patient's Record

→

Checks Out Patient & Schedules a Follow-up Appointment

Agrees to Infusion

→

Administers Infusion to Patient

→

Consults with Physician

→

Evaluates Patient

→

Checks Out Patient & Schedules a Follow-up Appointment

Arrives at Infusion Lab

→

Prepares Patient for Infusion

→

Prepares to Leave

→

Checks Out Patient & Schedules a Follow-up Appointment

→

Consults with Physician
Management of Ancillary Services

Ancillary services are services the practice can provide outside the rheumatology services traditionally offered. The evaluation and implementation of ancillary services is an important part of a medical practice due to ever decreasing reimbursement. These services may generate additional revenue to the medical practice. Adding ancillary services to the practice can add revenues without having to add additional providers. It is possible for all rheumatology practices to offer some form of ancillary service.

The two common types of ancillary services are diagnostic services (including laboratory, radiology, nuclear testing CT, MRI, and musculoskeletal ultrasounds), and therapeutic services (including physical therapy, occupational therapy and pain management).

A few examples of other commonly offered ancillary services are:

- Diagnostic testing, such as complete blood count test, physical exam, and urinalysis
- X-ray services
- Infusion therapy centers
- Fluoroscopic injections
- In-house durable medical equipment store/ retail product sales
- In-house pharmacy
- Dual energy X-ray absorptiometry services/scans
- Geriatric centers
- Clinical trials

When deciding what ancillary services to add, first think of the services currently referred out that would be possible for the practice to provide. Prepare a formal business plan to verify that the ancillary service will generate the revenues expected and is a viable service for the practice. It may be helpful to look into justifying the addition of an ancillary service(s) through an analysis of its return on investment, or ROI. A simple way to calculate ROI for the practice and its possible ancillary service is to first calculate costs (e.g., additional space, new equipment) and then projecting the revenue the practice will see in its increased sales or decreased costs realized through service efficiencies. Next, add up all the other benefits to adding an ancillary service such as: putting staff in control of the new service, enhancing patient satisfaction, and maximizing the practice’s internal skills through the service. Keep in mind the financial risks involved in adding a new service and do an overview of the practice’s environment and current patients to see if such a service is in demand or if a competitor is already providing it. Ensure payors will reimburse for this new service, and be sure to get a qualified health care attorney’s advice on certificate of need requirements for this service.4

As mentioned before, one example of an ancillary service is having in-office clinical research or trials. There are many opportunities through pharmaceutical company sponsored drug trials, database or medical record reviews, and investigator-initiated trials. Clinical research provides many benefits to the practice in addition to increased revenue.

There are some ethical considerations when performing clinical trials. If you plan to do clinical research, you must consider patient safety as your primary responsibility. This is different from regular clinical practice because the research may or may not benefit the individual patient. In clinical research the rheumatologist’s intent is to increase the knowledge base, benefit future patients, and perhaps the next patient who comes to the rheumatologist. If you cannot be clear on this concept, clinical research may not be right for you.

Most consortiums—Rheumatoid Arthritis Investigational Network, American College of Physicians practice-based research network, institutions such as universities, and the Veterans Affairs system—insist that all the investigators and personnel involved in clinical research complete an ethics course, either in person or online, and that the rheumatologist be re-certified every one to two years. Generally, the institutions provide this at no cost to the rheumatologist, except time. It takes up to two to four hours, or maybe longer for the practice’s staff.
In performing clinical research, the rheumatologist will agree to follow the protocol of the sponsor hosting, or the person who is asking the rheumatologist to conduct the type of research by doing the clinical trial. The rheumatologist cannot change procedures, drug schedules, or anything without advance permission of the participating patient and the clinical trial sponsor. Often, there is the opportunity to discuss protocol adjustments at the investigator meetings, or meetings held when the sponsor comes to observe the clinical trial, within limits. The rheumatologist and the sponsor will then have to get the Food and Drug Administration to agree to the changes.

In considering whether clinical research will be a profitable addition to the practice, available time should first be evaluated. There will be substantial paperwork to review including lab test results, notices about adverse events, changes in protocol, etc., in addition to the regulatory documents the rheumatologist must complete before being allowed to participate in the study.

The rheumatologist and the practice staff will also be required to attend numerous investigator meetings. Recruiting patients will also take considerable time. The rheumatologist may be required to pre-screen a certain number of charts, and asked to provide a list of patients contacted each week while recruiting.

Available space must also be considered. You will need adequate exam rooms and/or an infusion room, space for a study coordinator office (with ample space for document storage), a locked document storage cabinet or room, lab space available to process specimens for shipment, dry ice storage, centrifuge and a refrigerator for specimen storage before shipping.

Clinical trials can be a wonderful opportunity if the rheumatologist and the practice has staff that needs a challenge, would be excited to learn new things, and do some traveling to meetings; or, if the practice has more space in the office than can be used right now. Like any other business opportunity, substantial revenue performing clinical research (for drug companies) can be generated, but only if the budget and expenses are managed well. The clinical research sponsor will provide a suggested budget with each procedure itemized.

There are a number of ancillary services you may wish to explore. Even if you do not want to offer a service in the practice, you may want to invest in a service along with other rheumatologists, and have a management company oversee the operations.

**Management of Health Information Technology**

The use of technology in practice can serve to attract and retain patients as well as lead to more efficient workflow. Many different systems are available and offer a sort of “medical office in a box” approach to technology. But taking a gradual approach is often more appropriate for a small practice with a tight budget. Interoperability, or hardware compatibility, is the key when using this tactic. Creating a customized system as opposed to buying from a single vendor can keep the practice from being locked into high cost service contracts and expensive systems that do not quite perform as they need to. Identify what is required of the practice’s hardware and software and find computers, scanners, printers, an external hard drive, telephone, cell phone, PDA, paper shredder, and system back up to fulfill these needs.

It is important for every rheumatologist to know and understand the main clinical and administrative information technology systems that are being used in medical practices today. Key clinical and administrative information technology systems include:

**Electronic Medical Record/Electronic Health Record:** A medical practice’s EHR should offer the practice the ability to run a paperless office by generating notes and visits, capturing charges and ICD-9/CPT codes, and creating and automated super bill at the end of each patient visit. The EHR system needs to function according to the practice’s needs and workflow. Interoperability of the EHR with the practice management system is the solution to avoiding excess work and double entry errors. The EHR should also be able to effectively generate a summary of essential patient data such as current lists of medications, allergies, diagnoses, and a variety of practice wide statistics. The EHR should offer flexibility and accommodate a variety of documentation methods, particularly templates for simple visits, voice recognition and unrestricted keyboard entry for more complicated charting. It should include cut and paste functionality to and from other applications in order to provide for quick documentation of patient communication in the chart and help in sharing lab results with the patients.
The ACR partnered with several medical societies and Cientis Technologies to develop AmericanEHR Partners. AmericanEHR Partners is a web-based resource for EHR system selection/implementation to assist medical practices experiencing increasing pressure to adopt and use electronic health record systems. This resource includes interactive tools, educational materials, and podcasts. For more information, visit the ACR’s website at www.rheumatology.org/hit.

**Electronic Prescribing:** It is important that an EHR supports electronic prescribing, or e-prescribing, and is certified to establish an electronic connection with pharmacies. Many physicians believe that they are currently e-prescribing through their EHR when they are actually sending the prescription through electronic fax. In order to be in compliance with developing federal regulations that require e-prescribing, it is important to verify that the EHR is sending prescriptions the correct way. By visiting the ACR's website, you can find information about the benefits of e-prescribing, how to get started, interoperability with EHRs and more.

A benefit of e-prescribing is that it creates a more efficient and safer process for patients to access their medications. This electronic process helps to prevent, and in some cases, eliminate the top reasons for prescription errors which improves patient safety and helps to control ever increasing medication costs due to medication errors. The top reasons for prescription errors are illegible hand-writing, incorrect dosing, and missed drug/allergy reactions.

To get the practice’s e-prescribing system up and running requires an understanding of both the potential benefits as well as the needs and workflows of the practice. For the rheumatologist looking to adopt an e-prescribing system, the business case for acquiring and implementing the system will vary according to the size of the practice, type of practice, participation of health plans, participation of local pharmacies, practice setting, availability of information technology infrastructure and support, stand alone e-prescribing vs. EHR, and availability of incentives and ability to take advantage of them. There is no perfect system that will work for every practice, so it is important to identify the current practice prescribing workflow needs. With the right system, you can expect to realize the potential savings associated with increased practice efficiency handling medication renewal requests and increased prescriber accuracy resulting in fewer call-backs from pharmacies for legibility issues, drug incompatibility or ineligibility.

**Practice Management System:** In some cases, the practice management system will be incorporated with the EHR, but if it is not, the EHR should be compatible with the practice management system. The practice management system will, in most cases, provide applications for patient billing, insurance claims, appointment scheduling, reporting, and staff management in one comprehensive package. A good program can be worth its weight in gold as it can control patient flow and financial activities and help the staff work more efficiently. In order for the practice management system to promote maximum efficiency, it should be easy for the clinical and office staff to use. It is important that the practice management system’s appointment scheduling application be compatible with the practice’s current appointment schedule time slots. As with all medical software, the practice management system must be HIPAA compliant.

**Practice Website:** A practice website can be a very effective tool for marketing and controlling patient flow. Surfing the Web for services and utilizing websites to shop and book appointments is becoming standard procedure for many seniors and baby boomers. The information the practice includes on its website will depend on the individual practice itself, but at a minimum include contact details, directions to the practice and a short physician biography of each rheumatologist in the practice. Patient education resources may also be offered, and can include a simple list of links to the ACR’s website, educational videos, or step-by-step instructions for care.

The practice’s website can serve as a virtual front office to handle everything from patient scheduling to providing the operating hours for and directions to the practice. It can automate the non-clinical tasks of the practice by providing appointment scheduling and reminders, forms for medication refill requests, online account information and payment options, new patient forms for history taking and pre-appointment surveys, and patient education materials. Automation of these tasks will free up the time of the front receptionist, and can even reduce the number of staff needed in the front office and lower overhead. It does so by encouraging patients to use it to find forms, policies, appointment scheduling, directions, business hours, insurance
information, patient education, video links, e-mail links, refill request forms and surveys. Having these materials accessible to the patients can even reduce the time the patient has to wait to be seen by the rheumatologist. If the practice decides to implement an automated scheduling system through its website, make sure that the system chosen is compatible with the practice’s practice management system.

Building and maintaining a website is easier than one may think. There are a variety of website builder programs and hosting companies that provide either a cut and paste style or a template driven Web designs in order to help you get started. There are some Web builder service companies who are familiar with verifying that the website is HIPAA compliant, but it is always a good idea to have an attorney who is familiar with HIPAA regulations review the website. The attorney should review how the website is encrypted to the wording of the terms of service disclaimer. The ACR has information regarding getting a website for practices; see www.rheumatology.org/education/careers/articles/website.asp for more information.

Risks & Insurance
An important part of managing the clinical and business operations is risk management. Medical practices and rheumatologists are faced with everyday risks such as lawsuits and accidents that happen within the practice. Risk management for a medical practice is being able to identify, assess and reduce risks to patients, visitors, staff and your practice’s assets. It is important to have insurance that covers both the practice and its rheumatologists in case an accident or a lawsuit takes place. The federal government, state government, insurance companies, patients, employees, and even prospective employees all exert pressure on the practice to conform and provide services in a way that is safe, fair, and in accordance with various legal requirements. Following is a brief listing of the many types of business and professional insurances:

Malpractice Liability/Physician Insurance: Malpractice is a type of improper conduct or negligence in which the rheumatologist fails to follow commonly established professional standards in the medical community and causes harm or death to the patient. Medical malpractice can occur in a number of ways such as improper diagnosis or treatment, surgical mistakes, prescription errors, or more by a rheumatologist. It is necessary that all rheumatologists are covered under professional liability insurance to compensate the risks and costs of lawsuits based on medical malpractice. Laws and regulations regarding malpractice lawsuits can vary drastically in each state. There is a statute of limitations for medical malpractice lawsuits. The time length for filing a malpractice lawsuit is usually known as “periods of prescription,” and the length of this time period and when it actually begins vary by jurisdictions and by the type of malpractice conducted. For a state-by-state overview of medical malpractice laws, visit www.expertlaw.com/library/malpractice_by_state/.

Insurance that covers medical malpractice is usually called professional liability insurance. Professional liability insurance protects rheumatologists against possible negligence claims made by patients. In the medical field, professional liability insurance can be referred to as medical malpractice insurance. It can be called errors and omissions liability if liability is limited to acts of negligence. This type of insurance coverage is a specialty coverage that protects rheumatologists on the failure to perform, financial loss, error or omission of the products or services provided, and unintentional billing errors when filing claims. It will not protect the medical practice against having to refund any overpayment. Professional liability insurance policies are usually created based on the claims made during the policy period. The insurance coverage is a rheumatologist’s most critical insurance coverage, and they should take careful consideration before ever ending this type of coverage.

Choosing a medical liability insurance carrier is a very important decision. It is necessary to conduct research on the various medical malpractice liability insurance carriers to find coverage that best fits your needs. When making a decision, figure out how much insurance you should have and understand the differences between the types of insurance companies and the types of policies. You can search for a medical liability insurance carrier online, attending rheumatology medical conferences, or by asking colleagues within your community. Many times, insurance carriers will contact you in order to get your business.

Determining how much liability coverage a physician should carry depends on the physician’s specialty, the type and location of the practice, and the procedures performed. There is a large variation in insurance laws state-to-state. The amount of coverage a physician chooses will rely on state laws, assets and affordability.
Generally, rheumatologists purchase the claims-made professional liability insurance. Under a claims-made policy, coverage is limited to liability for claims occurring from incidents that happen and that are reported to the insurance company while the policy is in use. The claims-paid and occurrence policies are the less common professional liability insurances that physicians purchase. A claims-paid policy has premiums that are set only on those claims that were settled during the previous year or those likely to be settled in the coming year. An occurrence policy covers the physician for any occurrence that happens presently or in the past while the policy is effective. Under the occurrence policy, it doesn’t matter when the incident is reported or when it becomes a claim.

Below is a list of some of the common questions to ask before making the final decision on a professional liability insurance carrier:

1. What kind of policy is it?
2. What does the carrier’s policy cover beyond traditional medical malpractice insurance, such as incentives to participate in proactive risk management programs?
3. Does the carrier offer policy deductibles, or offers to pay an amount of the first money paid of a claim payment and to pay a lower premium for assuming the risk?
4. Does the carrier offer discounts for rheumatologists with good claims histories?
5. How long has the carrier been in the medical malpractice business?
6. What payment plan options does the carrier offer?
7. Does the carrier have a certificate of non-assessability, meaning that the carrier is suitably secure so that rheumatologists are not required to pay additional costs for past losses for which reserves are scarce?
8. How does the carrier’s ratings compare to its competitors by looking online or getting information from other colleagues?
9. Is there easy access to the carrier’s decision makers and to its policyholder services?
10. Will a claim be reviewed by a consultant of the rheumatologist’s own specialty?
11. Can coverage be carried to another state?

**Medical Practice Insurance:** Medical practice insurance is important for the actual practice to have so that it can be insured from the financial repercussions and business interruption costs in case of a fire, theft, staff issue or third party payer issue similar to any business. This type of insurance will cover all office equipment and supplies if any of these instances occur. Many insurance companies that provide these types of coverage can offer it to you under one plan. Some insurance companies even have customizable insurance plans just for medical practices.

Many insurance companies provide medical property and business liability insurance, which will cover all property in the medical practice, including medical and office equipment and supplies. This type of insurance policy will also cover ongoing medical office expenses and income loss resulting from office damage. Generally, this type of insurance provides medical practices reimbursement for net loss earnings and necessary continuing expenses.

**Worker’s Compensation:** In order to protect your staff, it is necessary for medical practices to purchase workers’ compensation insurance. Workers’ compensation insurance is mandatory in a medical practice in order to protect its staff from their own medical costs and for lost wages if they were ever to experience a work-related injury or illness. For example, a staff member could slip and fall in the hallway if there is a spill and twist an ankle. If there is not a “Caution Wet Floor” sign around the spill, the worker could demand that the practice pay for the ankle injury. Most workers’ compensation insurance covers
staff in case any of them receive rehabilitation after a work-related injury. While workers’ compensation insurance plans can vary depending on the medical practice’s jurisdiction, general damages for pain and suffering are not usually available in these types of plans. Workers’ compensation insurance can be found online, in medical magazine advertisements, or through word of mouth from colleagues. Some practice liability insurance companies will also offer workers’ compensation insurance. It is important to ask the practice’s current insurance liability carrier if this type of coverage is offered.

Crime Insurance: The medical practice should also protect itself from its staff by purchasing crime insurance. Crime insurance correlates with workers’ compensation insurance. This type of coverage can include insurance for staff dishonesty, embezzlement of the practice’s funds by staff, or if any staff were to take any equipment or supplies without permission. Crime insurance not only covers the medical practice in case of a staff mishap, it can also cover the practice in case of an outside source committing fraud, forgery, theft or any other type of crimes. This type of insurance can also protect electronic health records and other electronic systems of their medical practice. Crime insurance, just like workers’ compensation insurance, can be found online or by word of mouth from colleagues. Some practice liability insurance companies offer crime insurance. It is important to ask the practice’s current insurance liability carrier if this type of coverage is offered.

Addressing Other Risks
In order to avoid other risks that could occur within your practice, there are certain manuals that you should have, maintain and make available to every staff member such as:

- **Blood Borne Pathogen Standard Manual:** It is required by OSHA that every medical practice must maintain a manual that indicates the staff’s written blood borne pathogen standard policy for AIDS, tuberculosis, hepatitis, VD, and any other blood borne pathogens.

- **Hazardous Communication Standard Manual:** OSHA requires that every medical practice retain a manual concerning the employer’s written hazardous communication standard. It is necessary for this manual to summarize the items around the practice that could cause potential harm or a threat to employees and it should explain the steps to take in case of an exposure incident.

- **Material Safety Data-Sheet Manual:** OSHA’s Hazardous Communication Standard requires that a separate manual be kept organizing manufacturers’ Material Data Safety Sheets.

- **Discrimination and Sexual Harassment Policy Manual:** In order to avoid potential lawsuits relating to sexual harassment and discrimination, it is a good idea for medical practices to have a separate manual that outlines the practice’s policy against harassment and discrimination. It should also outline the reporting and investigative process and procedure. This policy should also be included in the employee policy and procedure manual.

- **Health Insurance Portability and Accountability Act Manual:** This manual, also known as a HIPAA manual, explains the practice’s policy relating to electronic connectivity, transmission, storage and retrieval, and confidentiality of all patient health care information. It is also required that all medical practices, staff, and physicians be in compliance with HIPAA.

- **Medicare Compliance Manual:** In order to avoid incidences of health care fraud, both intentional and unintentional, your practice should have a manual that describes the policies and procedures that the medical practice employs to avoid, detect, and correct any instances of health care fraud instances that take place.

- **Individual Managed Care Organizations’ Manuals:** Each managed care plan has its own policies and procedures and sends out periodic notices outlining highlights and plan changes or modifications. It is important that your practice keep a manual for each plan that can be easily accessed and reviewed to assist in patient requests and for appealing adverse plan decisions.
Conclusion

Making the decision to manage a practice does not come lightly and should be entered into carefully. There is a multitude of liabilities and risks involved and so the day-to-day operations must be handled properly and carefully. Managing a practice is an ongoing business – although there can be a lot of burn out with micro managing, you must keep in mind that this is your business and no one will care for it as much as you do. So, it is necessary to have a team that is well trained and experienced at the core of the practice so that it will be productive.

For long term success, be an effective leader and manage accordingly to the needs of the practice. There are many resources that are available to physicians on proper management of a business. See ACR resources in Chapter 1 to assist you with up-to-date information on practice management.

References
In order to be an effective practice owner, it is necessary to understand the financial circumstances and environment in which the practice operates. Well-managed practices prevent the practice from losing time and money. The main thing that keeps a practice’s doors open—meeting the needs of patients and staff compensation—is money. Therefore, it is very important that you have a basic understanding of accounting and the impact that it has on the bottom line of the practice in order to improve productivity and operating efficiencies.

You need to be able to read all financial statements, explanation of benefits and accounts receivable flowcharts. Controlling the practice’s assets, collecting the practice’s revenue, arranging the practice’s funding and reconciling all of the practice’s financial obligations are important functions to understand. The financial system of a medical practice will contribute to every other system within the practice. How it is managed could make or break the medical practice. Financial systems are set to record and report transactions that have an influence on what the practice is worth; assists processes in the practice and achieves cost and revenue enhancements; protects the practice’s assets and resources from theft, wastes or losses; assists management in short-term and long-term planning; and arrange capital funding to implement important management decisions. These functions are accomplished through the use of controllership and financial management and contain the following supporting activities:2

Transaction Accounting: Transaction accounting is records and reports all transactions affecting the actual worth of the practice. Those are any events or conditions that are recorded in the practice’s accounting books. Transactions fall into the categories of service transactions and resource transactions. Service transactions relate to the provision of health care services, and resource transactions relate to the attainment of resources. Once the data is gathered, it is organized with reporting actions through the managerial and financial accounting functions.

Managerial Accounting: Managerial accounting streamlines transaction accounting data to support planning, assist in setting goals, and improve the practice’s performance. It generates information for the internal practice that can be used by the practice manager and finance department to support decisions about practice systems and answer the questions regarding whether a system or service runs at an acceptable level of cost.

Financial Accounting: Financial accounting accomplishes the direct obligation to the owners, creditors, and to the public by stating the position of the practice as a whole, in terms of the value of its assets, the equity residual to its owners, and the change in value occurring in each accounting period. Financial accounting produces reports and financial statements every year, if not more often, that summarize the financial activities and situations of the practice. As a Medicare provider requirement, these financial statements must be audited by a public accounting firm that confirms that they fairly represent the financial position of the organization and are free of misrepresentation. These audited financial statements must then be reported to the federal government.

Budgeting: Budgeting for a practice is a full, detailed description of expected financial transactions, by each accounting period, for at least an entire year. The practice’s budget should summarize the goals for all operational practice performance measures and provide a plan for short-term financial operations and functions. The budget will generally be a list of all the practice’s planned expenses and revenues. It is used to help your practice save and plan for future spending and purchases.
Protection of Assets: Protection of assets is a financial system that is responsible for the physical protection of cash, securities, receivables, and other assets for ensuring that the physical office and equipment were used as anticipated, and estimating the actual loss of physical property. It protects the practice against unjustified free or unbilled service to patients, stealing of cash in the collections process, bribes and kickbacks in purchasing arrangements, supervision of financial conflicts of interest among practice’s board members and officers, diversion or theft of supplies and equipment, falsified employment and hours, and purchase of supplies or equipment without proper authorization.

Financial Planning: Financial planning is the part of the practice’s long-range financial plan that incorporates the expected future income and expense for every element of the strategic plan, specifying the amount and the time of its occurrence. Financial planning generates pro forma statements of income, asset and liability position, and cash flow for each of the future years. You should use the financial plan to recognize danger signals in advance and make the necessary adjustments. Generally, this financial planning task will help the practice find out how it can afford to achieve its goals and expectations.

Pricing Clinical Services: Pricing clinical services gives the practice a regular pricing response that integrates the practice’s financial needs and marketing realities. Major buyers, such as Medicare, Medicaid and large commercial buyers tend to set their prices and the structure they will use to pay. The terms are promulgated by Medicare and are not open to discussion. Buyers with less power in the marketplace are willing to negotiate both the structure and the level. A small portion of the market assumes the practice and its physicians will have a structure and a price schedule, and they expect to pay it.

Securing Long-Term Funds: Securing long-term funds allows the practice to estimate alternative financing means, develop a long range financial plan to implement the strategic plan, and recommend the best solution to the practice’s or management board. It arranges placement of debt and prepares sustaining financial information and pro formas, and manages repayment schedules, mandatory reserves, and other elements of debt obligation. It monitors the financial markets for opportunities to restructure financing, and manages endowments of not-for-profit health care organizations.

Managing Short-Term Assets and Liabilities: Managing short-term assets and liabilities is the part of the financial system that manages the practice’s working capital transactions and funds that are used to cover expenses made in advance of payment for services, to the maximum advantage for the organization. Working capital management deals in terms of days.

In-Office Accounting

Financial systems and functions in your practice should be organized. Even if you have an accountant in your practice, as the practice owner you need to understand these in-house finance systems and functions. The major accounting and financial functions that you will need to implement and execute in your practice include:

Cash collections and payments: Cash collections and payments are the money coming into the practice. This includes co-insurance and deductibles. It is very important to collect these at the time of service. Collections are important to the vitality of the practice and therefore there should be policies and procedures in place to ensure the money is properly collected.

Accounts receivable: Accounts receivable is money that a patient, or client, owes to a practice for services delivered. Since A/R financing is based on patient or client credit, it is easier for practices to obtain the amount owed, especially if the patient comes into the practice often. Depending on the practice’s Billing and Collections policies and procedures, receivables are usually due within a reasonably short period of time ranging from a few days to no more than 90 – 180 days depending on a payor.

Accounts payable: Accounts payable correlates to the various products and services acquired from vendors on credit. Normally, bills for these items require payment within thirty or sixty days from the date these items were purchased. Your practice’s accounts payable system should guarantee timely payment of these invoices when due, especially if a cash discount is offered for prompt payment. This is usually within ten or fifteen days of receipt.
**Financial Operations Management**

**Payroll:** Payroll is the computation of the staff’s time card. It will most likely be the biggest expense your practice has. Your practice may have a payroll system in which the practice owner will enter the time card data into that system. The payroll system could be considered one of the most important financial activities that will happen in the practice. There are also numerous governmental and state regulations that play a part in the computation of the staff’s final take-home pay. Ensure the payroll system upholds the government regulations relating to payroll.

**Financial Statements**

The practice’s financial statements are evidence of how the business part of your practice is doing in terms of dollars and cents. You don’t necessarily need to know how to prepare these statements if it’s the job of the practice’s accountant or practice manager, but knowing how to interpret them can give you valuable information as to how to modify the practice’s day-to-day tasks in order to run a more successful medical practice. Ensure you receive a copy of each of these financial statements every period to be able to accurately plan the financial stance of the practice.

Investors and lenders will be particularly interested in the practice’s financial statements as they reflect the financial position, profitability and cash flow of the practice. In particular, they will be looking to see what assets the practice has to cover the practice’s liabilities and generate profit. They will get this information from the three of the practice’s primary financial statements such as the balance sheet, the income statement, and the statement of cash flows.

**Balance Sheet:** The balance sheet is a way to view the practice’s assets, equity, and liabilities at that point in time. Practice managers should review it daily; however, the rheumatologist can review it when he or she deems it necessary. The good thing about a balance sheet is that it can be checked at anytime. The assets are things that the practice owns that hold value or worth, such as physical property. Liabilities are the debts that the practice owes to others, such as money borrowed from a bank, rent for the use of a building, money owed to vendors for supplies, payroll, or taxes owed to the government. Shareholder’s equity (sometimes called capital or net worth) is the money that would be left if the practice sold all of its assets and paid off all of its liabilities.

The practice is financed through the contribution of the physician-owner, and through borrowed money. Those funds are then used to acquire assets for the practice’s utilization. This concept gives rise to the basic accounting equation: Assets = Equity + Liabilities, which means that the total assets are funded by liabilities and owners’ equity. The balance sheet is set up like this accounting equation. Assets are listed on the left side and liabilities and shareholders’ equity are listed on the right. Assets are usually listed in order of how fast they can be converted into cash. Liabilities are listed according to the dates when they due to be paid. See Example 1 on page 66.

**Income Statement:** The income statement is a summary of all the revenues produced and expenses incurred during the period covered by the statement. Ensure you receive a copy of this statement to review at the end of each financial period. The bottom line of the income statement shows the practice’s net earnings or losses. At the top of the income statement is the total money brought in from sales of services. The next line is typically the cost of the sales. Added together, this gives the gross profit. Next, subtract selling expenses and administrative expenses and add other income to give the profit or loss before tax. See Example 2 on page 67.

**Statement of Cash Flows:** The statement of cash flows shows the cash receipts and the cash payments and shows how the practice’s cash situation has changed between two balance sheet dates. The cash flow statement shows changes over time rather than absolute dollar amounts at a point in time. Review this sheet at the end of every period, if not before then. The bottom line of the cash flow statement shows the net increase or decrease in cash for the period. Cash flow statements are typically divided into the operating activities, and analyze a company’s cash flow from net income or losses, investment activities, and financing activities. See Example 3 on page 68.
### Example 1: Balance Sheet

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>LIABILITIES &amp; EQUITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td><strong>Current Liabilities</strong></td>
</tr>
<tr>
<td>Cash</td>
<td>Accounts Payable</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>Short-Term Notes</td>
</tr>
<tr>
<td>(Less Doubtful Accounts)</td>
<td>Current Portion of Long-Term Notes</td>
</tr>
<tr>
<td>Inventory:</td>
<td>Interest Payable</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Taxes Payable</td>
</tr>
<tr>
<td>Office Supplies</td>
<td>Accrued Payroll</td>
</tr>
<tr>
<td>Other</td>
<td>Total Current Liabilities:</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td></td>
</tr>
<tr>
<td><strong>Total Current Assets:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td><strong>Long-Term Liabilities</strong></td>
</tr>
<tr>
<td>Long-Term Investments</td>
<td>Mortgage</td>
</tr>
<tr>
<td>Land</td>
<td>Other Long-Term Liabilities</td>
</tr>
<tr>
<td>Building</td>
<td>Total Long-Term Liabilities:</td>
</tr>
<tr>
<td>(Less Accumulated Depreciation)</td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Shareholders' Equity</td>
</tr>
<tr>
<td>(Less Accumulated Depreciation)</td>
<td>Capital Stock</td>
</tr>
<tr>
<td>Furniture &amp; Fixtures</td>
<td>Retained Earnings</td>
</tr>
<tr>
<td>(Less Accumulated Depreciation)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Net Fixed Asset:</strong></td>
<td>Total Shareholders' Equity:</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS:</strong></td>
<td><strong>TOTAL LIABILITIES &amp; EQUITY:</strong></td>
</tr>
</tbody>
</table>
Example 2: Income Statement

<table>
<thead>
<tr>
<th>Rheumatology Practice, LLC</th>
<th>Income Statement</th>
<th>(Time Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Sales</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Less: Sales Returns &amp; Allowances)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Sales:</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Cost of Goods Sold</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beginning Inventory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add:</td>
<td>Purchases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Freight-In</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Direct Labor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indirect Expenses</td>
<td></td>
</tr>
<tr>
<td>Inventory Available</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>(Less: Ending Inventory)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Cost of Goods Sold:</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Gross Profit (LOSS):</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advertising (Marketing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amortization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad Debts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank Charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract Labor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Benefit Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal &amp; Professional Fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>License &amp; Fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payroll Taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs and Maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Expenses:</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net Operating Income:</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>Other Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain (Loss) on Sale of Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Other Income:</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net Income (LOSS):</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
**Example 3: Statement of Cash Flows**

<table>
<thead>
<tr>
<th>Rheumatology Practice, LLC</th>
<th>Statement of Cash Flows</th>
<th>(Time Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows From Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Received From Customers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Paid for Merchandise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Paid for Wages &amp; Other Operating Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Paid for Interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Paid for Taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash Provided (Used) By Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Flows From Investing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Received From Sale of Capital Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Received From Disposition of Practice Segments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Received From Collection of Notes Receivable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Paid for Purchase of Capital Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Paid to Acquire Practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash Provided (Used) By Investing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Flows From Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Received From Issuing Stock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Received From Long-Term Borrowings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Paid to Repurchase Stock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Paid to Retire Long-Term Debt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Paid for Dividends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash Provided (Used) In Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Increase (Decrease) In Cash During the Period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Balance at the Beginning of the Period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Balance at the End of the Period</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reimbursement Systems

In the past, insurers reimbursed physicians according to what was considered usual, customary, and reasonable, and typically paid for what was charged. In the event that the usual, customary, and reasonable rate, or UCR rate, was less than the rate the physician charged and the insurer did not pay the total of the billed claim, the physician could then bill the patient for the remaining balance. This system of reimbursement soon gave birth to modern managed care and the reimbursement schemes as rheumatologists now know them.3 Keeping the overall goals of managed care in mind, physician reimbursement systems today are used as an instrument to align the compensation of physicians. Although it will not exert total control and ultimately lead to cost control alone, money does speak volumes and it is one of the strongest tools that a managed care organization has. Chapter 8 is devoted exclusively to understanding managed care.

There are three basic types of reimbursement systems: salary, fee for service, and capitation. These three systems are in many combined and hybrid forms due to a constantly evolving and competitive managed care environment. The managed care environment is formed by market forces, changes in managed health care medical practices, the creation of new laws and new regulations; withholds, risk sharing; and incentives. These three reimbursement systems will differ based on whether the rheumatologist is working in direct contract under the managed care system and guaranteed to receive compensation as stated in the contract, providing services as part of an organized physician group or integrated delivery system, or working in a staff model system. If the rheumatologist is providing services as part of a group, the group may blend these three systems to compensate members in the best way possible that suits the entire group. An explanation of the three forms of physician reimbursement systems are described below.

Salary: Salary is a reimbursement plan that is generally seen in closed panel HMO models and in situations where the rheumatologist is an employee of the practice, in a partnership, or in hospital-based practices. Salaried positions could provide a good opportunity for newly starting rheumatologists or for those rheumatologists who are moving into private practice. This type of plan can offer job security and a stable income.

Fee-for-service: A fee-for-service, or FFS, reimbursement plan is also known as an indemnity plan. It used primarily in PPOs, and is sometimes used in HMO reimbursement plans. Fee schedules vary from contract to contract with this type of reimbursement plan. FFS plans can also be used in combination with other reimbursement systems. Common FFS reimbursement methods are:

- **Percentage of Billed Charges:** Reimbursement by a percentage of billed charges compensates rheumatologists by a set percentage of the total amount that was billed for a treatment, service or procedure. The physician does not get a percentage of the amount that was billed by the practice, just a certain percentage of a maximum allowable charge for the billed treatment, service or procedure.

- **Percentage of usual, customary and reasonable:** Reimbursement by this method pays rheumatologists a percentage of the usual, customary and reasonable rate. The UCR rate is an amount that insurance companies calculate based on the charge of a specific service or procedure by rheumatologists in a geographic region. It is necessary for the rheumatologist to know the actual cost by which he performs a procedure, the UCR rate for a procedure, and the percentage of the UCR he or she will actually be reimbursed.4

- **Relative Value Scale:** The relative value scale, or RVS, is a way of measuring productivity and determining the value of one service as opposed to another service.5 The RVS allocates a relative value to each procedure and visit code and then pays the physician by multiplying a set dollar amount by that relative value. Rheumatologists’ services are paid mostly under the Medicare Fee Schedule and those services are each assigned a relative value, also known as a relative value unit. Rheumatologists’ work, practice expense and professional liability insurance form the relative value for each procedure. However, even though rheumatologists may spend more time performing a complete history and physical examination of a patient, rheumatologists often provide procedures that have higher charges than other cognitive services, which can be a rising problem for rheumatologists who use this method.
• Resource-Based Relative Value Scale: The resource-based relative value scale, or RBRVS, is a model used to figure out how much money physicians should be paid by providing procedures in a geographic region a relative value. The value is then multiplied by a fixed conversion factor to determine the amount that a physician gets paid. The conversion factor changes every year. The RBRVS combines three separate unit values for each procedure at the same time as factoring in regional variation in physicians' work, practice expenses and professional liability expenses. It was first used by Medicare in 1992, but has become commonly used by many insurers and some pay at different percentages than Medicare. The formula is: work relative value units + practice expense relative value units + malpractice expense = total relative value units.

Capitation: Capitation is a payment method for health care services that pay the rheumatologist a contracted rate for each patient assigned, regardless the number of services provided. It is a fixed payment paid to the rheumatologist at regular intervals. This type of reimbursement is almost exclusive to HMOs. Capitation is commonly used to reimburse primary care physicians, as they serve as gatekeepers in this type of model. Rheumatologists, as well as other specialty care physicians, can use different methods than primary care contracting to enter into a contract under capitation.

Capitation agreements carry both substantial benefits and risks. The basis of a capitated agreement is prepayment, which establishes a guaranteed number of patients to the practice and also secures a stable revenue source. Expect lower overhead with capitated contracts versus fee-for-service agreements since there will be no claims to process. A guaranteed check every month will increase cash flow and may provide opportunities to grow your practice in ways that would not exist in a strictly fee-for-service environment. The rheumatologist can also expect the market share to increase with capitated patients. In addition to the guaranteed volume, these patients are likely to refer other patients.

For physicians in specialty care, like rheumatology, capitation does come with risks due to capitation being considered as a risk-based compensation. If entering into capitation contracts you can expect some service risk as you are accepting a fixed payment for your specialty services. In this way, profit is relative to volume. If the service volume is high, the physician receives lower income per encounter. However, if volume is lower than what is expected, the physician can make a significant profit. The rheumatologist will also be at financial risk through controls put in place by the contracting party, such as withholds.

Rheumatologists also have concerns associated with utilization management when contracting under capitation. Under capitation contracts, rheumatologists have limited control over utilization and referrals by primary care physicians. In most situations, the primary care physician holds no financial risk for making referrals. It is important to educate primary care physicians on making appropriate referrals. You should be aware of the various capitation prospects available due to physician associates and large groups having the ability to accept full risk capitation contracts. This can make it difficult to find opportunities to secure a capitation contract.

Many specialists choose to share in capitation arrangements with their competitors in order to obtain large volume opportunities. These groups will agree to some sort of distribution of the monthly payment based on utilization or services performed. In these types of arrangements, utilization is followed monthly and divided according to fee-for-service measurements for the month. At the end of the month, the capitation payment is divided and paid to each provider according to percentage of services provided. Some groups like to weigh the procedures according to the RBRVS scale and then divide the income, due to this method often leading to overutilization.

It is not uncommon to consider accepting subcapitation agreements. A subcapitation is when a rheumatologist contracts with a primary care physician or physician association rather than with an HMO. This usually occurs when a primary care physician or a large group accepts full risk capitation agreements in which pays the primary care physician or group for all services both primary and specialty. The primary care physician or group will then offer a rheumatologist a subcapitation that will pay for a part of the capitation payment to the rheumatologist for providing specialty care to their patients who are under a capitation contract. It is important to verify that the subcapitation agreement adheres to all state insurance laws before agreeing to
accept the subcapitation as well as utilize cost data to settle on a financially acceptable contract. Several states believe that only a licensed HMO should be able to capitate and require a provider to acquire a special license to subcapitate. There are many times when an HMO will not have the necessary patient volume to hire a specialist, like a rheumatologist full-time. The HMO will then look into hiring a part-time rheumatologist to deliver specialty services. If hired part-time by an HMO, specialty care capitation is calculated based on the volume of referrals expected, the average cost, the ability to manage utilization and the relative discussed strengths of the HMO and the rheumatologist’s practice.

Success of the capitation not only lies in the bottom line per member per month payment, but also in the details of the capitation contract. All services covered must be clearly defined. Various capitation contracts will include payment of a percentage of the health care premium for a specific procedure or service, or carve-outs. Procedures will usually be carved out of the capitation deliberation since rheumatologists who perform high-cost procedures will be somewhat disadvantaged compared to those who perform only less expensive care, even if in the same specialty. There is a financial incentive to perform these services by carving out these procedures from the covered services. Carve-outs are usually based on cost assumptions for all rheumatologist services and are derived by calculating the percentage of costs incurred for services provided by a particular specialty.

**Conclusion**

Proper financial management is the heartbeat of any practice. It is vital to understand the operation and financial decisions to improve the cash flow of the medical practice while consistently providing quality health care.

There are many financial and reimbursement models available and you will need to identify the one that is right for your practice. Hire an accountant to oversee reimbursements, compensations and payouts for the practice—ensuring the checks and balance of the business.

Running an effective and efficient practice focuses both on patient care as well as creating a viable and profitable medical practice.

**References**

CHAPTER 7: STRATEGIC MARKETING

Marketing is vital for every medical practice, new or established, small or large. Health care marketing has been downplayed and ignored for too long, primarily because there is a lack of understanding as to what it is and how to do it effectively. Marketing for the practice is a broad thought that embraces strategic planning, public and media relations, information technology, metrics and advertising. Marketing a medical practice is a way to attract and retain patients. It can be as basic as making sure to ensure patient satisfaction, and it can be as complex as performing a demographic/payor study before deciding to invest in a dual energy X-ray absorptiometry, or DXA, machine or physical therapy services. It is important for a medical practice to use good marketing research before beginning a marketing plan to help better understand the practice’s patients, competition, operational performance and the impact on its patients, and the health care environments in which the practice operates.¹

In-office or external marketing strategies—typically both—can be used to achieve practice goals.

- Examples of in-office marketing: Distributing handouts or flyers in the waiting room or exam room that advertise the practice’s services; asking existing patients to refer friends or family.
- Examples of external marketing: developing a website and ensuring prospective patients know about it; direct mail; advertising in local publications or at health events.

The practice’s approach to marketing will depend on budget and business objectives. Marketing can be used to increase patient volume, raise your profile in the field of rheumatology, attract the best talent to the practice, expand the patient referral network, develop income streams from various areas, add ancillary service lines, and increase revenue from procedures or treatments not covered by insurance.

Getting Started

When you have decided to market your practice, perform an environmental market scan by looking at the market or the area where the practice is located. Performing an environmental market scan will help you understand your patients’ needs in the area. Generally, these patients’ needs and demands are more focused on particular services and treatments that patients with rheumatic diseases would look for when choosing a rheumatologist. For example, if your practice is located around a retirement community, containing a majority of patients with rheumatoid arthritis, it may be good for the practice to consider having an in-house infusion services to accommodate the majority of the patients in your community. You will also want to perform an environmental market scan to get an insight to services the other rheumatologists in your area are offering to patients. Reviewing what other practices offer will help you to identify opportunities for practice promotion, what services can be eliminated, and what areas of your practice need improvement in order to be successful.

Marketing your practice will help you build excellent relationships with other physicians. Considering most rheumatologists receive patients from referrals, marketing your practice makes your name known to primary care physicians or other physicians who would typically refer patients to a rheumatologist. Marketing your practice is also a way to let drug or product vendors know you are practicing in the area.

Developing a Marketing Plan

A marketing plan begins by deciding what goals you want to reach through marketing. In chapter three we discussed creating a mission statement and business plan for your practice, which included establishing goals for your practice. Refer to that document again so you can begin developing the marketing strategies necessary to achieve those goals.
The Marketing Strategy

The marketing strategy answers two key questions: **Who are our rheumatology patients and how can we best serve them?** These questions are answered through market segmentation, targeting, and the location of the practice.

Market segmentation consists of dividing the market into distinct groups of buyers with similar needs, characteristics or behavior. Your initial market segments will include current and prospective patients, future practice partners, referral sources, medical vendors, colleagues, current and future staff; community leaders, lawmakers, the media, and even potential purchasers of the practice may become key market segments as well. Each of these groups might require different services, so it’s important to focus on those segments that will help you best achieve your business objectives. For instance, colleagues and referral sources can refer patients in order to build the practice’s clientele; medical vendors could provide certain drugs and equipment at discounted prices. After defining the market segments, evaluate the attractiveness of each segment and select one or more segments to enter based on your ability to profitably generate the greatest customer value and sustain it over time. This process is called target marketing.

Target marketing is determining the area your types of services you provide engage within the needs of rheumatology patients. Create a simple position statement that markets the services you provide in a unique way to differentiate those services from other rheumatologists in order to give you a strategic advantage within the target markets. To do this, you must seek out possible competitive advantages that the practice has that will offer the patients greater value. For example, a position statement could describe the services you provide that the other rheumatologists in your area do not, such as an infusion lab, DEXA, or massage therapy. Keep in mind that you do not want to hinder any relationships you have developed with the other rheumatologists in your area. Be sure to only state your strengths without stating anything negative about the other rheumatologists in your area.

The Marketing Mix

A medical practice’s marketing mix, also known as the four P’s of marketing, will consist of the product, price, place, and promotion. These four P’s are the limits that the medical practice can control, subject to the internal and external constraints of the marketing environment. The goal here is to make decisions that center these four P’s on the patients in the target market in order to generate patient satisfaction. In a medical practice, the product is the type of service the rheumatologist offers, the price is the fee schedule that the rheumatologist sets, the place is the location of the practice, and the promotion includes advertising, referrals and public relations. In a rheumatology practice, for example, the product could be having a massage therapist, the price would be the price to hire and pay for a massage therapist, the place would be where the rheumatology practice is located, and the promotion could be newspaper advertisements about the practice’s massage therapist and referrals from relationships the rheumatologist has established with other physicians. Consideration of all elements must be used to create a plan that will achieve the practice’s objectives by delivering value to patients.

Marketing Action Plan

After understanding your practice’s market, you need to put the goals and objectives into an action plan. Your practice’s action plan should be created to achieve its specific goals and objectives over a defined period of time. A properly implemented marketing plan is constantly being assessed by accurate and consistent tracking systems to evaluate the plan’s performance against expectations.

Examples of how to get started in marketing your medical practice:

- Conduct a patient satisfaction survey. The practice may discover lurking problems as well as confirm what you’re doing right. See Appendix V for a sample patient satisfaction survey.
- If the practice does not already have one, create a website.
- Determine the “ideal patient” profile and how to reach those patients. Offer to speak to consumer groups or organizations on health and wellness topics in rheumatology. Sponsor a community or charitable event. Write a column for a local paper.
- List patient referral sources and ways to cultivate relationships with them. Make these lists available and accessible during their visit and on the practice’s website.

- Offer help as an expert in rheumatology to local media health reporters. Stay in touch by periodically sending them story ideas or commentary on current issues. Seek professional coaching to improve your comfort level and skills for media interviews.

- Host presentations for patients and the public. To broaden the reach and share costs, team up with businesses relevant to rheumatology.

- Publicize the practice’s good news including speaking engagements, new hires, and commentary on current developments in rheumatology, sponsorships and professional honors. Newsletters or simple bulletins work well, via print or e-mail, to your patient and referral database.

- Join the rheumatology state society.

- Advertise the practice in rheumatology newsletters or publications.

- Advertise on TV or radio.

- Hire a medical marketing consultant to help you get started.

- Join the local Chamber of Commerce and host a social or give them flyers to give out.

- Buy a full page ad in the area’s Welcome Wagon’s coupon booklet.

- Make the rheumatologist and the practice known to the local pharmacies, grocery stores, restaurants, etc.

- Contact and meet with local pharmaceutical reps. Reps know a lot of other physicians.

- Distribute refrigerator magnets, writing pens, and even envelop openers with the practice’s name and information on it.

- Consider having raffles, giveaways, or giving free first time visits to new patients if the practice can afford it.

- Reach out to other rheumatologists and physicians within the community by hosting a social or dinner meeting in order to get to know one another. Also, consider sending out flyers to physicians in the area who could potentially refer patients to the practice.

**Mini Marketing Plan Example**

*Mission Statement:* Advance Our Practice.

*Goals & Objectives:* Add a physical therapy department to our practice.

*Strengths & Weaknesses:* Strengths – good land to expand and add onto, great financial situation, great patient satisfaction, positive staff, have EHR system; Weaknesses – small practice (one rheumatologist), not enough patients, new to the area.

*Customer Analysis:* There are many patients in the area with rheumatic disease, and many of the patients we currently see need physical therapy.

*Competitor Analysis:* Strengths – been in the area for five years, have a DME store in practice, large number of patient clientele; Weaknesses – don’t have a physical therapy department, doesn’t have a good land to expand on, high turnover rate in staff, still does not have an EHR system.

*Environment Analysis:* Medium size community with a small assisted living community just inside the perimeter. Very advanced technology used within the area. Majority of area is age 40 or above.
Marketing Mix: Product – (One) Physical Therapy Department; Price - $65,000 (therapists salary-1), $250,000 (construction), $100,000 (equipment), $200.00 (advertisement), $615,000 (estimated total); Place – Connected to our practice (still in our community); Promotion – Newspaper ads, newsletters to our members, ad on our website, radio advertisement. See Appendix II for a more in-depth marketing plan example.

Conclusion
Like any other business, marketing your medical practice is essential to its success. Make sure you understand the needs of the community you will be serving as well as what you are able to spend to make your practice visible.

Be open minded and listen to those who are involved in this venture with you—spouse, partners and staff should be involved in developing a plan to grow the business. There are various marketing techniques and don’t be afraid to use all the resources available. Contact your local newspaper and the media to establish yourself as the medical expert in your area.

Keep in mind that this is your practice and it will only go as far as you take it—businesses can fail because of ineffective marketing.

References
CHAPTER 8: UNDERSTANDING MANAGED CARE

In the current health care environment, managed care has become the primary method for delivering health care. The term “managed care” is used to illustrate an assortment of methods to improve the quality of care for patients as well as to reduce the unnecessary costs of providing health care. The term can also be used to describe systems of financing and delivering health care to beneficiaries structured around managed care delivery systems. Practices or organizations that use these managed care methods are called managed care organizations, or MCOs. The passing of the Health Maintenance Organization Act of 1973 is what stimulated the growth of the managed care in the United States. Even though managed care is omnipresent in the United States, it has still gained some controversy because it has failed in its overall goal of controlling medical costs. The concept of managed care can best be understood through its key cost saving components such as: utilization management, price discounting, and risk contracting.1

**Utilization management**

Utilization management is when health care services and procedures are evaluated on their appropriateness, medical need and efficiency. They are evaluated based on the given criteria or guidelines set by an applicable health benefits plan. In general, it was created to decrease unnecessary health care procedures. Practically all managed care plans have some utilization management. Their procedures are based on the contract between the insurer and the beneficiary. Even though it may decrease the overall cost of health care, it can still increase costs for physicians by increasing their increase in paperwork and the staff cost associated with the approval of prior authorizations.

**Price discounting**

Price discounting is used to decrease overall health care costs through a lower charge for health care services or procedures. It is based on the retail performance of switching a discount from a retail charge with a guarantee of an increase in volume from the supplier. Generally, it is a reduction to a basic price of health care products or services. It can sometimes be referred to as trade discounting or quantity discounting. The discount equals the amount of the original price minus the price actually paid for the service or product.

**Risk contracting**

Risk contracting is a concept that ties an overall outcome and cost of medical care to a financial compensation rather than to the actual services provided by a physician or practice. It is common in capitation and fee-for-service arrangements. There has been a decline in plans using risk contracting due to specialists resisting to be involved as well as there being fewer patients in risk contracts.

**Managed Care Plans**

There are many types of managed care programs. Rheumatologists are most likely to deal with managed care plans such as managed indemnity plans, preferred provider organizations plans, and health maintenance organizations plans. However, all managed care plans range from more restrictive to less restrictive and differ greatly in price. The difference in the flexibility of these plans is best shown in the managed care continuum. The managed care continuum shows the broad categories of the managed care plans. The following is an explanation of the managed care plans that are listed on the managed care continuum.2

**Managed indemnity**

A managed indemnity plan is the least restrictive form of insurance when concerned with cost control measures. Managed indemnity can sometimes be described as using managed care techniques with a provider network. These plans do not have a
specialist referral requirement or many cost control features. These plans were common before the soar of managed care. They are a type of medical plan that reimburses the patient and/or the provider as expenses are incurred. The insurance company pays a percentage of each covered service after the physicians has provided the services to the patient. They are sometimes known as fee-for-service plans in which the provider sets the fee for each service in the practice.

**Service plans**
Service plans are similar to managed indemnity plans, but with the addition of a contracted provider network. Insurers under these plans contract directly with the providers. These types of plans stop practices from balance billing. Balance billing is when rheumatologists bill patients directly and charge more for services provided than what the insurer pays (minus any copays, deductibles and coinsurance). The insurer specifies a maximum fee schedule for the practice or physician.

**Preferred provider organizations**
Preferred provider organizations are also referred to as PPOs. These types of plans contract services from a select group of providers. The providers selected participate based on their cost efficiency, community reputation, and scope of service. Providers entering into a PPO agreement must abide by certain utilization guidelines and fee schedules. Under these plans, care is paid for as it is received. They provide a fair amount of patient choice and allow for access to out-of-network providers at a higher level of co-insurance and deductible. A patient under a PPO has a primary care physician within the network who will handle referrals to rheumatologists that will be covered by the PPO. For patients with Medicare, some Medicare Advantage Plans are PPOs.

**Exclusive provider organization**
An exclusive provider organization is also referred to as an EPO, and is similar to a PPO; however, it limits its beneficiaries to participating providers and provides no coverage for out-of-plan care. EPO insurance carriers are able to discuss lower rates with providers than other types of plans due to members only being allowed to use in-network physicians. In return for lower medical service rates, health care providers receive a steady stream of patients. Many of these plans use the gatekeeper approach, which requires a primary care physician referral for all specialist visits. An EPO usually focuses on preventative care and encourage members to take the necessary steps to remain healthy at all times.

**Point of service plans**
Point of service plans offer patients the option of using an out-of-network provider. The plans function as a combination of indemnity style and HMO coverage of out-of-network services. Patients under this plan can decide whether to use HMO benefits or indemnity style benefits for each instance of care. This allows for choice, but also helps control costs.

Point of service plans are organized in two categories, depending on vehicles, to provide the HMO services:

- **Primary care preferred provider organizations:** Primary care preferred provider organizations function as a cross between an HMO and a PPO. This model relies on the use of a gatekeeper to authorize services. The primary care physician will be reimbursed either by capitation (fixed annual fee) or by fee-for-service with the use of withholds.

- **Point of service HMO:** A point of service HMO plan allows members to choose whether to use HMO benefits or indemnity benefits for each encounter. It typically incorporates high deductibles and coinsurance to encourage members to use HMO style services within network rather than out-of-network service.

**Health maintenance organizations**
Health maintenance organizations, or HMOs, are the least flexible arrangements in managed care. They include both health care financing and the delivery of services to the enrolled beneficiaries. Several HMO models exist and are defined based on the relationship between the physician and the HMO. Two of the HMO models are listed below:

- **Open panel HMO:** The open panel HMO model closely resembles the PPO. It differs by not using the gatekeeper approach and by possibly charging a higher copayment or co-insurance based on a specialty to encourage patients
to use their primary care physicians. Many of these plans depend on the use of case managers to reduce costs. The Independent Practice Association, or IPA, model HMO is the most common form of the open panel HMO. IPA model HMO is formed when an HMO contracts with independent physicians in private practice or with an association of physicians who serve HMO members along with other patients.

- **Close panel HMO:** The close panel HMO model exclusively contracts with physicians and does not allow contracted physicians to see patients outside of the HMO. The most common forms of a closed panel HMO are the group HMO model and the staff HMO model. The group HMO model contracts with multi-specialty groups to provide services to their members and the physicians remain employees of the medical group rather than the HMO. The staff HMO model employs physicians who are paid on a salary basis. These physicians practice in HMO-owned medical facilities that only accept HMO beneficiaries. The HMO will employ physicians in the most common specialties and contract with physicians in subspecialties for services that are needed less frequently.

**Medicaid**

Medicaid is a federally and state governmentally funded program. This program, or health care plan, pays for the medical care of patients who cannot afford it. In order to get Medicaid, an individual must meet certain requirements, such as a certain income level, and must also go through a somewhat extensive application process. Each state is allowed to manage its own Medicaid program. States are allowed to put in place their own requirements and guidelines.

**Medicare**

Medicare is the largest single medical benefits program in the United States and is operated by the Centers for Medicare and Medicaid Services, or CMS. It was authorized by Congress as part of the Social Security Act Amendments of 1965 to offer identical benefits in all fifty states. Medicare is administered regionally by an insurance company chosen by CMS to act as the fiscal liaison. It serves Americans who are at least 65 years old, some disable people under age 65, and people of all ages with end-stage renal disease. Medicare was initially developed as a two part program, Parts A and B, but has added Parts C and D.

- **Medicare Part A** is available premium-free to all who are eligible for Medicare. Care received in hospitals, skilled nursing facilities, home health and hospice services are covered by this plan.

- **Medicare Part B** is available to Medicare beneficiaries for a monthly fee or premium and extends coverage to services not offered under Part A. This coverage includes physician services, outpatient hospital care, and other medical services such as clinical laboratory services, physical, occupational, and speech therapy and durable medical equipment.

- **Medicare Part C** is also known as Medicare Advantage, and allows beneficiaries to enroll in private health plans such as a PPO or HMO. Medicare then pays the insurer a set amount each month to provide benefits to beneficiaries. These benefits must be no less than as good as the original Medicare plans. They must cover everything that Medicare covers. Many of these plans propose extra benefits not offered through the original Medicare plans. Beneficiaries may have to pay a monthly fee or premium in addition to that paid for Medicare Part B and Beneficiaries may also be required to pay a copayment for each practice visit.

- **Medicare Part D** offers outpatient prescription drug coverage administered through private health plans. Health care plans will contract with Medicare as either an individual plan or as part of a Medicare Advantage plan. Medicare approves and regulates the programs, but the insurer is entitled to choose what drugs are covered and at what level they are covered. Beneficiaries who are considered eligible will receive financial support in obtaining Medicare Part D coverage.

Medicare as a primary insurance is often supplemented by private coverage, such as Medigap, which is sold by private insurers and employer sponsored supplement plan. This will help to cover the patient’s deductible and co-insurance requirements. Medicare serves mostly as a primary payor, but can sometimes act as a secondary payor. Medicare typically is secondary to group health coverage for those who continue to work past the age of 65, liability coverage such as automobile accidents, and workers compensation claims.
Medicare as a Payor

Physicians treating Medicare patients can contract as participating providers, non-participating providers, or may decide to opt out of Medicare and treat beneficiaries as private contractors. In order to become a participating provider, you must agree to an annual contract and accept Medicare’s allowed charges as payment in full for all claims. Generally, Medicare will pay 80 percent of the approved amount and the patient’s secondary insurer will then be responsible for paying the provider the remaining 20 percent of the approved amount. If the patient’s secondary insurer does not pay the remaining approved amount, the patient is then responsible to pay the balance of the approved fee schedule amount.

Medicare reimburses physicians according to the Medicare physician fee schedule, also known as RBRVS. The Medicare fee schedule is published every year in the Federal Register and takes effect on the first of January the following year. The Medicare fee schedule is used by most payors. More information on the Medicare fee schedule can be found in the online ACR Rheumatology Coding Manual.

There are several incentives that Medicare offers to encourage participation. These incentives can include a direct payment of all claims at a rate of five percent higher than nonparticipating providers, faster processing of claims, and a yearly publication of regional participating providers made available to beneficiaries. Participating providers who accept referred Medicare patients from non-participating providers will receive reimbursement at a rate of ninety-five percent the allowable amount, of which Medicare will reimburse eighty percent leaving the patient responsible to pay for twenty percent.

Medicare is only required to pay for services that are considered medically reasonable and necessary and will not cover any procedures considered experimental or investigational. For a procedure to be considered medically necessary, it must be:

- consistent with the symptoms or diagnosis of the illness or injury under treatment
- deemed necessary and consistent with the generally accepted professional medical standards
- provided primarily for the convenience of the patient, attending physician, or other provider

In order to receive compensation for a service that will not be approved by Medicare, an Advance Beneficiary Notice, or ABN, must be signed by the patient prior to receiving the service. The ABN explains the service that was provided, the reason why Medicare will deny the claim, and states that the patient is responsible for payment. The ABN must be signed and secured before the service is performed.

Medicare beneficiaries can also enter into a private contracting agreement directly with a physician who has opted out of Medicare. Providers cannot submit a claim to Medicare for two years after deciding to opt out of Medicare. Also, a provider must continually opt out every two years in order not to be automatically enrolled a Medicare provider again.

Under the private contracting agreement, no Medicare payment will be made for services provided to the patient and the patient is required to pay whatever the physician charges. In order for the Medicare beneficiary to enter into a private contract, the beneficiary must sign a contract that clearly states that he or she agrees to give up all Medicare payments for services furnished by the opted out physician; he or she agrees to the liability for all the physician’s charges without any of the Medicare balance billing limits; he or she accepts that Medigap or any other supplemental insurance will not pay towards the services provided; and he or she reserves the right to receive services from participating physicians. In order to formally opt out of Medicare, the physician must then file the signed contracting agreement with CMS.

Contracting

You are not entering into the contracting process as a rheumatologist, but as a private business owner. You have the right to choose whom you want to do business with. Entering into an adverse agreement because you feel an obligation to contract with the payor or without knowing how much it costs to deliver a service and what reimbursement is necessary to meet expenses are mistakes you cannot and should not make. If the delivery of services costs more than the reimbursement you receive, then you cannot afford to render services.
Managed care contracts are intended to support the managed care organization and they are constantly developing new contracting approaches that increase discounts for services and shift the financial risk to rheumatologists. In order to survive and thrive in today's managed care environment, it is necessary for every practice to develop a plan for success in managed care. That plan includes assessing the managed care environment, evaluating your business and the practice's strengths, analyzing the managed care's financial impact, and negotiating a good contract that can ensure a long and profitable life for the practice.

Assessing the Managed Care Environment
Managed care organizations remain financially practical through medical management and decreasing the use of more costly modalities of care, such as specialty care. Therefore, it is important for rheumatologists to understand their role in managed care and how to be competitive in the managed care market.

Knowing the market is the first step to successfully entering the managed care market. Carefully examine the environment to see what managed care plans are present. You need to know your referral sources, your costs for providing care, and how to provide care that meets your needs and the payor's requirements. Next, look for other opportunities within your environment and area. Look at other employers in the area to see what managed care products they are purchasing and how the rheumatologist fits into their plan. Also, identify what plans the rheumatologist's competitors and others in the health care community are contracting with. By doing this, it will help you to recognize those plans that are particularly desirable in your community.

In order to ensure that a favorable agreement is reached with a payor, conduct adequate preparation and planning before entering into any negotiations. It is important to make sure the payor is financially stable and has a good reputation for paying claims in a timely manner. Ensure the payor will give you the appropriate authority in the clinical decision-making process when treating their patients. Having a positive approach to managed care contracting will help you find the payors that are best for your practice.

Assessing the Practice
The payor will want to know the best and most attractive aspects of the practice. They may also want more details about the practice such as what specific attitudes, abilities and systems the rheumatologist has within the practice. They are going to want to make sure that the practice has the ability to manage utilization, comply with regulations and procedures, ability to work with other providers in the community, and to be able to follow guidelines. Collect data for each of the following areas before entering any payor negotiation:12

- **Patient Demographics:** Collect patient demographics within the community to compare your patient base with the beneficiary population of the managed care plan. This will keep you from contracting with managed care plans that have few patients with rheumatic diseases.

- **Medical Services Required:** Obtain billing records to determine the most frequently performed services and procedures in your practice. This can help keep track of the types of patients seen, the problems they have, and the treatments or services most often rendered.

- **Payer Mix:** All of the first, second, and third party forms of payment are included in your practice's payer mix. Review past billing records to create statistics on each payor's contribution to the practice's revenue and the number of patients who are covered by which payor.

- **Referral Source Mix:** Patients will either be self-referred or referred by other patients or physicians. Keep records of how each patient found out or came to your practice. Identify the referral patterns and which patient or primary care physician referred them to ensure a managed care contract will not affect current referral sources and relationships.

- **Referral Source and Patient Satisfaction:** Conduct surveys of patients and referral sources to determine what you are doing right and what you doing wrong so that you are aware of weaknesses rather than having the managed care payor point them out.
• **Treatment Outcomes:** Demonstrating the quality of care you provide through patient outcomes is vital. Patients’ outcomes can be found in their medical records. Continue to track the collected data mentioned above by keeping records of each topic, updating annually or semiannually.

After gathering all of the necessary information, adjust your practice to be more attractive and competitive in the managed care environment. Some other possible documentation to have on hand includes procedural manuals, staff job descriptions indicating responsibility for managed care related issues, written testimonials from relevant stakeholders and articles showing the rheumatologist’s involvement in the local and professional community. This documentation will support characteristics that the managed care organization is looking for like successful communication skills, positive grip of the managed care concept, compliance to change with the constantly evolving health care environment, admiration of the requirements from the managed care payor, obligation to your patients, and willingness to go the extra mile for their beneficiaries.

Know your accounting and financial figures too and when looking at your practice’s weaknesses, you should also know the weaknesses of your staff, technology, and even your practice’s décor. You need to be fully prepared in case the managed care payor picks your practice apart.

**Contracting with Managed Care Organizations**

In today’s health care environment where the majority of services are billed and reimbursed through third-party payors, physicians must know their patient and payor mix and understand the financial impact of every managed care contract on their practice. The more you depend on one contract as a source of revenue, the more power that payor has during renegotiation, making you more dependent on that payor for its financial stability. It is important that you try to contract with as many managed care organizations as you need in order to reduce the risks associated with and dependence on any one payor.

After thoroughly looking at your practice, find and negotiate a few contracts that will constitute a small portion of your payor mix. You can use these negotiations to practice and to learn about new requirements that you may not be prepared for. This will prepare you for contracting with the larger, better-paying payors which will represent a substantial portion of your net income. Therefore, it is important for you to have a successful contracting with these organizations due to them having the ability to make or break your practice.12

It is critical that you understand all terms found in the contract before agreeing and signing it. Most managed care contracts are standard agreements used for all physicians and remain consistent throughout the industry, sometimes only differing by payment arrangements. Always keep in mind that you do not always have to accept the contract as it is.7 Be sure to review all attachments, addenda, and documents included with the contract and ask to review copies of the managed care organization’s policies and procedures, especially the ones that typically address a wide array of patient care and other issues which may also be considered part of the contract. Refer to Appendix VII for a sample managed care contract.

**Anatomy of a Managed Care Contract**

The managed care contract should be approached as a document that will formalize the rheumatologist/managed care organization relationship and develop the framework for a long-term successful partnership in patient care. The contract should encourage a positive relationship by providing a positive gain for both parties, and also provide important and desired protections if the relationship becomes inconsistent. The contract should provide a clear understanding of the rights and responsibilities of both parties. Terms of managed care contracts vary according to the issues, concerns, objectives, and also by the negotiating strengths and weaknesses by each party. Below is a broad description of the standard managed care contract structure:2

- **Names:** This paragraph names both parties involved with entering into the agreement.
- **Recitals:** This part of the contract fully explains who both parties involved in the contract are and what both parties are trying to accomplish with the agreement.
- **Table of contents:** This page(s) of the managed care contract lists everything in the contract.
Definitions: Managed care contracts tend to contain complex terms that need further explanation. These complex terms that are on the “Definitions” page(s) and are often capitalized within the contract. The definition of some terms, such as medical necessity, can be directly associated to how and if a physician is paid for a service. Utilization review program, emergency, member, subscriber, medical director, provider, and payor are some of the common terms that are defined in a managed care contract that are important.

Provider obligations: This section includes parts like the following:

• Provider qualifications and credentialing: The managed care contract should state that the provider meets accreditation standards and Medicare conditions for participation such as: the provider meets the managed care plan’s relevant requirements to participate within the network; the provider has a legal, legitimate license; and that the provider has not been has not been barred from participation in any federal health care program.

• Provider services: The managed care contract should contain a description of the services for which the MCO is contracting. Sometimes these descriptions of services are in an attachment or could also be referred to as provider services to denote the range of services that is to be provided under the contract. The contract should also specify to whom the provider is obligated to provide services to and identify who is a covered enrollee. It should also assign the responsibility for payment if services are provided to a non-covered patient. The responsibilities to accept or refer enrolled patients, the list of days and times the provider has agreed to be available to provide services, and arrangements to have a substitute on-call (if required) are all possible provider responsibilities that will also be mentioned in detail on this section.

• Nondiscriminatory requirements: The section on nondiscriminatory requirements mentions that the provider should provide services in the same way as he or she provides services to those non-managed care patients. It also mentions nondiscriminatory regulations in agreement with federal law.

• Compliance with utilization management and quality improvement programs: The managed care contract will also have a part that lists out the responsibilities of the provider with regards to carrying out the managed care organization’s utilization review program. Since this information is updated frequently, the utilization review program is often added on to the contract as an exhibit or added as a reference. Always request and keep a copy of the guidelines if they are not included, and should thoroughly review them before signing the managed care contract. This section of the contract will also notify providers of their responsibility to cooperate or comply with the efforts to guarantee compliance and the implications of the provider not meeting the guidelines.

• Acceptance of enrollee patients: This clause typically states that the physician will accept enrollees regardless of health status and provide fair and reasonable procedures for allowing the provider to limit or prevent new members added to his or her panel. This section should also indicate the circumstances in which the provider can terminate being an enrollee’s physician. The language in the contract should be consistent with the language used in the MCO’s member subscriber agreement. The language should also be in compliance with all licensure requirements and/or requirements with the federal health care program.

• Enrollee complaints: This section may require that the provider cooperate in resolving enrollee complaints and to notify the managed care organization within a specified period of time when any complaints are conveyed to the provider.

• Maintenance and retention of records and confidentiality: This clause requires the provider to maintain both medical and business records for certain periods of time. It also usually states that the obligations endure the termination of the contract. The managed care organization may also want the right to legally have access to the provider’s financial, medical, and administrative records in order for the managed care organization, for representatives of the managed care organization, as well as for government agencies to be able to review, inspect and make or obtain copies.
Negotiate limiting the availability of this particular information to enrollees to only being available after reasonable notice and only during normal business hours. Review your state's laws to verify that the managed care organization can actually have the right to have access to your medical records before signing the managed care contract.

Payment: The payment terms are often attached as an exhibit to the contract and are cross-referenced throughout the agreement. A number of payment issues should be covered. These include who is responsible for collecting copayments and the managed care organization’s responsibilities for uncovered services. This section of the contract should give a clear understanding of what is required for a service to be authorized and the method in which the claim is to be made. It should also state the information that is to be provided in a claim and state whether or not the managed care organization has the right to delegate or revise that information in the future. The payment terms should explain all time obligations relating to provider submittal of claims and explain the managed care organization’s responsibility to pay the submitted claims. It is important that all payment terms be consistent with the proper state or federal laws regulating such payment. This section should also attend to the reconciliations to account for overpayments or under payments.

There are some states that have laws that limit the time period in which the managed care organization can recoup previously paid amounts from their contracted providers or the providers are allowed to request additional payment.

Risk-sharing arrangements: Risk-sharing arrangements can be the most complex and complicated portion of the managed care contract. Risks can be shared in varying degrees depending on the amount of risk transferred, the services for which the provider is at risk, and whether the managed care organization offers stop-loss protection. All risk-sharing provisions should be in compliance with the proper state and federal laws that regulate these arrangements within the managed care contract.

Other party liability: Subrogation and coordination of benefits: This section of the contract will contain provisions to address any situation in which a party, other than the enrollee or managed care organization, is financially responsible for all or part of the services rendered to an enrollee, meaning the managed care organization playing the role of a secondary carrier. Negotiate these provisions to state that the secondary payor will supplement the payment made by the primary payor. This way, the provider will receive the primary payor’s full allowable amount.

Hold harmless and no balance billing clauses: Under the hold harmless clause, the provider agrees not to sue or declare any claims against the enrollee for services covered under the contract, even if the managed care organization becomes bankrupt or fails to uphold its obligations. Under the no balance billing clause, the provider agrees not to balance bill a member for any payment owed by the plan, regardless of the reason for nonpayment.

Relationship of Parties: The managed care organization and the provider, under this provision, have an independent contractual arrangement and contest the statement that the provider serves as an employee of the managed care organization. A clause that is associated with this provision, and may also be included in this section, states that nothing contained in the agreement shall be interpreted to require physicians to suggest any procedure or treatment that physicians consider professionally inappropriate and affirms that the managed care organization is not engaged in the practice of medicine. That statement protects the managed care organization from provider’s negligence liability issues that may arise.

Use of Name and Proprietary Information: In this provision, the ability for both parties to use the name of the other is limited. It is completed by determining the circumstances in which the party’s name may or may not be used.

Notification: Under this section, the contract should show the information that is required to be communicated to the managed care organization as well as the time frames for providing this information.

Insurance and Indemnification: Insurance provisions are usually very straightforward. The obligations stated in the contract may be for both professional liability coverage and general liability coverage. The managed care organization likes to make certain that the physician sufficient coverage for any eventuality. The contract will state particular insurance limits,
given that the limits will leave it up to the managed care organization to specify. Cross-indemnification provisions are also common in managed care contracts. This provision states that each party indemnifies the other for damages caused by the other party.

**Term, suspension and termination:** This section identifies the term of the contract and the term of contract renewals. Many contracts have automatic renewal requirements if no party exercises its right to terminate within a specified time period before the renewal date. There are some contracts that give a right of suspension to the managed care organization. Under the suspension section, the contract continues; however, the provider loses specific rights. Under the termination provisions there are two categories: termination without cause, and termination with cause. If the managed care organization has the right to terminate without cause, usually the provider will also be given that right.

There are some states whose laws require providers to continue to provide services for a specified period of time after their contract has terminated. Those provisions are intended to guarantee continuity of care for people treated by a provider at the time of the provider’s termination, if a managed care plan includes a requirement to continue care in the contract. These provisions should ensure that the provider will continue meeting the contractual requirements with regard to the services for which the plan continues to cover after the termination. Many managed care contracts will give either party a period of time to cure any contract violations prior to termination. The contract should give the managed care organization the right to instantly terminate the contract upon the occurrence of certain events, including the provider’s loss of licensure or accreditation or barring from a federal health care program.

**Declarations:** In declarations clauses, the parties must provide answers to various “what if” questions. These clauses and provisions are common to all contracts:

- A force majeure clause relieves a party of responsibility if an event occurs beyond its power.
- A choice of law provision determines the law that will apply in the event of a dispute.

### HOW WELL DO YOU KNOW THE CONTRACT?

**Answer the questions below about your contract to find out:**

1. What payment method does the managed care plan use to determine compensation?
2. How does the proposed reimbursement mechanism relate to your payor mix and how does this fit into your practice's overall business plan?
3. Is the managed care contract short-term, long-term, or self-renewing?
4. Is the contract agreement clearly defined throughout the contract? Does the contract identify which plan(s) are covered in the contract? If the plans are changed or new plans are added, do you have the right to opt out of those plans?
5. Does the managed care contract contain an inflation guide?
6. Is the termination notification for only ninety days, with ninety days being the best practice?
7. What are the provider’s obligations to continue to care for patients in treatment at the expiration of the contract, and also the payor’s obligations to pay for it?
8. Is an advanced beneficiary notice accepted for uncovered services?
9. Does the provider have the right to obtain payments from members for uncovered services?
10. Is there an exclusivity clause?
11. Does the managed care organization subcontract claims processing, coordination of benefits and utilization management?
12. Does the managed care organization act as a third-party administrator for any self-insured plans?
13. Is the term “medically necessity” clearly defined in the contract? Do you know the criteria for medical necessity?
14. Is there a clearly, identified definition of “covered services”?
15. Does the managed care contract include a provision that bans reassignment of the contract without consent?
16. How many days of advance notice to providers is required for modifications in payments, covered services, procedures, documents, and requirements with “substantial impact”?
17. Is there an agreement within the contract that there will be HIPAA compliance?
18. Is there a clear definition of “observation services” or “observation care” within the contract?
19. Does the managed care contract include the definition of a clean claim, time frames for submission and payment of a clean claim, and mechanisms for dispute resolution audits and refunds?
20. What does the managed care contract outline as the disagreement resolution process and does the contract define the time period?
A merger clause indicates that only the language in the agreement will constitute the contract.

A provision allowing or not allowing parties to assign their rights is commonly included in managed care contracts.

A clause specifying how the contract will be revised is almost always included in a provider contract.

A severability clause allocates the contract to continue if a court invalidates a section of the contract.

A notice requirement identifying how notices are provided to parties and to who can also be included in managed care contracts.

Closing: In the closing section of the managed care contract, it is important for both parties to confirm that the parties identified at the beginning of the contract are the parties that signed the contract. In order to make sure all language of the contract is understood and that the original parties signed the contract, an attorney can be present during the negotiations. The practice should also have their attorney present.

Coding, Claims, Billing & Collections

Now that the contracts with managed care organizations are secure, make those contracts profitable. In order to achieve the greatest reimbursement for services performed, you should know and understand the entire claims generation process and work to ensure accurate billing and coding.\textsuperscript{14}

The coding of claims and billing process will sometimes include denials and appeals processes. The medical practice should also develop patient responsibility information that all staff and patients should be aware of. It is important that each medical practice develop a policy and procedure describing the patients’ performance of their financial responsibilities to the medical practice. This will also be viewed as their commitment to supporting the physician-patient relationship. This payment policy of patients’ financial obligations should be given to every patient and signed by every patient. By signing this financial policy, the patient is agreeing to allow the practice to discuss the patient’s financial account with the insurance carrier. In order to get a better understanding of these processes and policies, please refer to ACR resources like the ACR Rheumatology Coding Manual online at www.rheumatology.org/practice.

Cash Practices

Managed care contracting can be complex and frustrating for practices and physicians. Figuring out and understanding the managed care contract and its rules require a considerable amount of administrative costs and time. Most practices and physicians know that insurance companies are not always prompt in delivering reimbursement and for some practices that can cause significant financial problems. For these reasons, many practices and physicians are looking to alternative ways of running their practices, referred to as “cash practices.” A cash practice can be one or more of the models below:\textsuperscript{17}

• Fewer health insurer contracts: With this model, the practice reduces the number of health insurer contracts they have. You would continue to see patients who are under the terminated plans as an out-of-network physician. The practice can collect payment from these patients by either collecting payments in full at the time the services are rendered, or by billing the insurance company and then collecting the remaining balance not paid from the insurance company from the patient. Remember, that you terminate a contract with an insurance carrier, you are automatically considered an out-of-network physician and must collect more from patients as a non-participating physician than you did when contracted with the carrier.

• No health insurer contracts: Under this model, the medical practice chooses to terminate all health insurer contracts, including opting out of Medicare. Practices using this model should collect payments from patients in full at the time the services are rendered. A con for using this model could be the loss of referrals from participating physicians. A pro for using this model could be the significant decrease in overhead costs.
• **Concierge primary care with health insurer contracts:** A practice using this model registers patients for an annual fee in return for enhanced physician access, and contracts with a few insurers. These practices usually keep the contracts that are beneficial and reimburses in a timely manner. This model allows practices to be very selective in the contracts they keep because most of their revenue is derived from concierge provisions.

• **Concierge primary care with no health insurer contracts:** Practices who chose to practice under this model will strictly practice as a concierge practice and will have no contracts with health insurers. Most practices under this model are primary care physician practices, but sometimes combine primary and specialty care. An example would be a rheumatologist providing primary care for patients who have rheumatic diseases. Before implementing this model, you should be well-established within the community and have a loyal patient foundation; otherwise you may lose patients.

• **Time-of-service collections:** Using this model can help reduce patient billing and the risks of not being paid. This model requires patients to pay deductibles, coinsurance or copayments at the time services are rendered. With this model, you do not change any health insurer contracts. Using this model can help identify patients who are hesitant to pay so the situation can be handled immediately without months of billing disbursement and stress.

**Conclusion**

Managed care contracting can be, and often is, the main means of support of a medical practice. Ultimate financial survival of a medical practice depends on successful contracting with the managed care organization, providing services to their members, generating charges for those services, preparing and submitting a claim, and finally collecting the payments that the rheumatologist is entitled to.

Accurate billing and coding is dependent upon an understanding of the managed care organization, the policies and procedures it operates under, and the rules that the rheumatologist will be accountable for. The importance of claims management cannot be understated. There are some estimates of lost charges run as high as five percent of the total charges. This is a large amount for a small practice with relatively low margins.

Medical practices must also be aware that not every insurer is legitimate. Some phony health plans look and sound legitimate, but will leave the practice in financial ruin. These plans work hard to sound legitimate, they adopt legitimate sounding names, pay out small claims (although they ignore the larger ones), create authentic looking contracts and flashy marketing materials, promote their products through licensed insurance agents, partner with established trade associations and professional organizations and contract with established third-party administrators.

There are some steps that the rheumatologist can take to keep from falling prey to a phony health plan. First and foremost, always perform due diligence and know both the health plan and contract before signing. Trust one's instincts. Check with the state department of licensure and verify whether the plan is licensed. If something isn't right, file a complaint with the state department of insurance. For more resources regarding the managed care contract, visit the American Medical Association's website under their practice management center and review the National Managed Care Contract database and other helpful information.

**References**


CHAPTER 9: LEAVING THE PRACTICE

Educational leave, sabbatical, parental leave, extended illness, practice closure due to relocation, retirement, or better professional opportunities can all lead to the decision to leave a practice. The key to successfully closing, selling, joining another practice or simply handing over a practice, is planning. Planning for cessation of practice or leaving a practice should begin at least a year in advance. Tangible and intangible assets, medical records, avoiding claims of abandonment, addressing contractual obligations such as with health plans and malpractice carriers, notifying staff, notifying colleagues, and notifying patients are all issues to consider before leaving or selling a practice.

Follow these six steps to ensure your departure is a smooth one:

1. Address office space and equipment
2. Appropriately handle medical records
3. Review all contracts you’ve signed
4. Assess insurance coverage
5. Notify colleagues, employees and other professionals
6. Notify patients

Address Office Space and Equipment
Before leaving a practice due to retiring, joining another practice, or just selling your practice, determine how you will handle the physical office space, equipment, and other assets. If leasing, review the termination or transfer clauses. If you own the office space, consult with advisors to determine if the property will serve you better if it is maintained or sold. Contact both your accountant and attorney, and identify the best plan to proceed in a financially profitable way. You do not want to be forced to sell to the first bidder at the lowest price, so time is critical.

 Appropriately Handle Medical Records
Appropriate handling of medical records issues should be identified and managed at least six months prior to leaving or cessation of the practice. Obtain a copy of the state’s medical record laws and rules to identify how long and where you will need to maintain medical records. If you are selling the practice, the records may simply go to the buying rheumatologist or physician purchasing the practice; if you’re not selling, ensure that the handling of records is secure.

Identify how the administrative records should be handled, verifying how long to store records relating to the malpractice policy, corporation/practice documents, liability policy, business records (billing slips, encounter forms, accounts receivable and remittance advices), bank records, employment records, tax records and legal documents. If you are retiring, it is important that the method for termination of contract by checking with the contracted managed care organizations is determined.

Review Contracts
Take the time to review any and all contracts you have signed. This is the time to enlist the help of professional advisors, including your attorney and accountant who can help pick apart all contracts and mitigate any potential problems. This includes the review of employment agreements, managed care contracts, malpractice carrier contracts, and shareholders’ agreement if applicable. Review these closely and pay attention to advance notice provisions, non-compete covenants, and statements regarding accounts receivables and disbursement of final pay. These documents will detail what you promised to do and the practice’s obligations to you. The advance notice provisions will help to establish the departure timeline and keep
you in compliance with the requirements of the contracting managed care organizations. It is also important to go by the book. One might never know when they will need a reference from their former employer, so don’t burn any unnecessary bridges.

Non-compete clauses will factor into a new career path if you are planning to join or start a practice across town or down the street from the current practice. The contract may state a specific geographic distance for the new practice or that the rheumatologist will not be able to take any of your current patients or staff to the new practice. Be prepared and know what is expected after departure.

The language of managed care contracts will also play a role, if you are planning to start practicing in a new location within the same area. Depending on whether the managed care organization contracted with you individually or with your practice, you may have to go through the application and credentialing process again to enroll in some programs. If you are a partner or stockholder in the practice, review these documents to decide what your financial involvement will be after leaving the practice. You may have financial obligations after leaving the practice, especially if you personally assured any loans.  

Insurance Coverage
The timely notification for all individual organizations affected by your departure is an important step in ensuring a smooth transition. Malpractice carriers should be consulted. Ensure you have adequate coverage of all claims that are filed after departure. You may need to obtain a supplemental policy, or tail coverage, to insure for claims made after employment is formally terminated. Tail coverage is liability insurance that goes beyond the end of the policy period of a liability insurance policy. It is used with a claims-made policy to cover the rheumatologist for any claims made after he or she has dropped coverage with his or her prior carrier but in which the suspected claim of medical malpractice actually happened while he or she was covered by the prior carrier. This type of coverage is usually purchased from the previous claim-made carrier. Tail coverage usually costs between 1.5 and two times a rheumatologist’s annual premium and you will most likely be responsible for securing this policy, so it is necessary to be prepared for this expense. If moving directly to a new practice, try to negotiate tail coverage into the employment contract. Many employers will provide tail coverage or may be able to provide coverage with a retroactive endorsement date.

Notify colleagues, employees and others
The next step before discontinuing a practice is notifying colleagues, staff/employees, the local Drug Enforcement Administration office, and all outside companies. This group of people should be notified three months before discontinuing the practice.

The first parties that should be notified will be colleagues and staff. Take a proactive approach and discuss plans with them as soon as you’ve decided to leave since you’ll need their help to keep activities and events involved in the departure organized and free of problems. Colleagues or partners will need to have advance notice about the departure so that they can prepare and plan for business disruptions and possible workload increases. The rheumatologist or physicians who decide to stay may also want to begin the recruiting effort to find another rheumatologist. Then again, the departing rheumatologist’s partners may want to look at reducing staff hours after the departure and will need to take the proper steps in doing so.  

You have an ethical obligation to inform employees of your plans, especially if redundancies will be associated with the departure, such as closing the practice. These employees will need to find another job and start preparing for possible financial hardships until that employment is secured.

Specialty boards, professional societies, state licensing boards and federal agencies, such as the DEA, should be notified of the intent to cease practice as soon as possible. It is important to establish any changes in terms that will take effect. Ask each organization if they have any policies regarding notice and the handling of medical records, and provide a forwarding address for each organization. If moving to a new practice within the same area or the same state, ask these organizations about procedures to regain membership, licensure, or certification in the new area of practice. Don’t forget to draft letters requesting discontinuation of service or transference of name of the account, from providers of utilities (gas, water, sewer, electricity, etc.), telephone, answering service, janitorial service, linen service, landscaping services, etc. Request final bills from all these providers and keep copies of all notification of closure and other correspondence.
**Notify Patients**

Most states only declare that patients should be given ample notice to make alternate arrangements for care and that the physician should make sufficient attempts to notify all active patients. You may want to check with your state medical society to verify whether it has a set policy regarding the method and timing of notification. However, it is a good idea, and along the ethical guidelines of the American Medical Association, to give your patients, “reasonable notice and sufficient opportunity to make alternative arrangements for care.” This should be at minimum 30 days prior to your scheduled end date. Not only is patient notification of cessation of practice a necessity on ethical grounds, it also prevents allegations of patient abandonment. Patient abandonment is defined by the AMA as: “The termination of a professional relationship between physician and patient at an unreasonable time, and without providing the patient with the chance to find an equally qualified replacement.”

Some appropriate steps to take when terminating a patient relationship and transitioning your practice are:

1. As soon as appropriate, send patients a notification letter, including an authorization for the release of medical records, by certified or first class mail. These letters should:
   - Identify the reason for ceasing to practice
   - Include the official end date or closing date
   - Emphasize the importance of continued care for appropriate management of known conditions and preventative care
   - An introduction of a new physician, if appropriate, and how he or she may be contacted
   - Notification if a patient’s medical records will be transferred to that physician
   - A referral for continuity of patient care
   - Emphasize that the choice of a physician to continue care is ultimately up to the patients
   - Explain what patients need to do to obtain a copy of their medical records

2. Try to ensure that patients requiring ongoing care and those who require post-operative follow-up will continue to receive necessary care. Ideally, the physician should arrange to have another physician cover or assume care for these patients. For patients who are acutely ill or chronically ill and in need of continual medical management, inform them in person as well as with an official letter. Take this opportunity to reinforce the importance of continuing care and compliance.


4. Use other forms of notification in addition to an official letter, if appropriate. Consider an announcement that will play for patients when they are placed on hold or placing an announcement in a local newspaper.

5. Always give patients the information they will need to retrieve medical records. The physician may own the physical record, but the patient owns the information contained within it, and should have that made available for future care givers.

6. Take reasonable steps to ensure that patients can access the results of laboratory tests ordered by the physician, that all abnormal results undergo required review and follow-up, and that patients know whom to contact in order to obtain lab results.

If you are unable to interpret and follow up on tests personally, arrange to have another physician review results for patients with outstanding laboratory tests and make patients aware of the results and any requirements for follow up. Also arrange for patients to obtain their test results from the physician’s office or the testing facility, where the facility will permit, and provide patients with instructions to obtain follow up as soon as possible.
7. Make attempts to facilitate patient access to prescription medication required for long-term or chronic conditions. Where medically appropriate, provide the patient with renewals or repeats of the required medication in order to allow the patient reasonable time to find alternative care. Also advise the patient to attend another physician as soon as possible to have his or her prescription renewed.

After sending your official notice to patients, you will likely experience dramatic increases in appointment requests from patients who want to discuss their health concerns, plan or talk through options for continuing care, or just to say good-bye. It may be beneficial to plan ahead with staff and develop responses to anticipated questions. Remember that for some patients, ending the physician-patient relationship will be an emotional experience and appointments may take longer than usual. You should plan for additional time to reflect this need.

8. Finally, after your final patient has been seen, destroy all remaining prescription pads from your current practice and file your narcotics ledger for the required length of time.
### Closing/Leaving a Practice ✔ Checklist

#### One Year Before Closing/Leaving a Practice

**Office Space:**
- Space Leased by Rheumatologist
  - Review the office lease for specifics on termination.
- Space Owned by Rheumatologist
  - Consult with advisors to determine if the office space should be maintained or sold.
  - Contact accountant and attorney.
  - Look at accounts receivable.

**Six Months Before Closing/Leaving a Practice**

**Medical Records:**
- Obtain a copy of the state’s medical records laws and regulations.
- Maintain medical records 10 years from last patient encounter.
- Destroy X-ray films files after four years from last patient encounter if there is a separate interpretative report.
- Indefinitely maintain immunization records.
- Indefinitely maintain incompetent patients’ records.
- If selling practice, medical records may go to the rheumatologist/physician buying the practice.
- If closing practice, medical records will need to be stored and place must be determined.

**Health Plans Contracts:**
- Check all contracts for all payors to determine the method of termination of the contract.

**Malpractice Contracts:**
- Indefinitely maintain the malpractice policy, practice documents, and liability policy.
- Contact accountant and attorney regarding retention of practice office records (billing slips, encounter forms, accounts receivable, remittance advices from insurance payors) bank records, employment records, tax records, and legal documents.

#### Three Months Before Closing/Leaving a Practice

**Notification of Colleagues:**
- Notify all colleagues within the community and partners within the practice.

**Notification of Staff/Employees:**
- Notify all staff/employees within the practice.

**Notification of Professional Liability Carrier:**
- Notify the carrier of the intent to close/leave the practice and the rheumatologist’s plans to do so.
- Depending on type of policy, tail-coverage arrangements may be necessary.

#### Notification of Local DEA Office:
- Contact local DEA’s office for the approved method for drug disposal.

#### Notification of Operations/Maintenance/Bank Accounts/Creditors:
- Notify utility, telephone & answering services, janitorial services, linen services, landscaping and services.
- Notify banks in which the practice has an account.
- Pay all final bills needed to be paid.
- Notify all creditors of closure/leave by written letter.
- Request a final bill.
- Be sure to keep a record of all correspondences with creditors.

#### Notification of Professional Organizations:
- Notify the American College of Rheumatology of closure/leave.
- Notify the American Medical Association of closure/leave.
- Notify the State Rheumatology Society of closure/leave.

#### Notification of Patients:
- Send a letter to notify of the rheumatologist’s closure/leave to the patients that were seen within the last 36 months.
- Be sure to state the date of closure/leave in the letter.
- Ask for authorization to release records.
- Send a list of recommended rheumatologists for the patient to start seeing.
- Be sure to keep a copy of the letter sent out, the mailing list, and returned envelopes.

#### Notification of the Public:
- Place an advertisement in the local paper of the rheumatologist closing/leaving a practice.
- Place an advertisement in the local paper of the office equipment and supplies that may be for sale if closing a practice.

#### One Month Before Closure/Leaving a Practice

**Notification of Change of Address:**
- File a change of address form with the Post Office.
- Notify Medical Board of Examiners of address change.
- Notify change of address to all periodicals, journals, etc.

#### After Last Patient Has Been Seen

**Last Day Practice is Open or Rheumatologist is There:**
- Destroy all remaining prescription pads.
- For a minimum of two years, keep narcotics ledger.
- Conduct the proper disposal of drugs.
Conclusion

There are various important considerations when deciding to leave a practice. Whether it is a buy-out or closing the practice, it is necessary to have legal representation and an accountant to confirm that all essential paperwork is in order.

If you are not a partner in the practice you are leaving, make sure that you read your contract or employment agreement carefully to avoid violating any contractual responsibility. As a partner leaving a practice, verify any buy-out valuations of stock, valuations of any deferred compensation or financial aspects that will leave you liable.

Make sure to notify all licensing and professional agencies so you meet necessary requirements, especially if you are moving to another state. Leaving a practice is not easy but you should diligently prepare for your departure for a smooth and successful transition.

References


CHAPTER 10: ACR RESOURCES

The American College of Rheumatology provides the most important career development tools to jump start and successfully advance a rheumatology practice.

In today's uncertain health care climate, you cannot place too high a value on having a professional society on your side to look after your professional interests. Active ACR membership is the best way to establish a solid professional foundation at the very beginning of your career. Through the ACR, you will find a readymade support system for the unique challenges of the profession.

Practice Management Resources

Today's rheumatology practice is facing increasing pressures from both inside and outside of the practice. Staffing effectiveness and efficiency, overhead increases, coding and billing issues, litigious employees, conflict with colleagues, new competition, changing patient attitudes, new revenue constraints, and managed care contracting and compliance are just some of the pressures pushing practices to their limits. The ACR can assist in evaluating and assessing the current practice operations, services, and strategies and help you take the management principles that are required by any successful business and create a plan tailored to your needs.

The ACR's practice management department acts as a practice management partner in guiding rheumatologists through the politics and business of medicine. This department is available to help rheumatologists from initial business creation to retirement and offers a variety of services to help a practice function more effectively, efficiently and profitably.

Complete information is available at www.rheumatology.org/practice.

ACR Networking List Serves

Find out what type of issues and solutions other rheumatologists are facing every day by subscribing to the ACR list serves. This e-mail forum facilitates discussion among your peers, which allows for the exchanging of ideas, knowledge and experiences from colleagues. Join a list serve today at www.rheumatology.org/membership.

Benchmarking Resources

Members can download the most recent economic benchmarking survey to see where they fall within their region and network. Visit www.rheumatology.org/practice and click on Office Support.

ACR’s Health Plan Complaint Form

In an effort to better assist the membership in addressing both individual and system wide insurance issues, the ACR developed a standardized health plan complaints form. Members can send their form by mail, fax or e-mail to the ACR's practice management specialist. This form will allow the ACR to filter and aggregate members’ submissions, giving the ACR access to detailed complaints specific to payor, issue and geographic region. The data collected from this form will prove invaluable to the ACR in proactively identifying trends in payor interaction with rheumatology practices and addressing issues before they escalate. This form is available for members only and can be found at www.rheumatology.org/practice under Office Support.

Insurance Letter Templates

Members have access to previous letters sent to insurance companies regarding various insurance issues. Members can use these ACR template letters to generate responses to insurance carriers. The ACR can also send a letter to an insurance company on your behalf. To access the templates, visit www.rheumatology.org/practice and click on Office Support.
Sample Office & Patient Forms
Does your practice need a super bill or other office and patient forms? We offer a variety of sample forms for our members to download and print to assist rheumatologists in the office. They range from a super bill and the HAQ and DAS forms to different patient documentation forms. The ACR also offers resources that our members can provide to their patients on more than fifty patient education pieces on the different rheumatic diseases, various medications and treatments, and other related topics. Briefing papers are also available to outline the role of many health professionals that may be medically necessary during the treatment process. Spanish versions of many patient education pieces are now available.

Position Statements
Are you interested in the ACR’s position on Medicare Recovery Audit Contractors or biosimilars? Read the ACR position statements on these and other issues related to access and coverage, research, the role of rheumatology and treatment at www.rheumatology.org/practice under Clinical Support.

Documentation & Coding
Need help with coding and billing? The ACR has tools and references online to assist members with their practice, including coding reference guides, fee schedules, Medicare Part D information, claim processing tools, HIPAA information, forms and templates.

The ACR also has a certified professional coder available to help members identify billing issues and causes, can assist in correcting these problems to reduce overall denials, and can help members improve their coding and documentation so that they are in compliance and prepared for potential audits. Documentation and coding tools and reference can be found online at www.rheumatology.org/practice under Office Support.

Health Information Technology Support
Whether you are looking to implement an EHR or e-prescribing system, or working to make your practices more effective and efficient through the use of advanced system functionality and business management systems, the ACR can help. We have provided information on comparing certified EHR systems in order to help those un-easy members implement this new technology in their practice. Visit the ACR health information technology page at www.rheumatology.org/practice for more information on EHR incentive programs, meaningful use criteria and other areas of health information.

Drug Safety
The ACR has notification of drug recalls and shortages. Links to the Food and Drug Administration and Safety Alerts are also provided. The Drug Safety Quarterly online publication provides news, insight and critical review of safety issues relevant to anti-rheumatic therapy. For more information, please visit, www.rheumatology.org/practice under Clinical Support.

Practice & Political Advocacy
When you join the ACR, you are joining other rheumatologists as one strong voice in meaningful legislative action on behalf of our patients and the profession. The ACR advocates on behalf of its members in two key areas. Political Advocacy describes the activities the Government Affairs Committee undertakes regarding pending and proposed legislation that stands to have an impact on our members and their patients. Practice Advocacy describes the activities the College pursues with other bodies, such as insurance carriers and CMS, to ensure that rheumatologic care is properly valued.

The Advocacy section of the ACR website will help members to stay informed about the current practice issues that affect rheumatologists. Visit our Hot Issues Web page to see what the ACR is working on now. Found here is the ACR Issue Briefs, the ACR Legislative Tracking Sheet, RheumWATCH, talking points on numerous pieces of legislation that the ACR is tracking through Congress, and recent advocacy and legislative. To view these resources, visit http://www.rheumatology.org/advocacy.
Medicare Fee Schedule
The ACR has a section on its website dedicated to Medicare. Included in this section are the National Medicare Fee Schedule, National Relative Value Units Schedule, Medicare Drug Fee Schedule, and the Geographic Practice Cost Indices. Visit www.rheumatology.org/practice and click on Office Support.

Career Center
Whether you are looking for a new opportunity or searching for a candidate for employment in your practice, connect through the ACR’s Career Connection. This is free to job seekers searching for opportunities in the field of rheumatology and employers can cost effectively access a nationwide market of qualified rheumatology candidates. Career Connection is easy to use and offers a variety of tools and services for both the candidate and the employer. Post your job online today at http://assoc.healthecareers.com/acr.

Professional Education
Education is one of the primary functions of the ACR. Through our meetings, our publications, our products, and our online meeting highlights and curriculum cases, we advance the professionalism of our members, and expand access to information about treatment and care. Through several meetings per year, the ACR offers vital, cutting edge education to its members in a live format to help them stay current. The ACR/ARHP Annual Scientific Meeting, held each fall, is the premier scientific meeting devoted to the rheumatic diseases. This meeting draws thousands of rheumatologists and arthritis health professionals from around the world. A winter rheumatology symposium, spring clinical meetings, and other topical conferences round out the ACR’s educational offerings.

The ACR publishes *Arthritis & Rheumatism*, the premier scientific journal for research in the rheumatic diseases, which contains peer-reviewed articles on diagnosis, treatment, laboratory research and socioeconomic issues related to all forms of rheumatic disease. The Association of Rheumatology Health Professionals, or ARHP and a division of the ACR, publishes *Arthritis Care & Research*. This journal is a peer-reviewed research publication that publishes both original research and review articles that promote excellence in the clinical practice of rheumatology. Relevant to the care of individuals with arthritis and related disorders, major topics are evidence-based practice studies, clinical problems, practice guidelines, health care economics, health care policy, educational, social, and public health issues, and future trends in rheumatology practice.

Hotline
The ACR’s Hotline is produced by the ACR Communications and Marketing Committee and targets the busy practicing clinician. Topics for ACR Hotlines come from various sources including issues in the media related to rheumatology, deliberations of regulatory agencies (e.g., the USA Food and Drug Administration), and new information from scientific meetings. Hotlines reflect the views of the author(s) and do not represent position statements of the College. Topics are chosen by the Communications and Marketing Committee and the Hotline editors, but members are also encouraged to submit hotline topics or volunteer to write a Hotline.

Affiliate Society Council Resources Page
The ACR Affiliate Society Council is designed to address the practical needs of community rheumatologists by offering a range of services to state/local affiliates. It can help members get to know their state’s regional advisors. Learn how to book one of our certified professional coders, practice management specialists or health information technology advisors for a presentation during your next state and local society meeting by visiting www.rheumatology.org/practice and click on Clinical Support.

Quality and Best Practices
The quality movement has been gaining momentum over the last few years. Pay-for-performance, outcome measurement and similar concepts are swiftly becoming part of the health care landscape. The quality movement will impact how physicians treat patients and how physicians are reimbursed for their services.
The quality movement seeks to improve patient outcomes by identifying and promoting best practices ranging from use of diagnostics, medications and procedures to physician practices and hospital operations. Determining best practices includes analyzing the effectiveness of products and services; finding flaws in care-delivery systems that lead to medical errors; and measuring how physicians treat their patients—doctor-by-doctor and patient-by-patient. Once best practices are determined, professional organizations can use this information to produce treatment guidelines. Organizations may use best practices as the foundation for pay-for-performance programs, physician rankings and other initiatives. The ACR is defining best practices for treating rheumatic diseases, and not ceding that responsibility to others who are less knowledgeable than our members.

The quality movement promises to raise the quality of patient care overall. Establishing best practices for each rheumatic disease rheumatologists treat will help provide the right care at the right time to each patient. Payor incentive programs, when implemented appropriately, can serve as a bar that physicians can strive to reach, to the benefit of patients. High-quality care should consistently result in more efficient care, saving costs to the health system, and physician practices—over the long-term.

If quality is not pursued with adequate expert input, however, a one size-fits-all system of care could be created based on the following:

1. An oversimplification of appropriate rheumatologic treatment.
2. Short-term cost-savings.
3. Perverse incentive programs that adhere blindly to specific medical practices could punish physicians for providing appropriate care to some patients—an untenable conflict that would damage patients' trust. That is why the ACR is actively leading the effort to define quality care for patients with rheumatic diseases.

Broadly speaking, the ACR is working in the following areas:

**Classification and Response Criteria**
Classification and response criteria form the foundation for clinical studies in rheumatology. Such criteria allow investigators conducting trials to consistently define a study population, and to know when clinical improvement has occurred. In addition, epidemiologic studies rely on these criteria for identifying study cohorts and reporting endpoints. The ACR has classification and response criteria for rheumatic diseases, including childhood arthritis, rheumatoid arthritis, fibromyalgia and many others. The ACR has provided resource tools to members to be utilized in the classification and management of rheumatic diseases at [www.rheumatology.org/practice](http://www.rheumatology.org/practice) under Clinical Support.

**Quality of Care**
The ACR aims to develop tools and processes to help rheumatologists implement quality measures in their practices as well as the measures themselves. With both specialized scientific knowledge and clinical experience, rheumatologists are the most qualified professionals to develop effective measures of treatment of patients with often complex and challenging rheumatic illnesses. The ACR is investigating possible tools to help practitioners comply with increased demands from payors. For more information on Quality and the areas that the ACR is currently working on to improve patient care and quality in practices, visit [www.rheumatology.org/practice](http://www.rheumatology.org/practice) and click on Clinical Support.

**Rheumatology Training**
The ACR Rheumatology Fellowship Core Curriculum Outline addresses quality of care in a way that no previous curriculum outline has done. The ACR wants to prepare rheumatology fellows for work in an environment where evaluating and reporting on quality of medical care is an integral part of their practices. The purpose of rheumatology training programs is to train fellows to be accomplished practitioners and consultants in rheumatic diseases, as well as encourage the professional and scholarly attitudes and approaches of a competent sub-specialist that are needed to maintain an understanding of current concepts in rheumatology as advances occur.
**Practice Guidelines**

The American College of Rheumatology has developed practice guidelines for the purposes of reducing inappropriate care, controlling geographic variations in practice patterns, and making effective use of health care resources. This section contains the current guidelines on rheumatoid arthritis, osteoporosis, and other topics that can be especially helpful to new rheumatologist starting a practice. The ACR has developed practice guidelines to reduce inappropriate care, minimize geographic variations in practice patterns, and enable effective use of health care resources. ACR's guideline topics include: rheumatoid arthritis, osteoporosis, osteoarthritis, as well as other topics. Guidelines can be found online at www.rheumatology.org/practice under Clinical Support.

**Continuous Professional Development Program**

In a society where it is essential for physicians to be on the cutting edge of medical advancements, the ACR affirms a commitment to assisting physician progress and lifelong learning through new, continuous professional development programs. Whether rheumatologists are enrolled in the American Board of Internal Medicine of Certification program or seeking to participate in a self-assessment program or evaluate practice performance, these programs and necessary tools are designed to allow physicians to evaluate their level of medical knowledge, as well as assess and improve practice habits to better serve a growing patient population.

**Association of Rheumatology Health Professionals**

The Association of Rheumatology Health Professionals, a division of the American College of Rheumatology, is a professional membership society composed of non-physician health care professionals specializing in rheumatology, such as advanced practice nurses, nurses, occupational therapists, physical therapists, psychologists, social workers, epidemiologists, physician assistants, educators, clinicians, and researchers.

**ACR Research and Education Foundation**

Through the ACR Research and Education Foundation, the ACR seeks to increase research in the rheumatic diseases while fostering the careers of young investigators. The ACR also works to increase federal funding for research in the rheumatic diseases. The College is also an advocate in the formulation of public policy relating to the care of people with arthritis and other rheumatic diseases. For more information on the REF and to make a donation, visit www.rheumatology.org/REF.

**Conclusion**

Rheumatologists are an extremely diverse group. The ACR takes this collection of thousands of individuals with diverse talents and experiences, and has created a dynamic, powerful, and influential resource that benefits everyone who is committed to the practice of rheumatology. Our members practice in solo practices and partnerships, single and multi-specialty practices, academia, and HMO staff model practices, among many other settings. Each individual contributes something valuable and unique to the organization. Young rheumatologists bring their energy, fresh outlook, and enthusiasm for new technologies and approaches. More established rheumatologists offer years of leadership, practical experience, and dedication. The academic population serves to link us to the next generation of rheumatology practice and push the profession forward.

When you join the ACR, you are joining the largest professional organization of physicians, scientists, and health professionals devoted to the study and treatment of the rheumatic diseases. The ACR is a community of rheumatologists who maintain a strong commitment to research and education, advancing the understanding of the rheumatic diseases, and discovering new therapies to treat these diseases.

The ACR offers resources and opportunities almost as varied as our membership. For more information visit www.rheumatology.org.
Appendix I

Sample CV

NAME, TITLE
Street Address
City, State Zip Code
Phone Number

EDUCATION:
Medical School
Degree, Year Graduated
Honors, Organizations/Committees, (e.g., Summa Cum Laude)

Undergraduate School
Degree, Major, Year Graduated
Honors, Organizations/Committees, etc.
Specialty, Date Started-Date Completed

POSTGRADUATE EDUCATION:
Fellowship – Hospital/Medical Center, City, State
Specialty, Date Started-Date Completed

Residency – Hospital/Medical Center, City, State
Specialty, Date Started-Date Completed

Internship – Hospital/Medical Center, City, State
Specialty, Date Started-Date Completed

CERTIFICATION:
Name of Certification (Board)
Specialty- Date

LICENSURE:
State(s)

PROFESSIONAL EXPERIENCE:
List your professional experience (starting with most recent), City, State
List your specific job title, Date(s)

PROFESSIONAL SOCIETIES:
List the names of professional societies (vertically)
COMMITTEES:

Professional Society/Association/College

Name of committee Date Started – Date Completed (list these vertically)

DELEGATIONS:

Delegate, Professional Society/Association/College Date Started – Date Completed

STAFF APPOINTMENTS:

Hospital/Medical Center, City, State

Title/Name of Staff Appointment Date Started – Date Completed

OTHER POSITIONS:

Name of Place where the position was held

Title Date Started – Date Completed

AWARDS:

Name of Award

PUBLICATIONS:

Citation of publication arranged by date
Appendix II

Sample Cover Letter

Name
Address
City/State
Email Address
Date:

John Larson
Senior Manager, Physician Recruitment
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Dear Mr. Larson:

I am a graduate of the University of Minnesota Internal Medicine/Pediatrics residency program and currently a Medicine Chief Resident. I am interested in a position at Baystate Medical Center after I have completed my chief year. Ideally, I would like a mix of outpatient and inpatient medicine and pediatrics with an opportunity to interact with residents.

My interests include resident and medical student education as well as medical informatics. As a chief resident, I have been able to hone my teaching and presentation skills by leading morning reports and Morbidity and Mortality conferences. Also participating in the bioinformatics committee and making improvements on the Veterans Affairs computerized medical record system has given me an understanding about the implementation of computerized medical records.

I was born in New York, raised in Connecticut, and went to college in Massachusetts. As such, my family and many of my friends live in those areas, and my wife and I are planning to settle down in the Northeast.

Working at Baystate Medical center would give me the opportunity to live near my family, work in a tertiary care setting, and continue working with residents.

Thank you for your time,

(Name)

Medical Staff Recruiters Network 2007

The purpose of this business plan is to raise $150,000 for the development of a medical practice while showcasing the expected financials and operations over the next three years. The Medical Practice, Inc. (“the Company”) is a New York based corporation that will provide general medical care to customers in its targeted market. The Company was founded in 2009 by Dr. John Doe.

1.1 Products and Services
Dr. Doe will render family medicine services to adults and children within the greater targeted community. These services include examination, blood work, general medical counseling/advice, referrals to other physicians, and other family medicine services. The Company will also recognize revenues from the sale of medical appliances prescribed by Dr. Doe. The third section of the business plan will further describe the services offered by the Medical Practice.

1.2 The Financing
Dr. Doe is seeking to raise $150,000 from a bank loan. The interest rate and loan agreement are to be further discussed during negotiation. This business plan assumes that the business will receive a 10 year loan with a nine percent fixed interest rate.

1.3 Mission Statement
Dr. Doe’s mission is to become the recognized leader in its targeted market for general medical services.

1.4 Management Team
The Company was founded by Dr. John Doe. Dr. Doe has more than 10 years of experience as a practicing physician. Through his expertise, he will be able to bring the operations of the business to profitability within its first year of operations.

1.5 Sales Forecasts
Dr. Doe expects a strong rate of growth at the start of operations. Below are the expected financials over the next three years.

<table>
<thead>
<tr>
<th>Year</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sales</td>
<td>$655,290</td>
<td>$714,266</td>
<td>$778,550</td>
</tr>
<tr>
<td>Operating Costs</td>
<td>$377,526</td>
<td>$391,666</td>
<td>$424,768</td>
</tr>
<tr>
<td>EBITDA</td>
<td>$212,235</td>
<td>$251,173</td>
<td>$275,927</td>
</tr>
<tr>
<td>Taxes, Interest, and Depreciation</td>
<td>$99,649</td>
<td>$108,901</td>
<td>$117,691</td>
</tr>
<tr>
<td>Net Profit</td>
<td>$112,586</td>
<td>$148,165</td>
<td>$164,129</td>
</tr>
</tbody>
</table>

1.6 Expansion Plan
The Founder expects that the business will aggressively expand during the first three years of operation. Dr. Doe intends to implement marketing campaigns that will effectively target individuals and families within the target market.
2.0 Company and Financing Summary

2.1 Registered Name and Corporate Structure
Medical Practice, Inc. The Company is registered as a corporation in the State of New York.

2.2 Required Funds
At this time, the Medical Practice requires $150,000 of debt funds. Below is a breakdown of how these funds will be used:

<table>
<thead>
<tr>
<th>Use of Funds</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Lease Payments and Deposits</td>
<td>$25,000</td>
</tr>
<tr>
<td>Working Capital</td>
<td>$65,000</td>
</tr>
<tr>
<td>FF&amp;E</td>
<td>$25,000</td>
</tr>
<tr>
<td>Leasehold Improvements</td>
<td>$10,000</td>
</tr>
<tr>
<td>Security Deposits</td>
<td>$2,500</td>
</tr>
<tr>
<td>Opening Supplies</td>
<td>$10,000</td>
</tr>
<tr>
<td>Company Vehicle and Lease Deposits</td>
<td>$20,000</td>
</tr>
<tr>
<td>Marketing Budget</td>
<td>$10,000</td>
</tr>
<tr>
<td>Miscellaneous and Unforeseen Costs</td>
<td>$7,500</td>
</tr>
<tr>
<td><strong>Total Startup Costs</strong></td>
<td><strong>$175,000</strong></td>
</tr>
</tbody>
</table>

2.3 Investor Equity
Dr. Doe is not seeking an investment from a third party at this time.

2.4 Management Equity
John Doe owns 100 percent of the Medical Practice, Inc.

2.5 Exit Strategy
If the business is very successful, Dr. Doe may seek to sell the practice to a third party for a significant earnings multiple. Most likely, the Company will hire a qualified business broker to sell the business on behalf of the Medical Practice. Based on historical numbers, the business could fetch a sales premium of up to 2 to 3 times earnings.

3.0 Products and Services
Below is a description of the medical services offered by the Medical Practice.

3.1 Medical Services
The primary source of revenue for the business will be the medical services provided by Dr. Doe. The Company will offer many of the services that are common within this specialty including treatment of medical issues including high blood pressure, cholesterol, and diabetes. This part of the business will also provide work physicals, and provide cancer screenings, heart disease screenings, and other tests normally associated with the practice of a general physician. In the future, Dr. Doe will seek to hire additional general and pediatric physicians that will expand the practice organically through increased patient flow. These associate physicians may eventually acquire the practice from Dr. Doe upon his retirement or relocation. The practice will receive a bulk of its payments from co-pays and reimbursements from insurance companies.
3.2 Medical Appliances
The Company will also generate secondary revenues from the sale of medical appliances, prescribed by Dr. Doe to his patients. This is a very important revenue center for the business as the Company will generate substantial gross margins from each product sold.

4.0 Strategic and Market Analysis

4.1 Economic Outlook
This section of the analysis will detail the economic climate, the medical industry, the customer profile, and the competition that the business will face as it progresses through its business operations. Currently, the economic market condition in the United States is in recession. This slowdown in the economy has also greatly impacted real estate sales, which has halted to historical lows. Many economists expect that this recession will continue until mid-2009, at which point the economy will begin a prolonged recovery period. However, Medical Practices operate with great economic stability as people will continue to require medical care despite deleterious changes in the general economy.

4.2 Industry Analysis
Within the United States there are approximately 200,000 medical practices (excluding mental health practices) that comprise of one or more doctors that act in a private practice capacity. Each year, these practices generate more than $190 billion dollars of revenue and employ more than 1.8 million people (including the doctors). The growth of this industry has remained in lockstep with the growth of the general population. Approximately five percent of these doctors retire each year. Approximately 16,000 doctors enter private practice each year.

4.3 Customer Profile
In this section of the analysis, you should describe the type of customer you are seeking to acquire. These traits include income size, type of business/occupation; how far away from your business is to your customer, and what the customer is looking for. In this section, you can also put demographic information about your target market including population size, income demographics, level of education, etc.

4.4 Competitive Analysis
This is one of the sections of the business plan that you must write completely on your own. The key to writing a strong competitive analysis is that you do your research on the local competition. Find out who your competitors are by searching online directories and searching in your local Yellow Pages. If there are a number of competitors in the same industry (meaning that it is not feasible to describe each one) then showcase the number of businesses that compete with you, and why your business will provide customers with service/products that are of better quality or less expensive than your competition.

5.0 Marketing Plan
The Medical Practice intends to maintain an extensive marketing campaign that will ensure maximum visibility for the business in its targeted market. Below is an overview of the marketing strategies and objectives of the Medical Practice.

5.1 Marketing Objectives
- Develop an online presence by developing a website and placing the Company's name and contact information with online directories.
- Implement a local campaign with the Company's targeted market via the use of flyers, local newspaper advertisements, and word of mouth.
- Establish relationships with other doctors within the targeted market.
5.2 Marketing Strategies
Dr. Doe intends on using a number of marketing strategies that will allow the Medical Practice to easily target men, women, and families within the target market. These strategies include traditional print advertisements and ads placed on search engines on the Internet. Below is a description of how the business intends to market its services to the general public. The Medical Practice will also use an Internet based strategy. This is very important as many people seeking local services, such as doctors, now the Internet to conduct their preliminary searches. Dr. Doe will register the Practice with online portals so that potential customers can easily reach the business. The Company will also develop its own online website. The Company will maintain a sizable amount of print and traditional advertising methods within local markets to promote the general medical services that the Company is selling.

5.3 Pricing
In this section, describe the pricing of your services and products. You should provide as much information as possible about your pricing as possible in this section. However, if you have hundreds of items, condense your product list categorically. This section of the business plan should not span more than 1 page.

6.0 Organizational Plan and Personnel Summary

6.1 Corporate Organization

[Diagram of organizational structure]

Senior Management

Operations Staff
- Customer Service
- Facilities Management

Administrative Staff
- Accounting
- Sales—Marketing
- Administrative
6.2 Organizational Budget

### Personnel Plan — Yearly

<table>
<thead>
<tr>
<th>Year</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owners</td>
<td>$655,290</td>
<td>$714,266</td>
<td>$778,550</td>
</tr>
<tr>
<td>Associate</td>
<td>$377,526</td>
<td>$391,666</td>
<td>$424,768</td>
</tr>
<tr>
<td>Bookkeeper</td>
<td>$212,235</td>
<td>$251,173</td>
<td>$275,927</td>
</tr>
<tr>
<td>Tax Staff (Seasonal)</td>
<td>$99,649</td>
<td>$108,901</td>
<td>$117,691</td>
</tr>
<tr>
<td>Administrative Staff</td>
<td>$112,586</td>
<td>$148,165</td>
<td>$164,129</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$243,000</strong></td>
<td><strong>$250,290</strong></td>
<td><strong>$273,712</strong></td>
</tr>
</tbody>
</table>

### Numbers of Personnel

<table>
<thead>
<tr>
<th>Year</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owners</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Associate</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bookkeeper</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Tax Staff (Seasonal)</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Administrative Staff</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>8</strong></td>
<td><strong>8</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

### Personnel Expense Breakdown

![Pie Chart showing Personnel Expense Breakdown]

6.3 Management Biographies

In this section of the business plan, you should write a two to four paragraph biography about your work experience, your education, and your skill set. For each owner or key employee, you should provide a brief biography in this section.
7.0 Financial Plan

7.1 Underlying Assumptions

- The Medical Practice will have an annual revenue growth rate of 16 percent per year.
- The Owner will acquire $150,000 of debt funds to develop the business.
- The loan will have a 10 year term with a nine percent interest rate.

7.2 Sensitivity Analysis

In the event of an economic downturn, the Company will not see a major decline in revenues. Medical services are in demand regardless of the general economic climate as they are an essential service for health.

7.3 Source of Funds

<table>
<thead>
<tr>
<th>Financing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equity Contributions</strong></td>
<td></td>
</tr>
<tr>
<td>Management Investment</td>
<td>$25,000</td>
</tr>
<tr>
<td><strong>Total Equity Financing</strong></td>
<td>$25,000</td>
</tr>
<tr>
<td><strong>Banks and Lenders</strong></td>
<td></td>
</tr>
<tr>
<td>Banks and Lenders</td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>Total Debt Financing</strong></td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>Total Financing</strong></td>
<td>$125,000</td>
</tr>
</tbody>
</table>

7.4 General Assumptions

<table>
<thead>
<tr>
<th>General Assumptions</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Term Interest Rate</td>
<td>9.5%</td>
<td>9.5%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Long Term Interest Rate</td>
<td>10.0%</td>
<td>10.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Federal Tax Rate</td>
<td>33.0%</td>
<td>33.0%</td>
<td>33.0%</td>
</tr>
<tr>
<td>State Tax Rate</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Personnel Taxes</td>
<td>15.0%</td>
<td>15.0%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>
7.5 Profit and Loss Statements

### Profoma Profit and Loss (Yearly)

<table>
<thead>
<tr>
<th>Year</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sales</td>
<td>$655,290</td>
<td>$714,266</td>
<td>$778,550</td>
</tr>
<tr>
<td>Cost of Goods Sold</td>
<td>$65,529</td>
<td>$71,427</td>
<td>$77,855</td>
</tr>
<tr>
<td>Gross Margin</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
</tr>
<tr>
<td>Operating Income</td>
<td>$589,761</td>
<td>$642,839</td>
<td>$700,695</td>
</tr>
</tbody>
</table>

### Expenses

<table>
<thead>
<tr>
<th>Category</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payroll</td>
<td>$243,000</td>
<td>$250,290</td>
<td>$273,712</td>
</tr>
<tr>
<td>General and Administrative</td>
<td>$14,400</td>
<td>$14,976</td>
<td>$16,350</td>
</tr>
<tr>
<td>Marketing Expenses</td>
<td>$13,761</td>
<td>$15,000</td>
<td>$13,761</td>
</tr>
<tr>
<td>Professional Fees and Licensure</td>
<td>$25,000</td>
<td>$25,750</td>
<td>$26,523</td>
</tr>
<tr>
<td>Insurance Costs</td>
<td>$7,500</td>
<td>$7,875</td>
<td>$8,269</td>
</tr>
<tr>
<td>Travel, Vehicle Costs</td>
<td>$15,000</td>
<td>$16,500</td>
<td>$18,150</td>
</tr>
<tr>
<td>Rent and Utilities</td>
<td>$17,500</td>
<td>$18,375</td>
<td>$19,294</td>
</tr>
<tr>
<td>Miscellaneous Costs</td>
<td>$4,915</td>
<td>$5,367</td>
<td>$5,839</td>
</tr>
<tr>
<td>Payroll Taxes</td>
<td>$36,450</td>
<td>$37,544</td>
<td>$41,057</td>
</tr>
<tr>
<td>Total Operating Costs</td>
<td>$377,526</td>
<td>$391,666</td>
<td>$424,768</td>
</tr>
</tbody>
</table>

### EBITDA

- Year 1: $212,235
- Year 2: $251,173
- Year 3: $275,927

### Inflows

<table>
<thead>
<tr>
<th>Category</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash from Operations</td>
<td>$152,225</td>
<td>$222,217</td>
<td>$289,262</td>
</tr>
<tr>
<td>Cash from Receivables</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Operating Cash Inflow</td>
<td>$152,225</td>
<td>$222,217</td>
<td>$289,262</td>
</tr>
</tbody>
</table>

### Cash Flow Analysis—Yearly

<table>
<thead>
<tr>
<th>Year</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash from Operations</td>
<td>$152,225</td>
<td>$222,217</td>
<td>$289,262</td>
</tr>
<tr>
<td>Cash from Receivables</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Operating Cash Inflow</td>
<td>$152,225</td>
<td>$222,217</td>
<td>$289,262</td>
</tr>
<tr>
<td>Equity Investment</td>
<td>$25,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Increased Borrowings</td>
<td>$125,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Sales of Business Assets</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>A/P Increases</td>
<td>$37,902</td>
<td>$43,587</td>
<td>$50,125</td>
</tr>
<tr>
<td>Total Other Cash Inflows</td>
<td>$187,902</td>
<td>$43,587</td>
<td>$50,125</td>
</tr>
<tr>
<td>Total Cash Inflow</td>
<td>$340,127</td>
<td>$265,804</td>
<td>$339,388</td>
</tr>
</tbody>
</table>

### Outflows

<table>
<thead>
<tr>
<th>Category</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repayment of Principal</td>
<td>$8,079</td>
<td>$8,837</td>
<td>$9,666</td>
</tr>
<tr>
<td>A/P Decreases</td>
<td>$24,897</td>
<td>$29,876</td>
<td>$35,852</td>
</tr>
<tr>
<td>A/R Increases</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Asset Purchases</td>
<td>$5,893</td>
<td>$5,893</td>
<td>$72,316</td>
</tr>
<tr>
<td>Dividends</td>
<td>$106,558</td>
<td>$156,552</td>
<td>$202,484</td>
</tr>
<tr>
<td>Total Cash Outflows</td>
<td>$252,034</td>
<td>$249,820</td>
<td>$320,317</td>
</tr>
<tr>
<td>Net Cash Flow</td>
<td>$88,093</td>
<td>$15,985</td>
<td>$19,071</td>
</tr>
<tr>
<td>Cash Balance</td>
<td>$88,093</td>
<td>$104,078</td>
<td>$123,149</td>
</tr>
</tbody>
</table>

7.6 Cash Flow Analysis

### Profoma Cash Flow Analysis—Yearly

### Inflows

<table>
<thead>
<tr>
<th>Category</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cash Inflow</td>
<td>$340,127</td>
<td>$265,804</td>
<td>$339,388</td>
</tr>
</tbody>
</table>

### Outflows

<table>
<thead>
<tr>
<th>Category</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cash Outflows</td>
<td>$252,034</td>
<td>$249,820</td>
<td>$320,317</td>
</tr>
<tr>
<td>Net Cash Flow</td>
<td>$88,093</td>
<td>$15,985</td>
<td>$19,071</td>
</tr>
<tr>
<td>Cash Balance</td>
<td>$88,093</td>
<td>$104,078</td>
<td>$123,149</td>
</tr>
</tbody>
</table>
### 7.7 Balance Sheet

**Profoma Balance Sheet—Yearly**

<table>
<thead>
<tr>
<th>Year</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>$88,093</td>
<td>$104,078</td>
<td>$123,149</td>
</tr>
<tr>
<td>Amortized Development/Expansion Costs</td>
<td>$52,500</td>
<td>$58,055</td>
<td>$65,287</td>
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<tr>
<td>Inventory</td>
<td>$35,000</td>
<td>$62,777</td>
<td>$98,935</td>
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<tr>
<td>FF&amp;E</td>
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<td>$47,222</td>
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<tr>
<td>Accumulated Depreciation</td>
<td>($8,036)</td>
<td>($16,071)</td>
<td>($24,107)</td>
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<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$192,558</strong></td>
<td><strong>$256,061</strong></td>
<td><strong>$339,411</strong></td>
</tr>
<tr>
<td><strong>Liabilities and Equity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>$13,005</td>
<td>$26,716</td>
<td>$40,990</td>
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<td>Long Term Liabilities</td>
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<tr>
<td>Other Liabilities</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>$129,926</strong></td>
<td><strong>$134,800</strong></td>
<td><strong>$140,236</strong></td>
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<tr>
<td><strong>Net Worth</strong></td>
<td><strong>$62,632</strong></td>
<td><strong>$121,261</strong></td>
<td><strong>$199,175</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities and Equity</strong></td>
<td><strong>$192,558</strong></td>
<td><strong>$256,061</strong></td>
<td><strong>$339,411</strong></td>
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</table>

### 7.8 General Assumptions

**Monthly Break Even Analysis**

<table>
<thead>
<tr>
<th>Year</th>
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<tbody>
<tr>
<td><strong>Assets</strong></td>
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<tr>
<td>Monthly Revenue</td>
<td>$40,693</td>
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<td>Yearly Revenue</td>
<td>$488,319</td>
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### 7.9 Business Ratios

**Business Ratio – Yearly**

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<tbody>
<tr>
<td><strong>Sales</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Sales Growth</td>
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<td>17.0%</td>
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<tr>
<td>Gross Margin</td>
<td>70.0%</td>
<td>70.0%</td>
<td>70.0%</td>
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<tr>
<td><strong>Financials</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Profit Margin</td>
<td>16.68%</td>
<td>20.65%</td>
<td>23.18%</td>
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<tr>
<td>Assets to Liabilities</td>
<td>1.48</td>
<td>1.90</td>
<td>2.42</td>
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<tr>
<td>Equity to Liabilities</td>
<td>0.48</td>
<td>0.90</td>
<td>1.42</td>
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<tr>
<td>Assets to Equity</td>
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<td><strong>Liquidity</strong></td>
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<tr>
<td>Acid Test</td>
<td>0.68</td>
<td>0.77</td>
<td>0.88</td>
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<tr>
<td>Cash to Assets</td>
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### Expanded Profit and Loss Statements

#### Profit and Loss Statement (First Year)

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<tr>
<th>Months</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
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<td>$67,725</td>
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<td>$44,735</td>
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<td>Cost of Goods Sold</td>
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<td>$6,755</td>
<td>$6,773</td>
<td>$6,790</td>
<td>$4,474</td>
<td>$4,485</td>
<td>$4,497</td>
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<tr>
<td>Gross Margin</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
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<tr>
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<td>$61,110</td>
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#### Expenses

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<th>5</th>
<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
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<td>$20,250</td>
<td>$20,250</td>
<td>$20,250</td>
<td>$20,250</td>
<td>$20,250</td>
<td>$20,250</td>
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<tr>
<td>General and Administrative</td>
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<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Marketing Expenses</td>
<td>$1,147</td>
<td>$1,147</td>
<td>$1,147</td>
<td>$1,147</td>
<td>$1,147</td>
<td>$1,147</td>
<td>$1,147</td>
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<tr>
<td>Professional Fees and Licensure</td>
<td>$2,083</td>
<td>$2,083</td>
<td>$2,083</td>
<td>$2,083</td>
<td>$2,083</td>
<td>$2,083</td>
<td>$2,083</td>
</tr>
<tr>
<td>Insurance Costs</td>
<td>$625</td>
<td>$625</td>
<td>$625</td>
<td>$625</td>
<td>$625</td>
<td>$625</td>
<td>$625</td>
</tr>
<tr>
<td>Travel and Vehicle Costs</td>
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<td>$1,250</td>
<td>$1,250</td>
<td>$1,250</td>
<td>$1,250</td>
<td>$1,250</td>
</tr>
<tr>
<td>Rent and Utilities</td>
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<td>$1,458</td>
<td>$1,458</td>
<td>$1,458</td>
<td>$1,458</td>
<td>$1,458</td>
<td>$1,458</td>
</tr>
<tr>
<td>Miscellaneous Costs</td>
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<td>$410</td>
<td>$410</td>
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<td>$410</td>
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<tr>
<td>Payroll Taxes</td>
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<td>$3,038</td>
<td>$3,038</td>
<td>$3,038</td>
<td>$3,038</td>
<td>$3,038</td>
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<tr>
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<td>$31,460</td>
<td>$31,460</td>
<td>$31,460</td>
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#### EBITDA

<table>
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<tr>
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<tr>
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#### Federal Income Tax

<table>
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<tr>
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<th>6</th>
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</thead>
<tbody>
<tr>
<td>Federal Income Tax</td>
<td>$7,201</td>
<td>$7,220</td>
<td>$7,238</td>
<td>$7,257</td>
<td>$4,781</td>
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#### State Income Tax

<table>
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<tr>
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<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>State Income Tax</td>
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<td>$1,097</td>
<td>$1,100</td>
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<td>$726</td>
<td>$728</td>
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#### Interest Expense

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<th>6</th>
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<tbody>
<tr>
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<td>$1,113</td>
<td>$1,107</td>
<td>$1,101</td>
<td>$1,095</td>
<td>$1,089</td>
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#### Depreciation Expense

<table>
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<tr>
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<th>5</th>
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<th>7</th>
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<td>$491</td>
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<td>$491</td>
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#### Net Profit

<table>
<thead>
<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td>Net Profit</td>
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<td>$19,552</td>
<td>$19,694</td>
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### Profit and Loss Statement (First Year Cont.)

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<th>10</th>
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<th>12</th>
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<tr>
<td>Sales</td>
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<td>$6,895</td>
<td>$4,543</td>
<td>$4,554</td>
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<td>Gross Margin</td>
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<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
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<tr>
<td>Operating Income</td>
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<td>$2,083</td>
<td>$2,083</td>
<td>$2,083</td>
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<td>$7,500</td>
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<tr>
<td>Travel and Vehicle Costs</td>
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<td>$1,250</td>
<td>$1,250</td>
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<td>$1,458</td>
<td>$1,458</td>
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<td>Miscellaneous Costs</td>
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<td>$410</td>
<td>$4,915</td>
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<td>$491</td>
<td>$491</td>
<td>$491</td>
<td>$491</td>
<td>$5,893</td>
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### Profit and Loss Statement (Second Year)

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<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
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<tr>
<td><strong>Operating Income</strong></td>
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<td></td>
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<td></td>
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<tr>
<td>Payroll</td>
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<td>$50,058</td>
<td>$62,573</td>
<td>$67,578</td>
<td>$70,081</td>
<td>$250,290</td>
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<td>$4,200</td>
<td>$15,000</td>
</tr>
<tr>
<td>Professional Fees and Licensure</td>
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<td>$5,150</td>
<td>$6,438</td>
<td>$6,953</td>
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<td>$25,750</td>
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<td>$7,875</td>
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<td>$4,125</td>
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<tr>
<td><strong>Total Operating Costs</strong></td>
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### Profit and Loss Statement (Third Year)

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Expanded Cash Flow Analysis

### Cash Flow Analysis (First Year)

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<td>$19,902</td>
<td>$20,043</td>
<td>$20,185</td>
<td>$2,194</td>
<td>$2,289</td>
<td>$2,385</td>
<td>$2,480</td>
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<tr>
<td>Cash from Receivables</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Operating Cash Inflow</strong></td>
<td><strong>$19,760</strong></td>
<td><strong>$19,902</strong></td>
<td><strong>$20,043</strong></td>
<td><strong>$20,185</strong></td>
<td><strong>$2,194</strong></td>
<td><strong>$2,289</strong></td>
<td><strong>$2,385</strong></td>
<td><strong>$2,480</strong></td>
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<tr>
<td>Other Cash Inflows</td>
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<tr>
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<td><strong>$118,479</strong></td>
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<td><strong>$212,902</strong></td>
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<td>$2,075</td>
<td>$24,897</td>
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<tr>
<td><strong>Cash Balance</strong></td>
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<td><strong>$208,170</strong></td>
<td><strong>$211,185</strong></td>
<td><strong>$119,506</strong></td>
<td><strong>$176,069</strong></td>
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### Cash Flow Analysis (Second Year)

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<th>Q3</th>
<th>Q4</th>
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<tbody>
<tr>
<td>Cash from Operations</td>
<td>$30,812</td>
<td>$38,515</td>
<td>$41,596</td>
<td>$43,136</td>
<td>$154,058</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
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<td><strong>Operating Cash Inflow</strong></td>
<td>$30,812</td>
<td>$38,515</td>
<td>$41,596</td>
<td>$43,136</td>
<td>$154,058</td>
</tr>
</tbody>
</table>

| Other Cash Inflows | | | | | |
|-------------------|------|------|------|------|
| Equity Investment | $0   | $0   | $0   | $0   | $0   |
| Increased Borrowings | $0   | $0   | $0   | $0   | $0   |
| Sales of Business Assets | $0   | $0   | $0   | $0   | $0   |
| A/P Increases | $8,717 | $10,897 | $11,769 | $12,204 | $43,587 |
| **Total Other Cash Inflows** | $8,717 | $10,897 | $11,769 | $12,204 | $43,587 |

| Total Cash Inflow | $39,529 | $49,411 | $53,364 | $55,341 | $197,645 |

| Cash Outflows | | | | | |
|----------------|------|------|------|------|
| Repayment of Principal | $2,563 | $2,621 | $2,680 | $2,741 | $10,605 |
| A/P Decreases | $5,975 | $7,469 | $8,067 | $8,365 | $29,876 |
| A/R Increases | $0   | $0   | $0   | $0   | $0   |
| Asset Purchases | $3,081 | $03,851 | $4,160 | $4,314 | $15,406 |
| Dividends | $24,649 | $30,812 | $33,277 | $34,509 | $123,247 |
| **Total Cash Outflows** | $36,268 | $44,753 | $48,183 | $49,929 | $179,133 |

| Net Cash Flow | $3,261 | $4,658 | $5,181 | $95,412 | $18,512 |
| Cash Balance | $186,878 | $208,170 | $211,185 | $119,506 | $176,069 |
# Cash Flow Analysis (Third Year)

<table>
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<td>$0</td>
</tr>
<tr>
<td><strong>Operating Cash Inflow</strong></td>
<td>$34,004</td>
<td>$42,506</td>
<td>$45,906</td>
<td>$47,606</td>
<td>$170,022</td>
</tr>
<tr>
<td>Other Cash Inflows</td>
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</tr>
<tr>
<td>Equity Investment</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Increased Borrowings</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Sales of Business Assets</td>
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<td>$55,037</td>
<td>$59,440</td>
<td>$61,641</td>
<td>$220,148</td>
</tr>
</tbody>
</table>

## Cash Outflows

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repayment of Principal</td>
<td>$2,803</td>
<td>$2,867</td>
<td>$2,932</td>
<td>$2,998</td>
<td>$11,599</td>
</tr>
<tr>
<td>A/P Decreases</td>
<td>$7,170</td>
<td>$8,963</td>
<td>$9,680</td>
<td>$10,038</td>
<td>$35,852</td>
</tr>
<tr>
<td>A/R Increases</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Asset Purchases</td>
<td>$3,400</td>
<td>$0,251</td>
<td>$4,591</td>
<td>$4,761</td>
<td>$17,002</td>
</tr>
<tr>
<td>Dividends</td>
<td>$27,204</td>
<td>$34,004</td>
<td>$36,725</td>
<td>$38,085</td>
<td>$136,018</td>
</tr>
<tr>
<td><strong>Total Cash Outflows</strong></td>
<td>$40,577</td>
<td>$50,085</td>
<td>$53,927</td>
<td>$55,882</td>
<td>$200,471</td>
</tr>
</tbody>
</table>

## Net Cash Flow

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Cash Flow</strong></td>
<td>$3,452</td>
<td>$4,962</td>
<td>$5,513</td>
<td>$5,759</td>
<td>$19,677</td>
</tr>
<tr>
<td><strong>Cash Balance</strong></td>
<td>$141,470</td>
<td>$146,422</td>
<td>$151,935</td>
<td>$157,695</td>
<td>$157,695</td>
</tr>
</tbody>
</table>

Appendix IV

Legal Issues Relating to Employment
Some key legal issues relating to employment are listed below. This list is only an overview of selected rulings that currently govern the workplace. Always seek advice from a qualified legal professional regarding employment law.

The following legal summaries are taken from “Human Resources in Healthcare; Managing for Success”

Civil Rights Act of 1964
Title VII of the Civil Rights Act bars discrimination in hiring, promotion, compensation, training, benefits, and other aspects of employment. Discrimination is specifically prohibited on the basis of race, color, religion, gender, and national origin.

Age Discrimination in Employment Act
The ADEA forbids discrimination against men and women who are more than 40 years old by employers, unions, employment agencies, state and local governments, and the federal government.

Fair Labor Standards Act
The major provisions of the Fair Labor Standards Act concern minimum wage, overtime payments, child labor and equal pay.

Health Insurance Portability and Accountability Act of 1996
HIPAA was enacted to ensure that employees have health insurance coverage after leaving a job and to provide standards for electronic health care transactions. The HIPAA Privacy Rules regulate the use of protected health information that is electronically transmitted or maintained by health plans, health care clearinghouses and health care providers. The goal of the HIPAA Privacy Rules is to protect the use and disclosure of protected health information in this age of technology.

Americans with Disabilities Act
The ADA prohibits discrimination against individuals with disabilities in all aspects of the employee-employer relationship, including job application procedures, hiring, termination, promotions, compensation and training. The Americans with Disabilities Act of 1990 § 3(2)(a) defines a disability as “(a) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (b) a record of such impairment; or (c) being regarded as having such impairment.”

Consolidated Omnibus Budget Reconciliation Act
COBRA gives employees and their families the right to choose to continue to receive health benefits provided by the employer's group health plan for a limited period of time in such circumstances as voluntary or involuntary job loss, reduction in hours worked, transition between jobs, death, divorce, and other life events.

Consumer Credit Protection Act (Title III)
The CCPA prohibits an employer from discharging an employee because his or her earnings are subject to garnishment and from limiting the amount of wages that can be withheld for garnishment in a single week.

Drug-Free Workplace Act of 1988
The Drug-Free Workplace Act requires that all organizations that receive federal grants in any amount or federal contracts of $25,000 or more must certify that they are providing a drug-free workplace. Drug-free workplace certification is a precondition of receiving a federal grant, and criteria for compliance include the organization establishing an explicit drug policy, implementing it, and publicizing it to all employees.

Employee Polygraph Protection Act of 1988
The Employee Polygraph Protection Act generally prohibits employers from using lie-detector tests either for pre-employment screening or during the course of employment. A number of people are exempt from this act, including employees of security
firms; employees suspected of involvement in an incident resulting in economic loss to the employer; and prospective employ-
ees engaged in manufacturing, distributing, or dispensing controlled substances.

**Employee Retirement Income Security Act of 1974**
ERISA regulates private pension plans and sets minimum standards for most voluntarily established pension and health plans. ERISA requires plans to provide participants with information about plan features and funding, establishes fiduciary respon-
sibilities for those who manage and control plan assets, orders plans to establish grievances and appeals procedures for participants, and gives participants the right to sue for benefits and breaches of fiduciary duty.

The Equal Pay Act requires employers to pay all employees equally for equal work regardless of their gender. The intent of the act was to correct wage disparities experienced by women workers because of sex discrimination. Jobs are considered equal if they involve equal levels of skill, effort, and responsibility and if performed under similar conditions.

**Executive Orders 11246 and 11375**
Executive Orders 11246 and 11375 bar discrimination on the basis of race, color, religion, and national origin in federal employment and require government contractors to develop a written affirmative action program to help identify and analyze problems in workforce participation by women.

**Family and Medical Leave Act of 1993**
FMLA requires employers with 50 or more employees to provide 12 weeks of unpaid leave for family and medical emergencies, childbirth, or serious health conditions.

**Immigration Reform and Control Act of 1986**
The Immigration Reform and Control Act is intended to control unauthorized immigration to the United States and designates penalties for employers who hire people not authorized to work on the basis of national origin or citizenship.

**Occupational Safety and Health Administration**
OSHA serves two regulatory functions: setting standards and conducting inspections to ensure that employers are providing safe and healthful work places. OSHA established the National Institute for Occupational Safety and Health which is respon-
sible for a broad range of health and safety issues, including exposure to toxic chemicals, excessive noise levels, mechanical dangers, heat or cold stress and sanitation.

**Worker Adjustment and Retraining Notification Act**
WARN requires employers to provide notice to employees 60 days in advance of plant closings and mass layoffs. WARN’s intent is to provide workers and their families with transition time to adjust to the prospective loss of employment, to seek and obtain alternative jobs and, if necessary, to enter skills training or retraining.
Appendix V

Sample Employee Handbook

TABLE OF CONTENTS

Welcome To the Company .............................................. 110
Company Philosophy .................................................. 110
  Open-Door Policy.................................................. 110
  Equal Employment Opportunity ............................... 110
  Harassment Policy............................................... 110
Working and Compensation ......................................... 111
  Employment on an At-Will Basis ......................... 111
  Attendance and Reporting to Work ..................... 111
  Workday Hours and Scheduling ......................... 111
  Recording Hours Worked ..................................... 112
  Pay Period and Payday ....................................... 112
  Workweek & Overtime ....................................... 112
  Holidays ....................................................... 112
  Employment Classifications ................................. 113
  Maintaining Your Personnel Records .................. 113
Personnel Files ..................................................... 113
Performance Evaluations .......................................... 113
Standards and Expectations for the Workplace ............... 113
  Safety ......................................................... 113
  Care of Equipment and Supplies .......................... 114
  Smoking at the Workplace ................................. 115
  Violence and Weapons ....................................... 115
  Drug-Free Workplace ........................................ 115
  Responding to Customer Inquiries and Problems .... 115
  Appearance and Dress ......................................... 115
  Conflicts of Interest ........................................ 115
  Code of Ethical Conduct ..................................... 115
  Solicitation and Distribution ............................ 116
  Personal Calls, Visits, and Business ................... 116
  Business Expenses ........................................... 116
  Inspection of Personal and Company Property ....... 116
  Network and Electronic Resources Policy ............. 116
  Confidential and Proprietary Information ............... 117
  Rules of Conduct and Progressive Disciplinary Procedure 117
  Re-Employment ................................................ 118
  Moonlighting .................................................. 118
Benefits ............................................................. 119
  Mobile Phones ................................................. 119
  Paid Time Off ................................................ 119
  Leaves of Absence ........................................... 119
Acknowledgement of Receipt of Employee Handbook ........ 120
WELCOME TO THE COMPANY

The Company has prepared this handbook to provide you with an overview of the Company’s policies, benefits, and rules. It is intended to familiarize you with important information about the company, as well as provide guidelines for your employment experience with us in an effort to foster a safe and healthy work environment. Please understand that this booklet only highlights company policies, practices, and benefits for your personal understanding and cannot, therefore, be construed as a legal document. It is intended to provide general information about the policies, benefits, and regulations governing the employees of the company, and is not intended to be an express or implied contract. The guidelines presented in this handbook are not intended to be a substitute for sound management, judgment, and discretion.

It is obviously not possible to anticipate every situation that may arise in the workplace or to provide information that answers every possible question. In addition, circumstances will undoubtedly require that policies, practices, and benefits described in this handbook change from time to time. Accordingly, the company reserves the right to modify, supplement, rescind, or revise any provision of this handbook from time to time as it deems necessary or appropriate in its sole discretion with or without notice to you.

No business is free from day-to-day problems, but we believe our personnel policies and practices will help resolve such problems. All of us must work together to make the company a viable, healthy, and profitable organization. This is the only way we can provide a satisfactory working environment that promotes genuine concern and respect for others including all employees and our customers. If any statements in this handbook are not clear to you, please contact the company president or his designated representative for clarification. This handbook supersedes any and all prior policies, procedures, and handbooks of the company.

COMPANY PHILOSOPHY

OPEN-DOOR POLICY
In keeping with the company's philosophy of open communication, all employees have the right and are encouraged to speak freely with management about their job-related concerns.

We urge you to go directly to your supervisor to discuss your job-related ideas, recommendations, concerns and other issues which are important to you. If, after talking with your supervisor, you feel the need for additional discussion, you are encouraged to speak with the company president.

The most important relationship you will develop at the Company will be between you and your supervisor. However, should you need support from someone other than your supervisor, the entire management team, including the company president, is committed to resolving your individual concerns in a timely and appropriate manner.

EQUAL EMPLOYMENT OPPORTUNITY
It is the policy of the Company to provide equal employment opportunity to all employees and applicants for employment and not to discriminate on any basis prohibited by law, including race, color, sex, age, religion, national origin, disability, marital status or veteran status. It is our intent and desire that equal employment opportunities will be provided in employment, recruitment, selection, compensation, benefits, promotion, demotion, layoff, termination and all other terms and conditions of employment. The President of the Company and all managerial personnel are committed to this policy and its enforcement.

Employees are directed to bring any violation of this policy to the immediate attention of their supervisor or the company president. Any employee who violates this policy or knowingly retaliates against an employee reporting or complaining of a violation of this policy shall be subject to immediate disciplinary action, up to and including discharge. Complaints brought under this policy will be promptly investigated and handled with due regard for the privacy and respect of all involved.
HARASSMENT POLICY

The Company will not tolerate harassment or intimidation of our employees on any basis prohibited by law, including race, color, sex, age, religion, national origin, handicap, disability, marital status, or veteran status. Moreover, any suggestions made to any employee that sexual favors will affect any term or condition of employment with the Company will not be tolerated. It is the policy of the Company that any harassment, including acts creating a hostile work environment or any other discriminatory acts directed against our employees, will result in discipline, up to and including discharge. The Company also will not tolerate any such harassment of our employees by our clients or vendors.

For purposes of this policy, sexual harassment is defined as any type of sexually-oriented conduct, whether intentional or not, that is unwelcome and has the purpose or effect of creating a work environment that is hostile, offensive or coercive. The following are examples of conduct that, depending upon the circumstances, may constitute sexual harassment:

- Unwelcome sexual jokes, language, epithets, advances or propositions;
- Written or oral abuse of a sexual nature, sexually degrading or vulgar words to describe an individual;
- The display of sexually suggestive objects, pictures, posters or cartoons;
- Unwelcome comments about an individual’s body;
- Asking questions about sexual conduct;
- Unwelcome touching, leering, whistling, brushing against the body, or suggestive, insulting or obscene comments or gestures;
- Demanding sexual favors in exchange for favorable reviews, assignments, promotions, or continued employment, or promises of the same.

Employees must bring any violation of this policy to the immediate attention of their supervisor or the company president. The Company will thoroughly investigate all such claims with due regard for the privacy of the individuals involved. Any employee who knowingly retaliates against an employee who has reported workplace harassment or discrimination shall be subject to immediate disciplinary action, up to and including discharge.

WORK AND COMPENSATION

EMPLOYMENT ON AN AT-WILL BASIS

All employees of the company, regardless of their classification or position, are employed on an at-will basis. This means that each employee’s employment is terminable at the will of the employee or the company at any time, with or without cause and with or without notice. No officer, agent, representative, or employee of the company has any authority to enter into any agreement with any employee or applicant for employment on other than an at-will basis. Furthermore, nothing contained in the policies, procedures, handbooks, manuals, job descriptions, application for employment, or any other document of the company shall in any way create an express or implied contract of employment or an employment relationship on other than an at-will basis.

ATTENDANCE AND REPORTING TO WORK

Each employee is important to the overall success of our operation. When you are not here, someone else must do your job. Consequently, you are expected to report to work on time at the scheduled start of the workday. Reporting to work on time means that you are ready to start work, not just arriving at work, at your scheduled starting time.

The company depends on its employees to be at work at the times and locations scheduled. Excessive absenteeism and/or tardiness will lead to disciplinary action, up to and including termination. The determination of excessive absenteeism will be
made at the discretion of the company. Absence from work for three consecutive days without properly notifying your supervisor will be considered a voluntary resignation. After two days’ absence, you may be required to provide documentation from your physician to support an injury- or illness-related absence, and to ensure that you may safely return to work.

If you expect to be absent from the job for an approved reason (e.g., paid time off or a leave of absence), you should notify your supervisor of your upcoming absence as far in advance as possible. If you unexpectedly need to be absent from or late to work, you must notify your supervisor prior to the start of your scheduled workday that you will be late or absent and provide the reason for that absence or tardiness. If your supervisor is not available, you should contact the company’s main office prior to the start of your scheduled workday. Leave your number so that your supervisor can return your call. Failure to properly contact us will result in an unexcused absence for disciplinary purposes. Your attendance record is a part of your overall performance rating. Your attendance may be included during your review and may be considered for other disciplinary action up to and including termination.

Where possible, medical and dental appointments should be scheduled around your assigned work hours; otherwise, they may be considered absences without pay. If you are unable to schedule an appointment before or after your shift, you are required to talk to your supervisor to make special arrangements.

**WORKDAY HOURS AND SCHEDULING**

The regularly scheduled workday for our business office is: Monday through Friday, 7:30-8:00 a.m. to 4:30-5:00 p.m. The usual expected workday at jobsites is 8:00 a.m. to 4:30 p.m. These start and end times are only guidelines, however, and employees are required to be present for work during the workday established for them by their supervisors or by the company president. Particularly at jobsites, this regular schedule may vary depending on such factors as weather, materials supply, permit approval, etc. If you are unsure about expected starting times on any particular job assignment, ask your supervisor for clarification.

In case of unplanned conditions, such as bad weather, that may force a schedule change at the last minute, you should contact your supervisor or call the office directly.

The company does not generally schedule rest periods or breaks, other than meal breaks, during the workday. However, if the company does schedule such rest periods or breaks, they will be paid breaks and will usually be for 15 minutes. For lunch or meals, our policy is:

- Field employee meals will be 30 minutes.
- Office employee meals will be 1 hour.
- The meal period is unpaid.
- All employees are required to take a lunch break and no employee is authorized, without prior supervisory approval, to perform work during the lunch period.

**RECORDING HOURS WORKED**

All hourly employees are required to keep a time sheet. On your time sheet, you must correctly record the job number, job code, and time spent on each job number or code for each day worked. The company will provide you with a time sheet for reporting your hours. Only you are authorized to record your own time.

Completed time sheets are due in the office no later than 8:00 a.m. on the Wednesday following the end of a pay period. Failure to turn in time sheets by this deadline may delay your paycheck for that week.

**PAY PERIOD AND PAYDAY**

The company issues paychecks each Friday, on a weekly basis. Pay periods start on Wednesday morning and end on Tuesday afternoon. Therefore, each Friday, you will receive a paycheck for all hours worked in the pay period ending the previous Tues-
If an employee uses direct deposit, the employee’s pay may not be available for withdrawal from his or her bank account until the following Monday.

**WORKWEEK & OVERTIME**

The company’s workweek begins on Wednesday at 12:01 a.m. and ends on Tuesday at 12:00 midnight.

Occasionally it may be necessary for an employee to work beyond his or her normal workday hours. Overtime pay is paid only when work is scheduled, approved, and made known to you in advance by your supervisor. Under no circumstances shall an employee work overtime without the prior approval of his or her supervisor.

Hourly employees will receive overtime pay at a rate of one-and-one-half times their regular hourly rate for all hours worked in excess of 40 in a workweek.

To the extent possible, overtime will be distributed equally among all employees in the same classification and position, provided that the employees concerned are equally capable of performing the available work. Decisions regarding overtime work will be made by the Production Coordinator or his/her representative. Any employee asked to work overtime will be expected to rearrange his/her personal schedule to work the requested overtime.

**HOLIDAYS**

The company observes the following holidays:

- New Year’s Day
- Memorial Day
- Fourth of July
- Labor Day
- Thanksgiving
- Christmas

Full-time employees will be paid for these holidays as long as the employee was present for work on the workdays immediately before and after that holiday, or had an acceptable excuse for being absent on any such days. If a paid holiday falls within an employee’s vacation period, the holiday will not be counted as a vacation day.

Part-time employees are not eligible for holiday pay.

**EMPLOYMENT CLASSIFICATIONS**

Upon being hired by the Company, all new employees must serve a ninety (90) calendar day introductory period. It is especially important that you make your supervisor aware of any questions or problems you may encounter during this period. Your performance will be carefully monitored during this period. At the end of the introductory period, your performance will be reviewed, and if it has been satisfactory, you will become a Regular Full-Time or Regular Part-Time Employee. Satisfactory completion of the introductory period does not entitle you to employment for any specific term, but does entitle you to participation in many of the Company’s employee benefits programs.

For the sole purpose of determining the allowance of certain employee benefits, employees are classified as:

1. **Regular Full-Time Employees** - An employee who has satisfactorily completed the introductory period and is scheduled to work an average of forty (40) hours per week on a regular and continuous basis.

2. **Regular Part-Time Employees** - An employee who has satisfactorily completed the introductory period and is usually scheduled to work less than an average of forty (40) hours per week but not less than ten (10) hours per week on a regular and continuous basis.
3. Temporary Employees - An employee whose services are anticipated to be of limited duration falls into this classification. Temporary employees are not eligible for participation in those employee benefits programs made available for the Company Regular Full-Time and Regular Part-Time Employees, although separate benefit plans may be available for certain temporary employees assigned to work at the Company. Any such employees will be separately notified of any such programs. Service as a temporary does not count as service as a Regular Employee for benefit eligibility purposes.

For payroll purposes, employees will be classified as one of the following:

1. Exempt Employees - Certain employees such as executive, administrative, professional and outside sales employees are paid on a salary basis for all hours worked each week. Certain computer professionals may also be exempt, regardless of whether they are paid on a salary or hourly basis. These employees are expected to work whatever hours are required to accomplish their duties, even if it exceeds their normal workweek. No overtime premium pay will be paid to exempt employees in most circumstances.

2. Non-Exempt Employees - All employees who are not identified as exempt employees are considered non-exempt employees. Non-exempt employees are eligible for payment of overtime premium pay.

MAINTAINING YOUR PERSONNEL RECORDS
It is your responsibility to provide current information regarding your address, telephone number, insurance beneficiaries, change in dependents, marital status, etc. Please use the personnel records form to note any changes in your address, phone number, emergency contact information, marital status, number of dependents, etc. Changes in exemptions for tax purposes will only be made upon the receipt of a completed W-4 form.

PERSONNEL FILES
Employee personnel files are the property of the company, and do not belong to the employee. However, upon request, the company will provide employees with copies of performance evaluations and other performance-related documents that the employee has previously received.

PERFORMANCE EVALUATIONS
Employees may have their job performance reviewed on an annual basis by either their supervisor or by the president of the company.

STANDARDS AND EXPECTATIONS FOR THE WORKPLACE

SAFETY
The company believes in maintaining safe and healthy working conditions for our employees. However, to achieve our goal of providing a safe workplace, each employee must be safety conscious. We have established the following policies and procedures that allow us to provide safe and healthy working conditions. We expect each employee to follow these policies and procedures, to act safely, and to report unsafe conditions to his or her supervisor in a timely manner.

Reporting Unsafe Conditions or Practices
Employees are expected to continually be on the lookout for unsafe working conditions or practices. If you observe an unsafe condition, you should warn others, if possible, and report that condition to your supervisor immediately. If you have a question regarding the safety of your workplace and practices, ask your supervisor for clarification.

If you observe a coworker using an unsafe practice, you are expected to mention this to the coworker and to your supervisor. Likewise, if a coworker brings to your attention an unsafe practice you may be using, please thank the coworker and make any necessary adjustments to what you are doing. Safety at work is a team effort.
Maintaining a Safe Worksite
We expect employees to establish and maintain a safe worksite. This includes but is not limited to the following applications:

- Maintaining proper fall-protection systems.
- Building and maintaining walkways, handrails, and guardrails.
- Properly lifting and lowering heavy objects.
- Inspecting tools and equipment for defects before use.
- Keeping walkways clear of debris.
- Construction and use of safe scaffolding.
- Inspecting, cleaning, and properly storing tools and equipment after use.
- Following established safety rules.

Using Safety Equipment
Where needed, the company provides its employees with appropriate safety equipment and devices. You are required to use the equipment provided in the manner designated as proper and safe by the manufacturer. Failure to properly use safety equipment may lead to disciplinary action, up to and including termination.

If you require safety equipment that has not been provided, contact your supervisor before performing the job duty for which you need the safety equipment.

Reporting an Injury
Employees are required to report any injury, accident, or safety hazard immediately to their supervisor(s). Minor cuts or abrasions must be treated on the spot. More serious injuries or accidents will be treated accordingly. Serious injuries must be reported on the injury or accident report form available in the office.

Hazard Communications
If you believe that you are dealing with a hazardous material and lack the appropriate information and/or safety equipment, contact your supervisor immediately.

CARE OF EQUIPMENT AND SUPPLIES
All employees are expected to take care of all equipment and supplies provided to them. You are responsible for maintaining this material in proper working condition and for promptly reporting any unsafe or improper functioning of this material to your supervisor.

Neglect, theft, and/or destruction of the company's materials are grounds for disciplinary action, up to and including termination.

SMOKING AT THE WORKPLACE
The company's policy is to provide smoke-free environments for our employees, customers, and the general public. Smoking of any kind is prohibited inside our office and on our worksites. Employees may smoke on scheduled breaks or during meal times, as long as they do so outside the worksite or office. Employees who take excessive smoke breaks may be required to work longer hours to make up for time lost smoking.

Employees are also responsible to inform all those working on our job sites of this smoke-free policy, and report to their supervisor any violation of this policy.
VIOLENCE AND WEAPONS
The company believes in maintaining a safe and healthy workplace, in part by promoting open, friendly, and supportive working relationships among all employees. Violence or threats of violence have no place in our business. Violence is not an effective solution to any problem. Employees are strictly prohibited from bringing any weapons, including knives, pistols, rifles, stun guns, Mace, etc., to the worksite or office. Neither threats of violence nor fighting will be tolerated. Furthermore, if you have a problem that is creating stress or otherwise making you agitated, you are encouraged to discuss it with your supervisor.

You are expected to immediately report to your supervisor any violation of this policy. Any employee found threatening another employee, fighting, and/or carrying weapons to the worksite will be subject to disciplinary action, up to and including termination.

DRUG-FREE WORKPLACE
The company does not tolerate the presence of illegal drugs or the illegal use of legal drugs in our workplace. The use, possession, distribution, or sale of controlled substances such as drugs or alcohol, or being under the influence of such controlled substances is strictly prohibited while on duty, while on the company’s premises or worksites, or while operating the company’s equipment or vehicles. The use of illegal drugs as well as the illegal use of legal drugs is a threat to us all because it promotes problems with safety, customer service, productivity, and our ability to survive and prosper as a business. If you need to take a prescription drug that affects your ability to perform your job duties, you are required to discuss possible accommodations with your supervisor. Violation of this policy will result in disciplinary action, up to and including termination.

Prior to employment, each potential employee must undergo a drug test. The company may also require employees to take random drug tests during their employment with the company. A positive result on any such drug test is grounds for immediate termination.

Your receipt of this policy statement and signature on the handbook acknowledgment form signify your agreement to comply with this policy.

Any employee who is convicted of violating criminal drug statutes must notify an appropriate officer or senior official of the company of that conviction within five days of the conviction. Failure to do so may lead to disciplinary action.

RESPONDING TO CUSTOMER INQUIRIES AND PROBLEMS
At the company, client satisfaction is the measure of our success. It is the responsibility of each employee, within reason, to interact with the client to achieve this goal.

APPEARANCE AND DRESS
To present a business-like, professional image to our customers and the public, all employees are required to wear appropriate clothing on the job. By necessity, the dress standards for the business office are somewhat different than for jobsites.

• For the business office, casual to business-style dress is appropriate. Employees should be neatly groomed and clothes should be clean and in good repair. Leisure clothes such as cut-offs or halter tops are not acceptable attire for the business office. The company will provide employees with shirts bearing the Company’s logo, which employees are expected to wear as appropriate in the business office.

• For jobsites, employees are expected to wear work clothes appropriate for work to be done. Employees should be sensitive to the location and context of their work and should be ready to adjust their dress if the circumstances so warrant. Employees at a jobsite should wear clothing that protects their safety (steel-toed shoes, for example) and wear clothing in such a way as to be safe (e.g., shirts tucked in when working around machinery). The company will provide employees with shirts bearing the Company’s logo, which employees are expected to wear on the jobsite.
**CONFLICTS OF INTEREST**
You should avoid external business, financial, or employment interests that conflict with the company's business interests or with your ability to perform your job duties. This applies to your possible relationships with any other employer, consultant, contractor, customer, or supplier.

Violations of this rule may lead to disciplinary action, up to and including termination.

**CODE OF ETHICAL CONDUCT**
In order to avoid any appearance of a conflict of interest, employees are expected to abide by the following code of ethical conduct. Please consult your supervisor or an official of the company if you have any questions.

Employees of the company should not solicit anything of value from any person or organization with whom the company has a current or potential business relationship.

Employees of the company should not accept any item of value from any party in exchange for or in connection with a business transaction between the company and that other party.

Employees may accept items of incidental value (generally, no more than $25) from customers, suppliers, or others as long as the gift is not given in response to solicitation on your part and as long as it implies no exchange for business purposes. Items may include gifts, gratuities, food, drink and entertainment.

If you are faced with and are unsure how to handle a situation that you believe has the potential to violate this code of ethical conduct, notify your supervisor or the company president.

Violations of this code may lead to disciplinary action, up to and including termination.

**SOLICITATION AND DISTRIBUTION**
For the safety, convenience, and protection of all employees, the company has adopted the following rules concerning solicitation and the distribution of materials:

- The company prohibits solicitation and distribution of non-company materials on Company property or at Company jobsites at all times.

**PERSONAL CALLS, VISITS, AND BUSINESS**
The company expects the full attention of its employees while they are working. Although employees may occasionally have to take care of personal matters during the workday, employees should try to conduct such personal business either before or after the workday or during breaks or meal periods. Regardless of when any personal call is made, it should be kept short.

Employees should also limit incoming personal calls, visits, or personal transactions. The company's phones should be available to serve the Company's customers, and non-business use of the phones can hurt the company's business. A pattern of excessive personal phone calls, personal visits, and/or private business dealings is not acceptable and may lead to disciplinary action.

**BUSINESS EXPENSES**
Employees may occasionally incur expenses on behalf of the Company. The company will reimburse employees for typical business expenses, such as mileage (for example, when the Company asks an employee to travel to a different jobsite during the workday) and certain job-related supplies or materials. The company will pay mileage reimbursements at the end of each month, upon receipt of the employee's mileage record. In order to be reimbursed for job-related supplies or materials, employees must deliver a receipt for the supplies or materials to the company's business office within 7 days of the purchase.

Employees may also turn in such receipts by attaching them to the employee's weekly time sheet for the week in which the employee made the purchase.
INSPECTION OF PERSONAL AND COMPANY PROPERTY
The company's employees use the property and equipment the company owns and provides, and may also use the company's materials, information, and other supplies. While employees may decorate their office workspaces with their personal possessions (such as pictures, plants, and the like), employees must remember that property supplied by the company remains the property of the company. The company reserves the right to search any Company property (e.g., personal computers, desks, lockers, or other storage areas) at any time. The company also reserves the right to inspect personal property (e.g., tool boxes, purses, briefcases) during the workday or as employees leave their worksites. Refusal to allow inspection may lead to disciplinary action, up to and including termination.

NETWORK AND ELECTRONIC RESOURCES POLICY
Network and Electronic Resources, such as computers, other hardware, software, e-mail, landline and cellular telephones, fax machines and internet access, are tools that the Company provides its employees to assist them in their work. These Network and Electronic Resources and related access systems are proprietary Company property and subject to review or access by the Company at any time.

All employees who use the Company’s Network and Electronic Resources must follow the guidelines below:

1. Use Network and Electronic Resources for Company business purposes only.

2. Messages and communications sent via the Company’s Network and Electronic Resources are subject to subpoena and access by persons outside the Company and may be used in legal proceedings. Please consider this before sending any confidential messages or material via the Network and Electronic Resources.

3. E-Mail is not a substitute for face-to-face communication. If you have a conflict with someone or need to discuss an important issue, it should be handled in person or over the telephone if a meeting is not possible.

4. Remember that all of the Company's policies, including but not limited to policies on Equal Employment Opportunity, Harassment, Confidentiality, Personal Conduct and Rules of Conduct, apply to the use of the Company's Network and Electronic Resources. Employees must not review or forward sexually explicit, profane or otherwise unprofessional or unlawful material through the Company's Network and Electronic Resources.

5. Passwords protecting the use of the Company's Network and Electronic Resources are the Company's property and will be assigned to employees as needed. Employees may not change passwords without the consent of the company president. Employees must notify the company president of all passwords and encryption keys assigned to or used by them, and must notify the company president of any changes to such passwords or encryption keys.

6. Do not install any software or program on any Company computer or other hardware without the express consent of your supervisor or the company president.

7. The company expressly prohibits the unauthorized use, installation, copying or distribution of copyrighted, trademarked or patented material.

8. Employees must not attempt to override or evade any program or measure installed by the Company to protect the security or limit the use of its Network and Electronic Resources.

The Company retains the right to review all communications conducted and data saved, reviewed or accessed via the Company's Network and Electronic Resources, including Company computers, e-mail and Internet access. The company does not permit its non-management employees to access or use any Company password, e-mail or Internet access other than their own. Inappropriate use of Network and Electronic Resources may result in discipline, up to and including discharge. Employees should be careful to safeguard their passwords, log off their terminals when not in use and not permit others to access Company systems.
CONFIDENTIAL AND PROPRIETARY INFORMATION

The Company considers its confidential and proprietary information, including the confidential and proprietary information of our customers, to be one of its most valuable assets. As a result, employees must carefully protect and must not disclose to any third party all confidential and proprietary information belonging to the Company or its customers. Such protected information includes, but is not limited to, the following: matters of a technical nature, such as computer software, product sources, product research and designs; and matters of a business nature, such as customer lists, customer contact information, associate information, on-site program and support materials, candidate and recruit lists and information, personnel information, placement information, pricing lists, training programs, contracts, sales reports, sales, financial and marketing data, systems, forms, methods, procedures, and analyses, and any other proprietary information, whether communicated orally or in documentary, computerized or other tangible form, concerning the Company’s or its customers’ operations and business.

Employees should ensure that any materials containing confidential or proprietary information are filed and/or locked up before leaving their work areas each day. During the workday, employees should not leave any sensitive information lying about or unguarded.

If you have any questions about this policy, consult your supervisor or the company president.

RULES OF CONDUCT AND PROGRESSIVE DISCIPLINARY PROCEDURE

There are reasonable rules of conduct which must be followed in any organization to help a group of people work together effectively. The company expects each employee to present himself or herself in a professional appearance and manner. If an employee is not considerate of others and does not observe reasonable work rules, disciplinary action will be taken.

Depending on the severity or frequency of the disciplinary problems, a verbal or written reprimand, suspension without pay, disciplinary probation, or discharge may be necessary. It is within the company’s sole discretion to select the appropriate disciplinary action to be taken. Notwithstanding the availability of the various disciplinary options, the company reserves the right to discharge an employee at its discretion, with or without notice.

The following is not a complete list of offenses for which an employee may be subject to discipline, but it is illustrative of those offenses that may result in immediate discipline, up to and including dismissal, for a single offense:

1. Excessive absenteeism or tardiness.
2. Dishonesty, including falsification of Company-related documents, or misrepresentation of any fact.
3. Fighting, disorderly conduct, horseplay, or any other behavior which is dangerous or disruptive.
4. Possession of, consumption of, or being under the influence of alcoholic beverages while on Company or customer premises or on Company business.
5. Illegal manufacture, distribution, dispensation, sale, possession, or use of illegal drugs or unprescribed controlled substances.
6. Reporting for work with illegal drugs or unprescribed controlled substances in your body.
7. Possession of weapons, firearms, ammunition, explosives, or fireworks on Company or customer premises.
8. Failure to promptly report a workplace injury or accident involving any of the Company’s employees, clients, equipment, or property.
9. Willful neglect of safety practices, rules, and policies.
10. Speeding or reckless driving on Company business.
11. Commission of a crime, or other conduct which may damage the reputation of Company.
12. Use of profane language while on Company business.

13. Stealing, misappropriating, or intentionally damaging property belonging to the Company or its customers or employees.

14. Unauthorized use of the Company’s or its clients’ name, logo, funds, equipment, vehicles, or property.

15. Insubordination, including failure to comply with any work assignments or instructions given by any Company supervisor with the authority to do so.


17. Interference with the work performance of other employees.

18. Failure to cooperate with an internal investigation, including, but not limited to, investigations of violations of these work rules.

19. Failure to maintain the confidentiality of trade secrets or other confidential information belonging to the Company or its customers.

20. Failure to comply with the personnel policies and rules of the Company.

**RE-EMPLOYMENT**

Former employees who are rehired and return to work within three months of their termination will not be required to go through another orientation period, unless the company deems it necessary. Former employees who are rehired and return to work more than three months after their termination will be rehired only as new employees and must complete a new orientation period. They will be considered new employees for any and all benefits. As a general rule, the company will not rehire former employees who:

- Were dismissed by the company
- Resigned without giving two weeks’ notice
- Were dismissed for inability to perform job duties
- Had a poor attendance record
- Had a below-average evaluation
- Violated work rules or safety rules

**MOONLIGHTING**

The company discourages our employees from taking additional outside employment. Employees who wish to take on outside employment must first obtain permission from the company president. Work requirements for the company, including overtime, must take precedence over any outside employment.

The company will not permit any employee to take an outside job with a company in the same or related business as the company, or which is in any way a competitor of the company.

If the company permits an employee to take outside employment, the employee must report to his or her supervisor when the outside job has started. If, as a result of this moonlighting, the employee is unable to work when requested by the company, including overtime, or is unable to maintain a high work performance level at the company, permission to work at the outside job may be rescinded, or the employee may be subject to dismissal.

Employees are not permitted to work for any client of the company outside of the regular working hours as described above, without the express approval of the company president or his designated representative.

The company will not pay medical benefits for injuries or sickness resulting from employment by any employer other than the company.
BENEFITS

MOBILE PHONES
The company will supply employees with mobile telephones as needed. The company's mobile phones are to be used for the company's business purposes only.

PAID TIME OFF
The company provides its full-time employees with paid time off (“PTO”) each year as a way to express our appreciation and a way to renew and refresh our employees. Because our business is often very seasonal, the company reserves the right to grant PTO at times that are most suitable for our business conditions and to limit PTO during our busy season.

Full-time employees become eligible for 5 days (40 hours) of PTO per calendar year after 12 months of continuous employment with the company. After 36 months of continuous employment, employees become eligible for 10 days (80 hours) of PTO per calendar year.

Employees must use all PTO in the calendar year in which it is granted. It should be scheduled and approved by the company at least two weeks in advance. Any unused PTO will be forfeited at the end of each calendar year.

Upon termination of employment for any reason, employees forfeit any accumulated but unused PTO.

Part-time employees are not eligible for PTO.

LEAVES OF ABSENCE

Personal Leave
The company may, at its discretion, grant an employee a leave of absence without pay when sufficient personal reasons necessitate such a leave. However, employees are not eligible for a personal leave of absence until they have been continuously employed as full-time employees of the company for 12 months.

The company may require an employee to provide documentation, such as a doctor's certification of illness or disability, supporting the employee’s need for a leave of absence, and the company may periodically require the employee to provide such supporting documentation on basis during the leave of absence. Prior to or upon an employee’s return to work from a leave of absence, the company may also require the employee to provide documentation establishing the employee’s ability to return to work.

The Company reserves the right to determine the duration of the leave of absence, but no leave of absence shall exceed 12 weeks. If an employee fails to return to work immediately after his or her leave of absence expires, the employee will be considered to have voluntarily resigned his or her position with the company.

Employees may continue their health insurance benefits while on a leave of absence by paying the full cost of the employee portion of their premium to remain covered each month during the leave. Employees who wish to continue their insurance coverage should so advise the office manager before beginning their leave.

Leaves of absence will be without pay except that employees may be required to use any accrued paid time off during a leave. While on a leave of absence, employees will not accrue additional paid time off. Employees may be eligible for benefits during a leave under the Company's short-term and long-term disability plans.

Because operations sometimes require that vacant positions be filled, a leave of absence does not guarantee that the job will be available when the employee returns from a leave. The Company will, however, make an effort to place you in your previous position or a comparable job which you are qualified to perform. If no such position is available, you may be eligible for rehire as a new employee if you apply for an available position for which you are qualified and if your prior work history warrants your rehire.
**Bereavement Leave**
The company will provide up to three days of paid bereavement leave for an employee upon the death of an immediate family member. For purposes of this policy, “immediate family” is defined as the employee's or the employee's spouse's parents, siblings, children, grandparents, grandchildren, the employee's spouse, or any other relative who resides in the employee's household.

Employees should direct all requests for Bereavement Leave to their supervisors or to the company president.

While on Bereavement Leave, an employee will be paid at straight time for the hours the employee was scheduled to work on the days missed.

**Jury Leave**
Employees who are called for jury duty will be granted time off with pay to perform this civic duty. Employees must notify their supervisors as soon as they learn they have been summoned as a juror so that work arrangements can be made. In order to be paid for Jury Leave, an employee must provide his or her supervisor with the jury summons and a note from the Clerk of the Court indicating the times the employee was in court for jury duty. The company will pay employees straight time for their regularly scheduled hours of work, minus the compensation they received from the court for their service as jurors, for up to five days of jury service. An employee who is excused from jury duty prior to the end of a regularly scheduled workday must report for work for the remainder of that day, or otherwise notify his or her supervisor of his or her availability to work.

**Military Leave**
The company will grant employees called into military service an unpaid leave of absence and reemployment rights as provided by the laws of the United States. Employees may use accrued paid time off during a military leave of absence, but are not required to do so.
ACKNOWLEDGEMENT OF RECEIPT OF EMPLOYEE HANDBOOK

I have received the current company employee handbook and have read and understand the material covered. I have had the opportunity to ask questions about the policies in this handbook, and I understand that any future questions that I may have about the handbook or its contents will be answered by the Office Manager or his or her designated representative upon request. I agree to and will comply with the policies, procedures, and other guidelines set forth in the handbook. I understand that the company reserves the right to change, modify, or abolish any or all of the policies, benefits, rules, and regulations contained or described in the handbook as it deems appropriate at any time, with or without notice. I acknowledge that neither the handbook nor its contents are an express or implied contract regarding my employment.

I further understand that all employees of the company, regardless of their classification or position, are employed on an at-will basis, and their employment is terminable at the will of the employee or the company at any time, with or without cause, and with or without notice. I have also been informed and understand that no officer, agent, representative, or employee of the company has any authority to enter into any agreement with any applicant for employment or employee for an employment arrangement or relationship other than on an at-will basis and nothing contained in the policies, procedures, handbooks, or any other documents of the company shall in any way create an express or implied contract of employment or an employment relationship other than one on an at-will basis.

This handbook is the company property and must be returned upon separation.

Signature ________________________________ Date ______________________

Employee Name (Printed) ________________________________

Appendix VI

Sample Patient Satisfaction Survey

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Your Age: _______

Your Sex:
- Male
- Female

Your Race/Ethnicity:
- Asian
- Pacific Islander
- Black/African American
- American Indian/Alaska Native
- White (Not Hispanic or Latino)
- Hispanic or Latino (All Races)
- Unknown

Please circle how well you think we are doing in the following areas:

**GREAT=5, GOOD=4, OK=3, FAIR=2, POOR=1**

### Ease of getting care:
- Ability to get in to be seen: 5 4 3 2 1
- Hours Center is open: 5 4 3 2 1
- Convenience of Center’s location: 5 4 3 2 1
- Prompt return on calls: 5 4 3 2 1

### Waiting:
- Time in waiting room: 5 4 3 2 1
- Time in exam room: 5 4 3 2 1
- Waiting for tests to be performed: 5 4 3 2 1
- Waiting for test results: 5 4 3 2 1

### Staff:
- Provider: (Physician, Dentist, Physician Assistant, Nurse Practitioner)
  - Listens to you: 5 4 3 2 1
  - Takes enough time with you: 5 4 3 2 1
  - Explains what you want to know: 5 4 3 2 1
  - Gives you good advice and treatment: 5 4 3 2 1
- Nurses and Medical Assistants:
  - Friendly and helpful to you: 5 4 3 2 1
  - Answers your questions: 5 4 3 2 1
- All Others:
  - Friendly and helpful to you: 5 4 3 2 1
  - Answers your questions: 5 4 3 2 1

### Payment:
- What you pay: 5 4 3 2 1
- Explanation of charges: 5 4 3 2 1
- Collection of payment/money: 5 4 3 2 1

### Facility:
- Neat and clean building: 5 4 3 2 1
- Ease of finding where to go: 5 4 3 2 1
- Comfort and Safety while waiting: 5 4 3 2 1
- Privacy: 5 4 3 2 1

### Confidentiality:
- Keeping my personal information private: 5 4 3 2 1
- The likelihood of referring your friends and relatives to us: 5 4 3 2 1

What do you like best about our center? ________________________

What do you like least about our Center? ________________________

Suggestions for improvement? ____________________________________

Thank you for completing our survey!
Appendix VII

Sample Managed Care Contract

PHYSICIAN PARTICIPATION AGREEMENT

This Physician Participation Agreement ("Agreement") is made and entered into by and between the party named on the signature page below (hereinafter referred to as "Physician") and Humana Health Plan of Texas, Inc., and their affiliates that underwrite or administer health plans (hereinafter referred to as "Humana").

RELATIONSHIP OF THE PARTIES

1.1 In performance of their respective duties and obligations hereunder, Humana and Physician, and Physician's respective employees and agents, are at all times acting and performing as independent contractors, and neither party, nor their respective employees and agents, shall be considered the partner, agent, servant, employee of, or joint venturer with, the other party. Unless otherwise agreed to herein, the parties acknowledge and agree that neither Physician nor Humana will be liable for the activities of the other nor the agents and employees of the other, including but not limited to, any liabilities, losses, damages, suits, actions, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or governmental authority arising out of or in connection with: (i) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement, (ii) any negligent act or omission or other misconduct; (iii) the failure to comply with any applicable laws, rules or regulations; or (iv) any accident, injury or damage to persons or property. Notwithstanding anything to the contrary contained herein, Physician further agrees to and hereby does indemnify, defend and hold harmless Humana from any and all claims, judgments, costs, liabilities, damages and expenses whatsoever, including reasonable attorneys' fees, arising from any acts or omissions in the provision by Physician of medical services to Members. This provision shall survive termination or expiration of this Agreement.

1.2 The parties agree that Humana's affiliates whose Members receive services hereunder do not assume joint responsibility or liability between or among such affiliates for the acts or omissions of such other affiliates.

SERVICES TO MEMBERS

2.1 Subject at all times to the terms of this Agreement, Physician agrees to provide or arrange for medical and related health care services to individuals designated by Humana (herein referred to as "Members") with an identification card or other means of identifying them as Members covered under a self-funded or fully insured health benefits plan to which Physician has agreed to participate as set forth in the product participation list attachment.

2.2 Physician agrees to provide Physician's services to individuals covered under other third party payors' (hereinafter referred to as "Payor" or "Payors") health benefits contracts (hereinafter referred to as "Plan" or "Plans") and agrees to comply with such Payors' policies and procedures. For Covered Services rendered to such individuals, Physician acknowledges and agrees that all rights and responsibilities arising with respect to benefits to such individuals shall be subject to the terms of the Payor Plan covering such individuals. Individuals covered under such Plans will have an identification card as a means of identifying the Payor Plan which provides coverage. Such identification cards will display the Humana logo and/or name.

2.3 For Covered Services provided to those individuals identified in Section 2.2 above, Payor will make payments for Covered Services directly to Physician in accordance with the terms and conditions of this Agreement and the rates set forth in the payment attachment applicable to the Plan type of such individual. Physician agrees that in no event, including, but not limited to, nonpayment by Payor, or Payor's insolvency, shall Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Humana for services provided by Physician to Plans' members. This provision shall not prohibit collection by Physician from Plans' members for non-covered services and/or member cost share amounts in accordance with the terms of the applicable member Plan. Payors Plans will provide appropriate steering mechanisms including benefit designs and/or physician directory and web site listings to ensure their covered individuals will have incentives to

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136
utilize Physician's services. All obligations of Physician under this Agreement with respect to Humana's Members shall equally apply to the individuals identified in Section 2.2 above.

THIRD PARTY BENEFICIARIES

3.1 Except as is otherwise specifically provided in this Agreement, the parties have not created and do not intend to create by this Agreement any rights in other parties as third party beneficiaries of this Agreement, including, without limitation, Members.

SCOPE OF AGREEMENT

4.1 This Agreement sets forth the rights, responsibilities, terms and conditions governing: (i) the status of Physician and Physician's employees, subcontractors and/or independent contractors as health care providers (hereinafter referred to as "Participating Providers") providing health care services; and (ii) Physician's provision of professional medical services (hereinafter referred to as "Physician Services") to Members. All terms and conditions of this Agreement which are applicable to "Physician" are equally applicable to each Participating Provider, unless the context requires otherwise.

4.2 Physician represents and warrants that it is authorized to negotiate terms and conditions of provider agreements, including this Agreement, and further to execute such agreements for and on behalf of itself and its Participating Providers. Physician further represents and warrants that Participating Providers will abide by the terms and conditions of this Agreement, including each of Physicians employed, subcontracted or independently contracted physicians in the event Physician is organized and providing services hereunder as a group practice. The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between Physician and Members regarding the Members' medical conditions or treatment options, and Physician acknowledges that all patient care and related decisions are the sole responsibility of Physician and Humana does not dictate or control clinical decisions with respect to the medical care or treatment of Members.

4.3 Physician acknowledges and agrees that with respect to self-funded groups, unless otherwise provided herein, Humana's responsibilities hereunder are limited to provider network administration and/or claims processing.

SUBCONTRACTING PERFORMANCE

5.1 Physician shall provide directly, or through appropriate agreements with physicians and other licensed health care professionals and/or providers, Physician Services for Members. It is understood and agreed that Physician shall maintain written agreements with Participating Providers, if any, in a form comparable to, and consistent with, the terms and conditions established in this Agreement. Physician's downstream provider agreements, if any, shall include terms and conditions which comply with all applicable requirements for provider agreements under state and federal laws, rules and regulations. In the event of a conflict between the language of the downstream provider agreements and this Agreement, the language in this Agreement shall control.

5.2 Physician shall provide Humana an executed letter of agreement (in a form substantially similar to the form attached hereto as the letter of agreement attachment) for each Participating Provider who is a physician and who is subcontracted or independently contracted with Physician prior to the provision of services by such Participating Provider to Members. Such Participating Providers, if any, who do not execute a letter of agreement may not participate under this Agreement and may not be listed in Humana's provider directories.

TERM AND TERMINATION

6.1 The term of this Agreement shall commence on ______________, 20____ (the "Effective Date"). The initial term of this Agreement shall be for one (1) year. This Agreement shall automatically renew for subsequent one (1) year terms unless either party provides written notice of non-renewal to the other party at least ninety (90) days prior to the end of the initial term or any subsequent renewal terms.
6.2 Notwithstanding anything to the contrary herein, either party may terminate this Agreement without cause by providing to the other party one hundred twenty (120) days prior written notice of termination.

6.3 Humana may terminate this Agreement, or any individual Participating Provider, immediately upon written notice to Physician, stating the cause for such termination, in the event: (i) Physician's, or any individual Participating Provider's, continued participation under this Agreement may adversely affect the health, safety or welfare of any Member or brings Humana or its health care networks into disrepute; (ii) Physician or any individual Participating Provider fails to meet Humana's credentialing or re-credentialing criteria; (iii) Physician or any individual Participating Provider is excluded from participation in any federal health care program; (iv) Physician or any individual Participating Provider voluntarily or involuntarily seeks protection from creditors through bankruptcy proceedings or engages in or acquiesces to receivership or assignment of accounts for the benefit of creditors; or (v) Humana loses its authority to do business in total or as to any limited segment of business, but then only as to that segment.

6.4 In the event of a breach of this Agreement by either party, the non-breaching party may terminate this Agreement upon at least sixty (60) days prior written notice to the breaching party, which notice shall specify in detail the nature of the alleged breach; provided, however, that if the alleged breach is susceptible to cure, the breaching party shall have thirty (30) days from the date of receipt of notice of termination to cure such breach, and if such breach is cured, then the notice of termination shall be void of and of no effect. If the breach is not cured within the thirty (30) day period, then the date of termination shall be the date set forth in the notice of termination. Notwithstanding the foregoing, any breach related to credentialing or re-credentialing, quality assurance issues or alleged breach regarding termination by Humana in the event that Humana determines that continued participation under this Agreement may affect adversely the health, safety or welfare of any Member or bring Humana or its health care networks into disrepute, shall not be subject to cure and shall be cause for immediate termination upon written notice to Physician.

6.5 Physician agrees that the notice of termination or expiration of this Agreement shall not relieve Physician's obligation to provide or arrange for the provision of Physician Services through the effective date of termination or expiration of this Agreement.

POLICIES AND PROCEDURES

7.1 Physician agrees to comply with Humana's quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Humana from time to time and, in addition, those policies and procedures which are set forth in Humana's Physician's Administration Manual, or its successor (hereinafter referred to as the "Manual"), and bulletins or other written materials that may be promulgated by Humana from time to time to supplement the Manual. The Manual and updated policies and procedures may be issued and distributed by Humana in electronic format. Paper copies may be obtained by Physician upon written request. Revisions to such policies and procedures shall become binding upon Physician ninety (90) days after such notice to Physician by mail or electronic means, or such other period of time as necessary for Humana to comply with any statutory, regulatory and/or accreditation requirements.

7.2 Humana shall maintain an authorization procedure for Physician to verify coverage of Members under a Humana health benefits contract.

7.3 Physician agrees to comply with the policies and procedures set forth in the Manual regarding inpatient and outpatient admissions including, but not limited to, notifying Humana of the admission or obtaining preadmission authorization as the Manual so requires. Physician recognizes that failure to comply with the Manual with respect to a Member admission could result in limitations on Humana's ability to administer Members' benefits. In the event Physician fails to comply with the Manual regarding a Member inpatient or outpatient admission, Physician's claim will be pending and may either not be paid (if it is not Medically Necessary) or be subject to an administrative reduction in an amount equal to fifty percent (50%) of the allowed amount. Physician agrees it shall not balance bill the Member for the amount of the reduction in payment. In the event the reduction described herein is effected, the Member's Copayments, if any, will be adjusted accordingly.
CREDENTIALING AND PROFESSIONAL LIABILITY INSURANCE

8.1 Participation under this Agreement by Physician and Participating Providers is subject to the satisfaction of all applicable credentialing and re-credentialing standards established by Humana. Physician shall provide Humana, or its designee, information necessary to ensure compliance with such standards at no cost to Humana or its designee. Physician agrees to use electronic credentialing and recredentialing processes when administratively feasible. Physician, as applicable, and all Participating Providers providing Physician Services to Humana Members shall be credentialed in accordance with Humana’s credentialing process prior to receiving participating status with Humana.

8.2 Physician shall maintain, at no expense to Humana, policies of comprehensive general liability, professional liability, and workers’ compensation coverage, insuring Physician and Physician’s employees and agents against any claim or claims for damages arising as a result of injury to property or person, including death, occasioned directly or indirectly in connection with the provision of Physician Services contemplated by this Agreement and/or the maintenance of Physician’s facilities and equipment. Upon request, Physician shall provide Humana with evidence of said coverage. Physician shall within ten (10) business days following service upon Physician, or such other period of time as may be required by any applicable law, rule or regulation, notify Humana in writing of any Member lawsuit alleging malpractice involving a Member.

PROVISION OF MEDICAL SERVICES

9.1 Physician shall provide Members all available medical services within the normal scope of and in accordance with Physician’s: (a) licenses and certifications, and (b) privileges to provide certain services based upon Physician’s qualifications as determined by Humana. Physician agrees to comply with all requests for information related to Physician’s qualifications in connection with Humana’s determination whether to extend privileges to provide certain services and/or procedures to Members. Physician shall not bill, charge, seek payment or have any recourse against Humana or Members for any amounts related to the provision of Physician Services for which Humana has notified Physician that privileges to perform such services have not been extended.

9.2 Physician shall maintain all office medical equipment including, but not limited to, imaging, diagnostic and/or therapeutic equipment (hereinafter referred to as “Equipment”) in acceptable working order and condition and in accordance with the Equipment manufacturer’s recommendations for scheduled service and maintenance. Such Equipment shall be located in Physician’s office locations that promote patient and employee safety. Physician shall provide Humana or its agents with access to such Equipment for inspection and an opportunity to review all records reflecting Equipment maintenance and service history. Such Equipment shall only be operated by qualified technicians with appropriate training and required licenses and certifications.

9.3 Equipment owned and/or operated by Physician shall comply with all standards for use of such Equipment and technician qualifications established by Humana. Physician agrees to comply with all requests for information related to Equipment and Physician’s and/or Physician’s staff, qualifications for use of same. In the event: (i) Physician’s Equipment fails to meet Humana’s standards; or (ii) Physician declines to comply with Humana’s standards for use of Equipment, Physician agrees that it will not use such Equipment while providing services to Members and shall not bill, charge, seek payment or have any recourse against Humana or Members for any amounts for services with respect to such Equipment.

STANDARDS OF PROFESSIONAL PRACTICE

10.1 Physician Services shall be made available to Members without discrimination on the basis of type of health benefits plan, source of payment, sex, age, race, color, religion, national origin, health status or disability. Physician shall provide Physician Services to Members in the same manner as provided to their other patients and in accordance with prevailing practices and standards of the profession.
11.1 **Physician** shall prepare, maintain and retain as confidential the medical records of all Members receiving Physician Services, and Members’ other personally identifiable health information received from **Humana**, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which Physician is subject, and in accordance with accepted medical practice. **Physician** shall obtain authorization of Members permitting **Humana**, and/or any state or federal agency as permitted by law, to obtain a copy and have access, upon reasonable request, to any medical record of Member related to services provided by **Physician** pursuant to applicable state and federal laws. Copies of such records for the purpose of claims processing shall be made and provided by **Physician** at no cost to **Humana** or the Member.

11.2 **Physician** and **Humana** agree to maintain the confidentiality of information maintained in the medical records of Members, and information obtained from **Humana** through the verification of Member eligibility, as required by law. This Section 11 shall survive expiration or termination of this Agreement, regardless of the cause.

**GRIEVANCE AND APPEALS PROCESS/BINDING ARBITRATION**

12.1 **Grievance and Appeals; Internal Administrative Review.** **Physician** shall cooperate and participate with **Humana** in grievance and appeals procedures to resolve disputes that may arise between **Humana** and its Members. **Physician** and **Humana** further agree that in the event they are unable to resolve disputes that may arise with respect to this Agreement, **Physician** will first exhaust any internal **Humana** administrative review or appeal procedures prior to submitting any matters to binding arbitration.

12.2 **Agreement to Arbitrate.** The parties agree that any dispute arising out of their business relationship which cannot be settled by mutual agreement shall be submitted to final and binding arbitration under the Commercial Arbitration Rules of the American Arbitration Association (“AAA”), including disputes concerning the scope, validity or applicability of this agreement to arbitrate (“Arbitration Agreement”). The parties agree that this Arbitration Agreement is subject to, and shall be interpreted in accordance with, the Federal Arbitration Act, 9 U.S.C. §§ 1-14. No claim or allegation shall be excepted from this Arbitration Agreement, including alleged breaches of the Agreement, alleged violations of state or federal statutes or regulations, tort or other common law claims, and claims of any kind that a party to the Agreement has conspired or coordinated with, or aided and abetted, one or more third parties in violation of law. Without limiting the foregoing, this Arbitration Agreement requires arbitration of disputes involving antitrust, racketeering and similar claims. This Arbitration Agreement supersedes any prior arbitration agreement between the parties. The parties agree to arbitrate disputes arising from the parties’ business relationship prior to the effective date of the Agreement under the terms of this arbitration provision. This Arbitration Agreement, however, does not revive any claims that were barred by the terms of prior contracts, by applicable statutes of limitations or otherwise.

12.3 **Arbitration Process.** The arbitration shall be conducted by one neutral arbitrator selected by the parties from a panel of arbitrators proposed by the AAA. The arbitrator shall have prior professional, business or academic experience in healthcare, managed care or health insurance matters. In the event of an arbitration of antitrust claims, the arbitrator shall have prior professional, business or academic experience in antitrust matters. The arbitration shall be conducted in a location selected by mutual agreement or, failing agreement, at a location selected by the AAA that is no more than fifty (50) miles from **Physician’s** place of business. The cost of any arbitration proceeding(s) hereunder shall be borne equally by the parties. With respect to any arbitration proceeding between **Humana** and **Physician** whereby **Physician** practices individually or in a physician group of less than six (6) physicians, **Humana** agrees that it shall refund any applicable filing fees or arbitrators’ fees paid by such **Physician** in the event that **Physician** is the prevailing party with respect to such arbitration proceeding; provided, however, that this paragraph shall not apply with respect to any arbitration proceeding in which **Physician** purports to represent physicians outside his or her physician group. Each party shall be responsible for its own attorneys’ fees and such other costs and expenses incurred related to the proceedings, except to the extent the applicable substantive law specifically provides otherwise.
12.4 **Joinder: Class Litigation.** Any arbitration under this Arbitration Agreement shall be solely between Humana and Physician, shall not be joined with another lawsuit, claim, dispute or arbitration commenced by any other person, and may not be maintained on behalf of any purported class.

12.5 **Expense of Compelling Arbitration.** If either party commences a judicial proceeding asserting claims subject to this Arbitration Agreement or refuses to participate in an arbitration commenced by the other party, and the other party obtains a judicial order compelling arbitration of such claims, the party that commenced the judicial proceeding or refused to participate in an arbitration in violation of this Arbitration Agreement shall pay the other party's costs incurred in obtaining an order compelling arbitration, including the other party's reasonable attorneys' fees.

12.6 **Judgment on the Decision and Award.** Judgment upon the decision and award rendered by an arbitrator under this Arbitration Agreement may be entered in any court having jurisdiction thereof.

12.7 **MDL Settlement.** Notwithstanding anything to the contrary in Section 12.2 above, Section 12.2 shall not apply to any dispute between Physician and Humana: (i) which is subject to resolution through either Section 7.10 or Section 7.11 of that certain settlement agreement dated October 17, 2005 between Humana Inc. and Humana Health Plan, Inc. and the representative plaintiffs, the signatory medical societies, and class counsel ("MDL Settlement"); and (ii) for which Physician seeks resolution pursuant thereto; provided, however, any dispute subject to resolution under Section 7.11 of the MDL Settlement which does not result in a binding determination on the parties pursuant to the terms of Section 7.11 and for which Physician desires to continue to pursue shall be resolved by binding arbitration in accordance with Section 12.2 of this Agreement. A description of Sections 7.10 and 7.11 of the MDL Settlement are set forth in the Manual. All final determinations rendered in accordance with Sections 7.10 or 7.11 of the MDL Settlement are binding upon Physician and Humana. Notwithstanding anything to the contrary in this Section 12.3 or in Section 22.1 below, at Humana's option, Sections 7.10 or 7.11 of the MDL Settlement shall not apply to any physician, including Physician, who has opted-out of the MDL Settlement.

**USE OF PHYSICIAN'S NAME**

13.1 **Humana** may include the following information in any and all marketing and administrative materials published or distributed in any medium: Physician's name, telephone number, address, office hours, type of practice or specialty, hospital affiliation, Internet web-site address, and the names of Participating Providers, including physicians providing care at Physician's office, and hospital affiliation, board certification, and other education and training history, if applicable, of Participating Providers. Humana will provide Physician with access to such information or copies of such administrative or marketing materials upon request.

13.2 **Physician** may advertise or utilize marketing materials, logos, trade names, service marks, or other materials created or owned by Humana after obtaining Humana's written consent. Physician shall not acquire any right or title in or to such materials as a result of such permissive use.

13.3 **Physician** agrees to allow Humana to distribute a public announcement of Physician's affiliation with Humana.

**PAYMENT**

14.1 **Physician** shall accept payment from Humana for those services for which benefits are payable under a Member's health benefits contract (hereinafter referred to as "Covered Services") provided to Member in accordance with the reimbursement terms in the payment attachment. Physician shall collect directly from Member any co-payment, coinsurance, or other member cost share amounts (hereinafter referred to as "Copayments") applicable to the Covered Services provided and shall not waive, discount or rebate any such Copayments. Payments made in accordance with the payment attachment less the Copayments owed by Members pursuant to their health benefits contracts shall be accepted by Physician as payment in full from Humana for all Covered Services. This provision shall not prohibit collection by Physician from Member for any services not covered under the terms of the applicable Member health
benefits contract. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

14.2 Physician agrees that payment may not be made by Humana for services rendered to Members which are determined by Humana not to be Medically Necessary. "Medically Necessary" (or "Medical Necessity"), unless otherwise defined by applicable law, shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors. Physician agrees that in the event of a denial of payment for Physician Services rendered to Members determined not to be Medically Necessary by Humana, that Physician shall not bill, charge, seek payment or have any recourse against Member for such services. Notwithstanding the immediately preceding sentence, Physician may bill the Member for services determined not to be Medically Necessary if Physician provides the Member with advance written notice that: (a) identifies the proposed services, (b) informs the Member that such services may be deemed by Humana to be not Medically Necessary, and (c) provides an estimate of the cost to the Member for such services and the Member agrees in writing in advance of receiving such services to assume financial responsibility for such services.

14.3 Physician agrees that Humana may recover overpayments made to Physician by Humana by offsetting such amounts from later payments to Physician, including, without limitation, making retroactive adjustments to payments to Physician for errors and omissions relating to data entry errors and incorrectly submitted claims or incorrectly applied discounts. Humana shall provide Physician thirty (30) days advance written notice of Humana's intent to offset such amounts prior to deduction of any monies due. If Physician does not refund said monies or request review of the overpayments described in the notice within thirty (30) days following receipt of notice from Humana, Humana may without further notice to Physician deduct such amounts from later payments to Physician. Humana may make retroactive adjustments to payments for a period not to exceed eighteen (18) months from original date of payment or such other period as may be required by applicable law.

14.4 In the event Humana has access to Physician's, or a Participating Provider's, services through one or more other agreements or arrangements in addition to this Agreement, Humana will determine under which agreement or arrangement payment for Covered Services will be made.

14.5 Nothing contained in this Agreement is intended by Humana to be a financial incentive or payment that directly or indirectly acts as an inducement for Physician to limit Medically Necessary services.
SUBMISSION OF CLAIMS

15.1 **Physician** shall submit all claims to **Humana** or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant 837 electronic format, or a CMS 1500 and/or UB-92, or their successors. Claims shall include the **Physician's** NPI and the valid taxonomy code that most accurately describes the services reported on the claim. Claims shall be submitted within one hundred eighty (180) days from the later of: (i) the date of service; or (ii) the date of **Physician's** receipt of the explanation of benefits from the primary payor when **Humana** is the secondary payor; provided, however, all claims under self-insured plans must be submitted within ninety (90) days of the date of service. Notwithstanding the foregoing, self-insured plans may specify a shorter period of time in which claims must be submitted. **Humana** may, in its sole discretion, deny payment for any claim(s) received by **Humana** after the later of the dates specified above. **Physician** acknowledges and agrees that Members shall not be responsible for any payments to **Physician** except for applicable Copayments and non-covered services provided to such Members.

15.2 **Humana** will process **Physician** claims which are accurate and complete in accordance with **Humana's** normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing. Such claims processing procedures may include, without limitation, automated systems applications which identify, analyze and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the services provided to Members. These automated systems may result in an adjustment of the payment to the **Physician** for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service. In no event may **Physician** bill a member for any amount adjusted in payment.

15.3 **Physician** shall use best efforts to submit all claims to **Humana** by electronic means available and accepted as industry standards that are mutually agreeable, and which may include claims clearinghouses or electronic data interface companies used by **Humana.** **Physician** acknowledges that **Humana** may market certain products that will require electronic submission of claims in order for **Physician** to participate.

COORDINATION OF BENEFITS

16.1 When a Member has coverage, other than with **Humana**, which requires or permits coordination of benefits from a third party payor in addition to **Humana**, **Humana** will coordinate its benefits with such other payor(s). In all cases, **Humana** will coordinate benefits payments in accordance with applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, **Humana** will pay the lesser of: (i) the amount due under this Agreement; (ii) the amount due under this Agreement less the amount payable or to be paid by the other payor(s); or (iii) the difference between allowed billed charges and the amount paid by the other payor(s). In no event, however, will **Humana**, when its plan is a secondary payor, pay an amount which, when combined with payments from the other payor(s), exceeds the rates set out in this Agreement; provided, however, if Medicare is the primary payor, **Humana** will, to the extent required by applicable law, regulation or Centers for Medicare and Medicaid Services ("CMS") Office of Inspector General ("OIG") guidance, pay **Physician** an amount up to the amount **Humana** would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

NO LIABILITY TO MEMBER FOR PAYMENT

17.1 **Physician** agrees that in no event, including, but not limited to, nonpayment by **Humana**, **Humana's** insolvency or breach of this Agreement, shall **Physician** or any Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than **Humana** (or the payor issuing the health benefits contract administered by **Humana**) for Covered Services provided by **Physician**. This provision shall not prohibit collection by **Physician** from Member for any non-covered service and/or Copayments in accordance with the terms of the applicable Member health benefits contract.
17.2 **Physician** further agrees that: (i) this provision shall survive the expiration or termination of this Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Physician and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees, agents, trustees, assignees, subcontractors, and independent contractors of Physician, and Physician shall obtain from such persons specific agreement to this provision.

17.3 Any modification to this Section 17 shall not become effective unless approved by the Commissioner of Insurance, in the event such approval is required by applicable state law or regulation, or such changes are deemed approved in accordance with state law or regulation.

**ACCESS TO INFORMATION**

18.1 Physician agrees that Humana, or any state or federal regulatory agency as required by law, shall have reasonable access and an opportunity to examine Physician's financial and administrative records as they relate to services provided to Members during normal business hours, on at least seventy-two (72) hours advance notice, or such shorter notice as may be imposed on Humana by a federal or state regulatory agency or accreditation organization.

**NEW PRODUCT INTRODUCTION**

19.1 From time to time during the term of this Agreement, Humana may develop or implement new products. Should Humana offer participation in any such new product to Physician, Physician shall be provided with ninety (90) days' written notice prior to the implementation of such new product. If Physician does not object in writing to its participation in such new product within such ninety (90) day notice period, Physician shall be deemed to have accepted participation in the new product. In the event Physician objects to its participation in a new product, the parties shall confer in good faith to reach agreement on the terms of Physician's participation. If agreement on such new product cannot be reached, such new product shall not apply to this Agreement. Humana may in its discretion, establish, develop, manage and market provider networks in which Physician may not be selected to participate.

**ASSIGNMENT AND DELEGATION**

20.1 The assignment by Physician of this Agreement or any interest hereunder shall require notice to and the written consent of Humana. As used in this paragraph, the term “assignment” shall also include a change of control in Physician's practice by merger, consolidation, transfer, or the sale of thirty-three percent (33%) or more stock or other ownership interest in Physician's practice. Any attempt by Physician to assign this Agreement or any interest hereunder without complying with the terms of this paragraph shall be void and of no effect, and Humana, at its option, may elect to terminate this Agreement upon thirty (30) days written notice to Physician, without any further liability or obligation to Physician. Humana may assign this Agreement in whole or in part to any purchaser of or successor to the assets or operations of Humana, or to any affiliate of Humana, provided that the assignee agrees to assume Humana’s obligations under this Agreement. Upon notice of an assignment by Humana, Physician may terminate this Agreement upon thirty (30) days written notice to Humana.

**COMPLIANCE WITH REGULATORY REQUIREMENTS**

21.1 Physician acknowledges, understands and agrees that this Agreement may be subject to the review and approval of state regulatory agencies with regulatory authority over the subject matter to which this Agreement may be subject. Any modification of this Agreement requested by such agencies or required by applicable law or regulations shall be incorporated herein as provided in Section 23.10, of this Agreement.

21.2 Physician and Humana agree to be bound by and comply with the provisions of all applicable state and/or federal laws, rules and regulations. The alleged failure by either party to comply with applicable state and/or federal laws, rules or regulations shall not be construed as allowing either party a private right of action against the other in any court, administrative or arbitration proceeding in matters in which such
right is not recognized or authorized by such law or regulation. Physician and Participating Providers agree to procure and maintain for the term of this Agreement all license(s) and/or certification(s) as is required by applicable law and Humana’s policies and procedures. Physician shall notify Humana immediately of any changes in licensure or certification status of Physician or Participating Providers. If Physician or any individual Participating Provider violates any of the provisions of applicable state and/or federal laws, rules and regulations, or commits any act or engages in conduct for which Physician’s or Participating Providers’ professional licenses are revoked or suspended, or otherwise is restricted by any state licensing or certification agency by which Physician or Participating Providers are licensed or certified, Humana may immediately terminate this Agreement or any individual Participating Provider.

DISPUTE RESOLUTION/LIMITATIONS ON PROCEEDINGS

22.1 Physician may contest the amount of the payment, denial or nonpayment of a claim only within a period of eighteen (18) months following the date such claim was paid, denied or not paid by the required date by Humana. In order to contest such payments, Physician shall provide to Humana, at a minimum, in a clear and acceptable written format, the following information: Member name and identification number, date of service, relationship of the Member to the patient, claim number, name of the provider of the services, charge amount, payment amount, the allegedly correct payment amount, difference between the amount paid, and the allegedly correct payment amount, and a brief explanation of the basis for the contestation. Humana will review such contestation(s) and respond to Physician within thirty (30) days of the date of receipt by Humana of such contestation. Notwithstanding the foregoing, in the event the claims contestation is subject to resolution under Section 7.11 of the MDL Settlement, Physician may elect to pursue resolution thereunder in lieu of the contestation procedure set forth in this Section 22.1; provided, however, any commencement of an appeal under Section 7.11 shall be brought within the eighteen (18) month timeframe set forth in this Section 22.1 or shall otherwise be barred. Further, in the event Physician fails to exercise the contestation rights set forth in this Section 22.1, Physician shall not be entitled to pursue an appeal under Section 7.10 of the MDL Settlement.

22.2 In the event of a determination, following either the review of the claims contestations by Humana, or following the arbitration proceedings described in Section 12.2 above, that the claims in dispute, in the aggregate, were processed and paid correctly, Physician shall, upon request of Humana, reimburse Humana for its costs in reviewing the claims contestations and reprocessing the claims and, in the event the matter was submitted by either party for arbitration, the costs and expenses, and attorneys fees incurred by Humana that are attributable to the arbitration proceeding. In the event of a determination, following either the review of the claims contestations by Humana or following the arbitration proceedings described in Section 12.2 above, that the claims in dispute, in the aggregate, were not processed and paid correctly by Humana, Humana shall, upon request of Physician, reimburse Physician's costs in preparing the claims contestation submission to Humana, and, in the event the matter was submitted by either party for arbitration, the costs and expenses, and attorneys fees incurred by Physician that are attributable to the mediation or arbitration proceeding.

MISCELLANEOUS PROVISIONS

23.1 SEVERABILITY. If any part of this Agreement should be determined to be invalid, unenforceable, or contrary to law, that part shall be reformed, if possible, to conform to law, and if reformation is not possible, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

23.2 GOVERNING LAW. This Agreement shall be governed by and construed in accordance with the applicable laws of the State of Texas. The parties agree that applicable state and/or federal laws and/or regulations may make it necessary to include in this Agreement specific provisions relevant to the subject matter contained herein. Such state law provisions, if any, are set forth in the state law coordinating provisions attachment hereto. Such federal law provisions, if any, are set forth in the Medicare Advantage provisions attachment hereto. The parties agree to comply with any and all such provisions and in the event of a conflict between the provisions in the state law coordinating provisions attachment and/or the Medicare Advantage provisions attachment and any other provisions in this Agreement, the provisions in those attachments, as applicable, shall control. In the event that state and/or federal laws and/or regulations enacted after the Effective Date expressly require specific language to be included in this Agreement, such provisions are hereby incorporated by reference without further notice by or action of the
party and such provisions shall be effective as of the effective date stated in such laws, rules or regulations.

23.3 **WAIVER.** The waiver, whether express or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any subsequent or continuing breach of the same provision. In addition, the waiver of any of the remedies available to either party in the event of a default or breach of this Agreement by the other party shall not at any time be deemed a waiver of any party’s right to elect such remedy at any subsequent time if a condition of default continues or recurs.

23.4 **NOTICES.** Any notices, requests, demands or other communications, except notices of changes in policies and procedures pursuant to Section 7, required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been given: (i) on the date of personal delivery; or (ii) provided such notice, request, demand or other communication is received by the party to which it is addressed in the ordinary course of delivery: (a) on the third day following deposit in the United States mail, postage prepaid or by certified mail, return receipt requested; (b) on the date of transmission by facsimile transmission; or (c) on the date following delivery to a nationally recognized overnight courier service, each addressed to the other party at the address set forth below their respective signatures to this Agreement, or to such other person or entity as either party shall designate by written notice to the other in accordance herewith. Humana may also provide such notices to Physician by electronic means to the e-mail address of Physician set forth on the Cover Sheet to this Agreement or to other e-mail addresses Physician provides to Humana by notice as set forth herein. Unless a notice specifically limits its scope, notice to any one party included in the term “Physician” or “Humana” shall constitute notice to all parties included in the respective terms.

23.5 **CONFIDENTIALITY.** Physician agrees that the terms of this Agreement and information regarding any dispute arising out of this Agreement are confidential, and agrees not to disclose the terms of this Agreement or information regarding any dispute arising out of this Agreement to any third party without the express written consent of Humana, except pursuant to a valid court order, or when disclosure is required by a governmental agency. Notwithstanding anything to the contrary herein, the parties acknowledge and agree that Physician may discuss the payment methodology included herein with Members requesting such information.

23.6 **COUNTERPARTS, HEADINGS AND CONSTRUCTION.** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, and all of which together constitute one and the same instrument. The headings in this Agreement are for reference purposes only and shall not be considered a part of this Agreement in construing or interpreting any of its provisions. Unless the context otherwise requires, when used in this Agreement, the singular shall include the plural, the plural shall include the singular, and all nouns, pronouns and any variations thereof shall be deemed to refer to the masculine, feminine or neuter, as the identity of the person or persons may require. It is the parties desire that if any provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is to be construed against its drafter shall not apply to the interpretation of the provision.

23.7 **INCORPORATION OF ATTACHMENTS.** All attachments attached hereto are incorporated herein by reference.

23.8 **FORCE MAJEURE.** Neither party to this Agreement shall be deemed to breach its obligations under this Agreement if that party’s failure to perform under the terms of this Agreement is due to an act of God, riot, war or natural disaster.

23.9 **ENTIRE AGREEMENT.** This Agreement, including the attachments, addenda and amendments hereto and the documents incorporated herein, constitutes the entire agreement between Humana and Physician with respect to the subject matter hereof, and it supersedes any prior or contemporaneous agreements, oral or written, between Humana and Physician.

23.10 **MODIFICATION OF AGREEMENT.** This Agreement may be amended in writing as mutually agreed upon by Physician and Humana. In addition, Humana may amend this Agreement upon ninety (90) days’ written notice to Physician. Failure of Physician to object in writing to such amendment during the ninety (90) day notice period shall constitute acceptance of such amendment by Physician.
23.11 **MATERIAL ADVERSE CHANGES.** Notwithstanding anything to the contrary in Sections 6, 7.1, 19.1, 23.10 or the payment attachment, in the event **Humana** makes a material adverse change in the terms of this Agreement it shall provide at least ninety (90) days written notice to **Physician** of such change; except where a shorter notice period is required to comply with applicable law or regulation. If **Physician** objects to the change that is the subject of the notice, then **Physician** must within thirty (30) days of the date of the notice give written notice of termination of this Agreement which notice shall be effective at the end of the notice period of the material adverse change; provided, however, if **Humana** provides written notice within sixty-five (65) days of the date of the original notice of the material adverse change that it will not implement such change as to **Physician**, then **Physician's** notice of termination shall be of no force or effect.
IN WITNESS WHEREOF, the parties have the authority necessary to bind the entities identified herein and have executed this Agreement to be effective as of the Effective Date.

PHYSICIAN/AUTHORIZED SIGNATORY

Signature: _________________________

Printed Name: Redakfo Molina, MD

Title: President

Date: 04/05/2010

Address For Notice:

PHYSICIAN: Arthritis Associates, PA
Attn: Brian Loggin's
4511 Horizon Hill Blvd #150
San Antonio, TX 78229

HUMANA:

Signature: _________________________

Printed Name: Dianna Seals

Title: Director of Provider Contracting

Date: ___________________________

Copy to:
Humana Inc.
P.O. Box 1438
Louisville, Kentucky 40201-1438
Attn: Law Department
PRODUCT PARTICIPATION LIST
ATTACHMENT

Physician agrees to participate in the health benefits plan(s) selected below, whether self-funded or fully insured, that are offered or administered by Humana.

Health Benefits Plan  (Check only those which apply)

- Commercial PPO Plans  X
- Commercial HMO Plans  X
- Commercial POS Plans  X
- Commercial EPO Plans  X
- Medicare PPO Plans  X
- Medicare POS Plans  X
- Medicare Network PFFS Plans  X
- Medicare HMO Plans  X
- Traditional Plans  X

Provided Medicare Advantage Network Private Fee-For-Service ("PFFS") Plans are marked above, Physician agrees that, effective as of January 1, 2011, this Agreement shall address the provision of services to Humana PFFS Members who choose a network plan option ("Network PFFS Members"). The provision of services to other Humana PFFS Members shall be governed by Humana's PFFS Terms and Conditions posted on its website and not this Agreement.
PHYSICIAN INFORMATION
ATTACHMENT

(To be provided by Physician prior to execution of this Agreement.)

The following information is to be listed below for Physician and each Participating Provider: address, phone number, fax number, tax identification number, contact person, area of specialty, office hours, and area hospitals where Physician and Participating Providers have admitting privileges and the corresponding hospital privilege category.
LETTER OF AGREEMENT
ATTACHMENT

WHEREAS, Humana Insurance Company, Humana Health Plan of Texas, Inc., and their affiliates that underwrite or administer health plans (hereinafter referred to as "Humana") and ______________________________ (hereinafter referred to as "Physician") entered into a Physician Participation Agreement (hereinafter "Agreement") on __________________________, AND

WHEREAS, Physician and Humana agreed to be bound by the terms and conditions of the Agreement, AND

WHEREAS, the undersigned physician (hereinafter referred to as 'Participating Provider') is a member of Physician, and a Participating Provider pursuant to the Agreement between Physician and Humana, AND

WHEREAS, Participating Provider acknowledges and agrees that the joinder of the Humana companies above shall not be construed as imposing joint responsibility or cross guarantee between or among Humana companies.

NOW, THEREFORE, the parties hereby agree as follows:

Participating Provider agrees to abide by all of the terms and conditions set forth in the Agreement, and to abide by all Humana policies and procedures established and revised from time to time by Humana including, but not limited to, quality assurance, quality improvement, risk management, utilization management, credentialing and recredentialing, and grievances/appeals.

Participating Provider unconditionally authorizes Humana and Physician to share information, including but not limited to credentialing, recredentialing, quality management and utilization management information as related to treatment of individuals covered under those Humana health benefits plans covered under the Agreement (hereinafter "Members"). However, it is understood expressly that the information shall not be shared with anyone not a party to the Agreement, unless required by law or pursuant to prior written consent of Participating Provider.

Participating Provider acknowledges that Participating Provider has been provided an opportunity to read the Agreement, all of the terms of which are hereby incorporated by reference.

Participating Provider further agrees that payment to Physician or Participating Provider, as applicable, from Humana, less any Copayments owed by the Member, is payment in full for health care services provided or arranged for Members in accordance with the applicable Member health benefits contract and the terms and conditions of this Agreement. Participating Provider shall look solely to Physician for payment and agrees that payments made by Humana to Physician for Covered Services rendered to Members by Participating Provider constitutes payment in full to Participating Provider.

Participating Provider further agrees that in the event of termination or expiration of the Agreement, or in the event Physician is dissolved for whatever reason, Participating Provider shall continue to provide health care services under the terms and conditions of the Agreement and Humana agrees to continue to pay Participating Provider in accordance with the fee-for-service payment arrangements stated in the payment attachment of the Agreement for a period of one hundred and eighty (180) days after notice of dissolution of Physician or the effective date of termination or expiration of the Agreement, during which time a new physician agreement may be negotiated between Humana and the individual Participating Provider. Humana may terminate such Participating Provider participation at any time after dissolution of Physician or termination or expiration of the Agreement upon written notice to Participating Provider.

HUMANA

Signature: ____________________________
Print Name: Dianna Seals
Date: _______________________________

PARTICIPATING PROVIDER

Signature: ____________________________
Print Name: ___________________________
Date: _______________________________
STATE LAW COORDINATING PROVISIONS
ATTACHMENT

TEXAS

This page is intentionally left blank if there are no state laws, rules or regulations required for provider contracts at the time of execution of this Agreement. [Please note that none of the provisions of this attachment apply to any Medicare line(s) of business covered by this Agreement]

Provisions for PPO

Humana and Physician agree that the following provisions are incorporated into the Agreement to the extent specifically required to ensure compliance with Texas laws, rules and regulations.

1. MEMBER BILLING

Physician shall not bill a Member for unnecessary care, if a physician or practitioner panel has determined the care was unnecessary. Physician shall only bill Members for Copayments, deductibles or other payments for which Member is responsible and Physician agrees to base the bill on the Physician’s discounted contract rate and not on the full charge. This provision shall not prohibit collection from Member for any non-covered service and/or Copayment amounts in accordance with the terms of the applicable Member health benefits contract and this Agreement.

2. CONTINUITY OF CARE

The termination of this Agreement, except for reason of medical competence or professional behavior, does not release the obligation of Humana to reimburse Physician who is treating a Member of special circumstance, such as a Member who has a disability, acute condition, life threatening illness, is past the twenty-fourth (24th) week of pregnancy, or other condition, at no less than the rates provided for in this Agreement for the Member’s care in exchange for continuity of ongoing treatment of a Member receiving Medically Necessary treatment such that the Physician reasonably believes that discontinuing care by the Physician could cause harm to the patient. Special circumstance shall be identified by the Physician who must request that the Member be permitted to continue treatment under the Physician’s care and agree not to seek payment from the Member of any amounts for which the Member would not be responsible if the Agreement had not terminated. Any dispute between Humana and the Physician regarding the necessity of continued treatment by the Physician shall be submitted to the quality assurance committee or utilization committee of Humana. Humana will continue to reimburse Physician for treating a Member who has special circumstances until: (i) the ninetieth (90th) day after the effective date of the termination; or (ii) if the Member has been diagnosed with a terminal illness at the time of termination, the expiration of the nine (9) month period after the effective date of the termination; or (iii) if an Member is past the twenty-fourth (24th) week of pregnancy at the time of termination, through delivery of the child and for immediate postpartum care and a follow-up checkup within the six (6) week period after delivery.

3. NOTICE TO MEMBER OF TERMINATION OF PHYSICIAN

Reasonable advance notice will be given to a Member of the impending termination from the plan of Physician who is currently treating the Member. If Physician voluntarily terminates this Agreement, Physician, with Humana’s assistance, shall provide Members under Physician’s care with reasonable notice. If Humana terminates this Agreement, Humana will notify Members on the later of the effective date of the termination or when a review panel (described below) makes a formal recommendation. If Physician is terminated for reasons related to imminent harm, Humana will notify Members immediately.

4. COMPLAINT RESOLUTION

Humana shall not engage in any retaliatory action, including termination or refusal to renew a contract, against Physician because Physician has, on behalf of a Member, reasonably filed a complaint against Humana or has appealed a decision of Humana.
5. DISCLOSURE OF PAYMENT INFORMATION

Physician may request a description and copy of the coding guidelines, including any underlying bundling, recoding or other payment process and fee schedules applicable to specific procedures that the Physician will receive under the contract. Humana will provide the coding guidelines not later than thirty (30) days after receipt of the request. Humana will provide notice of changes to the coding guidelines and fee schedule that will result in a change of payment not later than the ninetieth (90th) day before the date the change takes effect. Physician may terminate this Agreement in accordance with termination provisions of the Agreement on or before the thirtieth (30th) day after Physician receives information requested without penalty or discrimination in participation in other health care products or plans.

6. FINANCIAL INCENTIVE

Nothing contained herein is intended by Humana to be a financial incentive or payment, which directly or indirectly acts as an inducement for Physician to limit Medically Necessary services.

7. COMMUNICATIONS WITH MEMBERS

The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between Physician, dentist or provider and Members regarding a patient's medical condition and/or treatment options; information or opinions regarding the terms, requirements, or services of the health care plan as they relate to the medical needs of the patient, or the termination of the Physician's, dentist's, or provider's contract with the health care plan or the fact that the Physician, dentist, or provider will otherwise no longer be providing medical care, dental care, or health care services under the health care plan.

8. ECONOMIC PROFILING

Upon request of Physician, Humana will make available the Physician's economic profile, if any, including the standards by which the Physician is measured. If Humana uses an economic profile, Humana will recognize the characteristics of the Physician's practice that may account for variations from expected costs.

9. PROMPT PAYMENT

As described more fully in the Physician's Administration Manual ("Manual"), Humana shall pay Physician in accordance with this Agreement within the statutory time period, any clean claim for Medically Necessary Covered Services rendered to Members. Provided, however, if necessary to determine whether a claim is payable, Humana may within thirty (30) days of receipt of a clean claim, request additional information. In which case, Humana will determine whether the claim is payable and pay, deny or audit the claim on or before the later of the remaining time in the statutory time period or fifteen (15) days after receipt of the requested information or written notice from Physician that the Physician does not possess the requested information.

10. HOSPITALISTS

Physician may elect to participate in Humana's hospitalist programs as they are developed and implemented. If Physician elects to participate and subsequently ends participation in Humana's hospitalist programs, Physician shall participate in the hospitalist programs for those Members who are hospitalized at the time Physician discontinues participation until those Members are discharged.

11. PAYMENT FOR WOMEN'S REPRODUCTIVE HEALTH AND ONCOLOGY

Humana will reimburse Physician for reproductive health and oncology services provided to women an amount not less than the annual average compensation per hour or unit as would be paid in the service area to a provider for the same medical, surgical, hospital, pharmaceutical, nursing, or other similar resources, as applicable, that would be used in providing health services exclusively to men or to the general population.
12. TERMINATION OF PARTICIPATION

At least ninety (90) days prior to the effective date of termination of this Agreement, Humana shall provide a written explanation to the Physician of the reason(s) for termination and shall comply with all relevant regulations promulgated by the Texas Department of Insurance. Exceptions to this provision are: (i) cases of imminent harm to patient health; (ii) action against license to practice; or (iii) fraud pursuant to Insurance Code Article 20.18A(b), in which cases termination may be immediate.

13. ADVISORY PANEL REVIEW

Physician, upon written request and before the effective date of termination of a Physician from participation under this Agreement, will be entitled to an advisory panel review of such termination. The advisory panel will be appointed by Humana, and will be comprised of Humana participating providers, including at least one representative in the individual provider’s specialty, if available, appointed to serve on Humana’s quality assurance or utilization review committee(s). Humana shall abide by the requirements set forth in Texas state regulations concerning the advisory panel. This provision shall not apply in cases where there is: (i) imminent or the threat of imminent harm to a Humana Member’s health, safety or welfare; (ii) action taken by a state medical, dental or other professional licensing board, or other governmental agency that effectively impairs the individual provider’s ability to practice their profession; or (iii) fraud or other malfeasance. The decision of the advisory panel must be considered but is not binding upon Humana. Humana shall provide the individual provider upon written request, a copy of the recommendation of the advisory panel and Humana’s final determination.

14. EMERGENCY SERVICES

Humana will pay for emergency care services for covered Members, which services are rendered by Physician as follows:

(i) Any medical screening examination or other evaluation required by state or federal law which is necessary to determine whether an emergency medical condition exists will be provided to a covered Member in the emergency department of a hospital;

(ii) Medically Necessary emergency care services, including treatment and stabilization of an emergency medical condition; and

(iii) Covered Services originating in a hospital emergency department following treatment of an emergency medical condition as provided for by Humana.

Humana will approve or deny coverage of post stabilization care as requested by the Physician within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one (1) hour. Humana will respond to inquiries from the Physician in compliance with this provision which appears in the Humana health benefit contract with covered Members.

15. SUBMISSION OF CLAIMS

Physician shall submit claims within ninety-five (95) days after the date services are rendered, and further agrees and acknowledges that Humana is not obligated to pay claims which are submitted ninety-five (95) days after the date services are rendered. Physician shall not resubmit any claim until, at a minimum, the forty-sixth (46th) day, the thirty-first (31st) day if filed electronically, or the twenty-second (22nd) day if for prescription benefits, after the date the original claim was received.

Physician shall submit all claims to Humana electronically by means available and accepted as industry standards, which may include claims clearinghouses, or electronic data interface companies used by Humana, and in accordance with Humana claims policies, procedures and guidelines unless Physician has obtained a written waiver from Humana for submitting claims electronically. Should Physician fail to comply with the terms contained herein, Humana may, in its sole discretion, pend payment of monies to Physician until completed claims are submitted electronically. In no event will Humana’s Members be responsible for monies in addition to those Copayments due under the applicable Member health benefits contract. Should Physician be unable to
submit claims electronically on the effective date of this Agreement. Physician shall make such arrangements as may be necessary, at its sole expense, to do so within six (6) months from the effective date of this Agreement.

16. OVERPAYMENTS

Humana may recover a refund due to an overpayment or completion of an audit if Humana notifies Physician in writing not later than one hundred and eighty (180) days after the overpayment or completion of the audit. If Physician has not made arrangements to repay or otherwise appeal Humana's notice within forty-five (45) days of Humana's notice of overpayment or within thirty (30) days of notice of completion of audit, Humana will offset the amount of the overpayment against future payments owing to Physician for any reason. If Physician disagrees with Humana's request for recovery of overpayment or refund, Physician may appeal the request in writing as provided for in Humana's notice of its intent to recover the overpayment.

17. COORDINATION OF BENEFIT INFORMATION

Physician shall collect and maintain primary payer information in the Member's medical or billing records and shall provide such information to Humana, upon request, so that Humana can coordinate benefits according to the Member's health benefits contract and the Agreement.

Provisions for HMO

Humana and Physician agree that the following provisions are incorporated into the Agreement solely to the extent specifically required to ensure compliance with applicable Texas laws, rules and regulations.

1. CONTINUITY OF CARE

The termination of this Agreement, except for reason of medical competence or professional behavior, does not release the obligation of Humana to reimburse Physician who is treating a Member of special circumstance, such as a Member who has a disability, acute condition, life threatening illness, is past the twenty-fourth (24th) week of pregnancy, or other condition, at no less than the rates provided for in this Agreement for the Member's care in exchange for continuity of ongoing treatment of a Member receiving Medically Necessary treatment such that the Physician reasonably believes that discontinuing care by the Physician could cause harm to the patient. Special circumstance shall be identified by the Physician who must request that the Member be permitted to continue treatment under the Physician's care and agree not to seek payment from the Member of any amounts for which the Member would not be responsible if the Agreement had not terminated. Any dispute between Humana and Physician regarding the necessity of continued treatment by the Physician shall be submitted to the quality assurance committee or utilization committee of Humana. Humana will continue to reimburse Physician for treating a Member who has special circumstances until: (i) the ninetenth (90th) day after the effective date of the termination; or (ii) if the Member has been diagnosed with a terminal illness at the time of termination, the expiration of the nine (9) month period after the effective date of the termination; or (iii) if a Member is past the twenty-fourth (24th) week of pregnancy at the time of termination, through delivery of the child and for immediate postpartum care and a follow-up checkup within the six (6) week period after delivery.

2. NOTICE TO MEMBER OF TERMINATION OF PHYSICIAN

Reasonable advance notice will be given to a Member of the impending termination from the plan of Physician who is currently treating the Member.

3. MEMBER COMPLAINT PROCESS

Physician shall post in Physician's medical office a notice to Members on the process for resolving complaints with Humana. The notice shall include the Texas Department of Insurance's toll-free telephone number for filing complaints.

Humana shall not engage in any retaliatory action, including termination or refusal to renew a contract, against the Physician because the Physician has, on behalf of a Member, reasonably filed a complaint against Humana or has appealed a decision of Humana.
4. DISCLOSURE OF PAYMENT INFORMATION

Physician may request a description and copy of the coding guidelines, including any underlying bundling, recoding or other payment process and fee schedules applicable to specific procedures that the Physician will receive under the contract. Humana will provide the coding guidelines not later than thirty (30) days after receipt of the request. Humana will provide notice of changes to the coding guidelines and fee schedule that will result in a change of payment not later than the ninetieth (90th) day before the date the change takes effect. Physician may terminate this Agreement in accordance with termination provisions of the Agreement on or before the thirtieth (30th) day after Physician receives information requested without penalty or discrimination in participation in other health care products or plans.

5. NO DISCRIMINATION BASED ON LICENSURE TYPE

Humana will not deny a Physician licensed or otherwise authorized to practice in this state an opportunity to participate in providing health care services that are delivered by Humana and that are within the scope of the provider's license or authorization solely because of the type of license or authorization held by the provider. If a hospital, facility, agency, or supplier is certified by the Medicare program, Title XVIII of the Social Security Act (42 U.S.C. § 1395, et seq.), or accredited by the Joint Commission on Accreditation of Healthcare Organizations or another national accrediting body, Humana will accept that certification or accreditation.

6. FINANCIAL INCENTIVE

Nothing contained herein is intended by Humana to be a financial incentive or payment, which directly or indirectly acts as an inducement for Physician to limit Medically Necessary services.

7. COMMUNICATIONS WITH MEMBERS

The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between Physician or provider and Members regarding a patient's medical condition and/or treatment options, information or opinions regarding the terms, requirements, or services of the health care plan, as they relate to the medical needs of the patient; or the termination of the Physician's or provider's contract with the health care plan or the fact that the Physician or provider will otherwise no longer be providing medical care, or health care services under the health care plan.

8. ECONOMIC PROFILING

Upon request of the Physician, Humana will make available the Physician's economic profile, if any, including the standards by which the Physician is measured. If Humana uses an economic profile, Humana will recognize the characteristics of the Physician's practice that may account for variations from expected costs.

9. PROMPT PAYMENT

As described more fully in the Physician's Administration Manual ("Manual"), Humana shall pay Physician in accordance with this Agreement within the statutory time period, any clean claim for Medically Necessary Covered Services rendered to Members. Provided, however, if necessary to determine whether a claim is payable, Humana may within thirty (30) days of receipt of a clean claim, request additional information. In which case, Humana will determine whether the claim is payable and pay, deny or audit the claim on or before the later of the remaining time in the statutory time period or fifteen (15) days after receipt of the requested information or written notice from Physician that the Physician does not possess the requested information.

10. PAYMENT OF CAPITATION

[If applicable, Humana will begin payment of capitated amounts to a Member's primary care physician, computed from the date of enrollment, not later than the sixtieth (60th) day after the date the Member selects or is assigned a primary care physician.]
11. MEMBER SELECTION OF PRIMARY CARE PHYSICIAN

If a Member does not select a primary care physician at the time of application or enrollment, Humana will assign the Member to a primary care physician. Humana will notify a physician of a Member's selection of that person as the primary care physician, or of the assignment of the Member to that physician by the health maintenance organization, not later than the thirtieth (30th) working day after the date of the selection or assignment.

12. HOSPITALISTS

Physician may elect to participate in Humana's hospitalist programs as they are developed and implemented. If Physician elects to participate and subsequently ends participation in Humana's hospitalist programs, Physician shall participate in the hospitalist programs for those Members who are hospitalized at the time Physician discontinues participation until those Members are discharged.

13. PAYMENT FOR WOMEN'S REPRODUCTIVE HEALTH AND ONCOLOGY

Humana will reimburse Physician for reproductive health and oncology services provided to women an amount not less than the annual average compensation per hour or unit as would be paid in the service area to a provider for the same medical, surgical, hospital, pharmaceutical, nursing, or other similar resources, as applicable, that would be used in providing health services exclusively to men or to the general population.

14. TERMINATION OF PARTICIPATION

At least ninety (90) days prior to the effective date of termination of this Agreement, Humana shall provide a written explanation to the Physician of the reason(s) for termination and shall comply with all relevant regulations promulgated by the Texas Department of Insurance. Exceptions to this provision are: (i) cases of imminent harm to patient health; (ii) action against license to practice; or (iii) fraud pursuant to Insurance Code Article 20.18A(b), in which cases termination may be immediate.

15. ADVISORY PANEL REVIEW

Not later than 30 days following receipt of written notification of termination, Physician may request a review by an advisory review panel of such termination. The advisory review panel will be appointed by Humana, and will be comprised of participating providers, including at least one representative in the individual provider's specialty, if available, appointed to serve on Humana's quality assurance or utilization review committee(s). Humana shall abide by the requirements set forth in Texas state regulations concerning the advisory panel. This provision shall not apply in cases where there is: (i) imminent or the threat of imminent harm to a Humana Member's health, safety or welfare; (ii) action taken by a state medical, dental or other professional licensing board, or other governmental agency that effectively impairs the individual provider's ability to practice their profession; or (iii) fraud or other malfeasance. The decision of the advisory panel must be considered but is not binding upon Humana. The advisory review panel shall make its formal recommendation and Humana will communicate its decision to the Physician within 60 days following receipt of Physician's request for review.

16. EMERGENCY SERVICES

Humana will pay for emergency care services for covered Members, which services are rendered by Physician as follows:

(i) Any medical screening examination or other evaluation required by state or federal law which is necessary to determine whether an emergency medical condition exists will be provided to a covered Member in the emergency department of a hospital;

(ii) Medically Necessary emergency care services, including treatment and stabilization of an emergency medical condition; and

(iii) Covered Services originating in a hospital emergency department following treatment of an emergency medical condition as provided for by Humana.
Humana will approve or deny coverage of post stabilization care as requested by the Physician within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one (1) hour. Humana will respond to inquiries from the Physician in compliance with this provision which appears in the Humana health benefit contract with covered Members.

17. SUBMISSION OF CLAIMS

Physician shall submit claims within ninety-five (95) days after the date services are rendered, and further agrees and acknowledges that Humana is not obligated to pay claims which are submitted ninety-five (95) days after the date services are rendered. Physician shall not resubmit any claim until, at a minimum, the forty-sixth (46th) day, the thirty-first (31st) day if filed electronically, or the twenty-second (22nd) day if for prescription benefits, after the date the original claim was received.

Physician shall submit all claims to Humana electronically by means available and accepted as industry standards, which may include claims clearinghouses, or electronic data interchange companies used by Humana, and in accordance with Humana claims policies, procedures and guidelines unless Physician has obtained a written waiver from Humana for submitting claims electronically.

Should Physician fail to comply with the terms contained herein, Humana may, in its sole discretion, pend payment of monies to Physician until completed claims are submitted electronically. In no event will Humana's Members be responsible for monies in addition to those Copayments due under the applicable Member health benefits contract. Should Physician be unable to submit claims electronically on the effective date of this Agreement, Physician shall make such arrangements as may be necessary, at its sole expense, to do so within six (6) months from the effective date of this Agreement.

In the event there is a systems failure or a catastrophic event that substantially interferes with the business operations of the Physician, the Physician may submit non-electronic claims in accordance with the requirements of §21.3701 of Title 28 of the Texas Administrative Code by providing written notice of the Physician's intent to submit non-electronic claims to Humana within 5 calendar days of the catastrophic event or systems failure.

18. OVERPAYMENTS

Physician agrees that Humana may recover a refund due to an overpayment or completion of an audit if Humana notifies Physician in writing not later than one hundred and eighty (180) days after the overpayment or completion of the audit. If Physician has not made arrangements to repay or otherwise appeal Humana's notice within forty-five (45) days of Humana's notice of overpayment or within thirty (30) days of notice of completion of audit, Humana will offset the amount of the overpayment against future payments owing to Physician for any reason. If Physician disagrees with Humana's request for recovery of overpayment or refund, Physician may appeal the request in writing as provided for in Humana's notice of its intent to recover the overpayment.

19. COORDINATION OF BENEFIT INFORMATION

Physician shall collect and maintain primary payor information in the Member's medical or billing records and shall provide such information to Humana, upon request, so that Humana can coordinate benefits according to the Member's health benefits contract and the Agreement.
MEDICARE ADVANTAGE PROVISIONS
ATTACHMENT

The following additional provisions relate specifically to Medicare Advantage products and plans and are hereby incorporated by reference into the Agreement.

a) **Physician** agrees to: (i) abide by all federal and state laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information, (ii) ensure that medical information is released only in accordance with applicable state or federal law, or pursuant to court orders or subpoenas, (iii) maintain all Member records and information in an accurate and timely manner, and (iv) allow timely access by Members to the records and information that pertain to them.

b) **Humana** and **Physician** agree that **Humana** will process all claims for Covered Services which are accurate and complete within thirty (30) days from the date of receipt.

c) **Physician** agrees that in no event, including, but not limited to, nonpayment by **Humana**, **Humana's** insolvency or breach of this Agreement, shall **Physician** bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than **Humana** (or the payor issuing the health benefits contract administered by **Humana**) for Covered Services provided by **Physician** for which payment is the legal obligation of **Humana**. This provision shall not prohibit collection by **Physician** from Member for any non-covered service and/or Copayments in accordance with the terms of the applicable Member health benefits contract. **Physician** further agrees that: (i) this provision shall survive the expiration or termination of this Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between **Physician** and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees, agents, trustees, assignees, subcontractors, and independent contractors of **Physician**, and **Physician** shall obtain from such persons specific agreement to this provision.

d) **Physician** agrees to cooperate with **Humana** in its efforts to monitor compliance with its Medicare Advantage contract(s) and/or Medicare Advantage rules and regulations and to assist **Humana** in complying with corrective action plans necessary for **Humana** to comply with such rules and regulations.

e) **Physician** agrees that nothing in the Agreement shall be construed as relieving **Humana** of its responsibility for performance of duties agreed to through its Medicare Advantage contracts existing now or entered into in the future with CMS.

f) **Physician** agrees to comply with and be subject to all applicable Medicare program laws, rules and regulations, reporting requirements, and CMS instructions as implemented and amended by CMS. This includes, without limitation, federal and state regulatory agencies including, but not limited to, HHS, the Comptroller General or their designees right to evaluate, inspect and audit **Physician's** operations, books, records, and other documentation and pertinent information related to **Physician's** obligations under the Agreement, as well as all other federal and state laws, rules and regulations applicable to individuals and entities receiving federal funds. **Physician** further agrees HHS, the Comptroller General's, or their designees right to inspect, evaluate and audit any pertinent information for any particular contract period will exist through ten (10) years from the final date of the contract period between **Humana** and CMS or from the date of completion of any audit, whichever is later, and agrees to cooperate, assist and provide information as requested by such entities.

g) **Physician** agrees to retain all contracts, books, documents, papers and other records related to the provision of services to Medicare Advantage Members and/or related to **Physician's** obligations under the Agreement for a period of not less than ten (10) years from: (i) each successive December 31; or (ii) the end of the contract period between **Humana** and CMS; or (iii) from the date of completion of any audit, whichever is later.

h) **Physician** agrees in the event certain identified activity(ies) have been delegated to **Physician** under the Agreement, any sub-delegation of the noted activity(ies) by **Physician** requires the prior written approval
of Humana. Notwithstanding anything to the contrary in the Agreement, Humana will monitor Physician’s performance of any delegated activity(ies) on an ongoing basis and hereby retains the right to modify, suspend or revoke such delegated activity(ies) in the event Humana and/or CMS determines, in their discretion, that Physician is not meeting or has failed to meet its obligations under the Agreement related to such delegated activity(ies). In the event that Humana has delegated all or any part of the claims payment process to Physician under the Agreement, Physician shall comply with all prompt payment requirements to which Humana is subject. Humana agrees that it shall review the credentials of Physician or, if Humana has delegated the credentialing process to Physician, Humana shall review and approve Physician’s credentialing process and audit it on an ongoing basis.

i) Physician agrees to comply with Humana’s policies and procedures.

j) Physician agrees to maintain full participation status in the federal Medicare program. This also includes all of Physician’s employees, subcontractors, and/or independent contractors who will provide services, including, without limitation, health care, utilization review, medical social work, and/or administrative services under the Agreement.

k) Physician agrees that payment from Humana for services rendered to Humana’s Medicare Advantage Members is derived, in whole or in part, from federal funds received by Humana from CMS.

l) Physician agrees to disclose to Humana, upon request and within thirty (30) days or such lesser period of time required for Humana to comply with all applicable state or federal laws, all of the terms and conditions of any payment arrangement that constitutes a “physician incentive plan” as defined by CMS and/or any federal law or regulation. Such disclosure should identify, at a minimum, whether services not furnished by the physician/provider are included, the type of incentive plan including the amount, identified as a percentage, of any withhold or bonus, the amount and type of any stop-loss coverage provided for or required of the physician/provider, and the patient panel size broken down by total group or individual physician/provider panel size, and by the type of insurance coverage (i.e., Commercial HMO, Medicare Advantage HMO, Medicare PPO, and Medicaid HMO).

m) Physician agrees that in the event of Humana’s insolvency or termination of Humana’s contract with CMS, benefits to Members will continue through the period for which premium has been paid and benefits to Members confined in an inpatient facility will continue until their discharge.

n) Physician agrees to provide or arrange for continued treatment, including, but not limited to, medication therapy, to Medicare Advantage Members upon expiration or termination of the Agreement. In accordance with all applicable state and federal laws, rules and/or regulations, treatment must continue until the Member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the Medicare Advantage Member’s course of treatment; or until Humana has made arrangements for substitute care for the Medicare Advantage Member; and (ii) until the date of discharge for Medicare Advantage Members hospitalized on the effective date of termination or expiration of the Agreement. Physician agrees to accept as payment in full from Humana for Covered Services rendered to Humana’s Medicare Advantage Members, the rates set forth in the payment attachment which are applicable to such Member.

o) Physician agrees to cooperate with the activities and/or requests of any independent quality review and improvement organization utilized by and/or under contract with Humana as related to the provision of services to Medicare Advantage Members.

p) Physician agrees to cooperate with Humana’s health risk assessment program.

q) Physician agrees to provide to Humana accurate and complete information regarding the provision of Covered Services by Physician to Members ("Data") on a complete CMS 1500 or UB 92 form, or their respective successor forms as may be required by CMS, or such other form as may be required by law when submitting claims and encounters in an electronic format, or such other format as is mutually agreed upon by both parties. The Data shall be provided to Humana on or before the last day of each month for encounters occurring in the immediately preceding month, or such lesser period of time as may be required in the Agreement, or as is otherwise agreed upon by the parties in writing. The submission of the
Data to Humana and/or CMS shall include a certification from Physician that the Data is accurate, complete and truthful. In the event the Data is not submitted to Humana by the date and in the form specified above, Humana may, in its sole option, withhold payment otherwise required to be made under the terms of the Agreement until the Data is submitted to Humana.

r) Physician agrees not to collect or attempt to collect copayments, coinsurance, deductibles or other cost-share amounts from any Humana Medicare Advantage Member who has been designated as a Qualified Medicare Beneficiary ("QMB") by CMS.

s) Physician agrees to maintain written agreements with employed and contracted health care providers and health care professionals providing services under the Agreement in a form comparable to, and consistent with, the terms and conditions of the Agreement. Physician's downstream provider agreements shall include terms and conditions which comply with all applicable requirements for provider agreements under state and federal laws, rules and regulations including, without limitation, the Medicare Advantage rules and regulations to which Humana is subject. In the event of a conflict between the language of the downstream provider agreements and the Agreement, the language in the Agreement shall control.

t) With respect to any members who are eligible for both Medicare and Medicaid, Physician agrees that such members will not be held liable for Medicare Part A and Medicare Part B cost sharing when the State is responsible for paying such amounts. Further, with respect to such members, Physician agrees to: (i) accept the payment amount from Humana as payment in full, or (ii) bill the appropriate State source.
HMO PROVISIONS ATTACHMENT

The following provisions apply solely to commercial HMO and/or Medicare Advantage HMO products and plans, as applicable.

I. Services to Members. In the event Physician provides a Member a non-covered service or refers a Member to an out-of-network provider without pre-authorization from Humana, Physician shall, prior to the provision of such non-covered service or out-of-network referral, inform the Member: (i) of the service(s) to be provided or referral(s) to be made; (ii) that Humana will not pay or be liable financially for such non-covered service(s) or out-of-network referral(s); and (iii) that Member will be responsible financially for non-covered service(s) and/or out-of-network referral(s) that are requested by the Member.

II. Continuity of Care. Subject to and in accordance with all applicable state and/or federal laws, rules and/or regulations, treatment following termination or expiration of this Agreement must continue until the Member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the Member's course of treatment, or until Humana has made arrangements for substitute care for the Member; and (ii) until the date of discharge for Members hospitalized on the effective date of termination or expiration of this Agreement. Physician agrees to accept as payment in full from Humana for Covered Services rendered to such Members, the rates set forth in the payment attachment, less any Copayments due from such Members.

Notwithstanding the foregoing, if upon notice from Physician or a Member that Member is in a continuation of care situation as noted above or in accordance with applicable law and Humana does not use due diligence to make alternative care available to the Member within ninety (90) days after receipt of such notice, then Humana shall pay to Physician for continuity of care services the standard rates paid to non-participating physicians for that geographical area. The preceding sentence shall not apply if other participating physicians, physician groups or physician organizations are not available to replace the terminating Physician due to: (i) geographic or travel-time barriers; or (ii) contractual provisions between the terminating Physician and a facility at which the Member receives care that limits or precludes other participating physicians, physician groups or physician organizations from rendering replacement services to Members (for example, an exclusive contract is in place between the terminating Physician and a facility where the Member receives services).

III. Medical Records. Upon request from Humana or a Member, Physician shall transfer a complete copy of the medical records of any Member transferred to another physician and/or facility for any reason, including termination or expiration of this Agreement. The copy and transfer of medical records shall be made at no cost to Humana or the Member and shall be made within a reasonable time following the request, but in no event more than five (5) business days, except in cases of emergency where the transfer shall be immediate. Physician agrees that such timely transfer of medical records is necessary to provide for the continuity of care for Members. Physician agrees to pay court costs and/or legal fees incurred by Humana or the Member to enforce the terms of this provision.

IV. Acquisitions. In the event Physician acquires, through an asset acquisition, merger, consolidation, lease or other means, or enters into a management agreement to manage the practice(s) of physician(s) or physician group(s) in San Antonio, TX, and such practices or groups have in effect an agreement with Humana to provide services to Humana's Members at rates which are more favorable to Humana than those contained herein, the rates contained herein shall be adjusted downward to reflect such more favorable rate.

V. Equal Access. Physician agrees to accept Humana Members as patients within the normal scope of Physician's medical practice. If, due to overcapacity, Physician closes his/her practice to new patients, such closure will apply to all prospective patients without discrimination or regard to payer or source of payment for services. Should Physician subsequently reopen his/her practice to new patients, Physician agrees to accept Humana Members seeking assignment and/or referral to Physician's practice to the same extent and in the same manner as all other non-Humana patients seeking Physician's services.
VI. **Physician Responsibilities.**

A. **Services**

Physician agrees to be responsible twenty-four (24) hours a day, seven (7) days a week for providing Covered Services for Members including, but not limited to, prescribing, directing and monitoring all urgent and emergency care for Members.

Physician agrees to provide Humana upon request a written description of its arrangements for emergency and urgent care and service coverage in the event of unavailability due to vacation, illness, and after regular office hours. Physician shall ensure that all physicians providing such coverage are contracted and credentialed physicians with Humana. Physician will ensure that all physicians providing such coverage render services under the same terms and conditions and in compliance with all provisions of this Agreement. Compensation to physicians for "on call" coverage will be the responsibility of Physician.

In the event that emergency or urgent care services are needed by a Member outside the service area, Physician agrees to monitor and authorize the out-of-area care to provide direct care as soon as the Member is able to return to the service area for treatment without medically harmful or injurious consequences.

B. **Specific Referrals**

Except in the case of a medical emergency, Physician agrees to use its best efforts to admit, refer, and cooperate with the transfer of Members for Covered Services only to providers designated, specifically approved by or under contract with Humana.

In addition, Physician acknowledges and agrees that certain Members may have health benefits contracts that limit coverage to certain types of participating providers. For such Members, referrals are required to be made to specific providers designated by Humana.

C. **Disease/Case Management Programs**

Physician agrees to participate in Humana's disease/case management programs as they are developed and implemented.

D. **Humana First**

Physician agrees to participate in Humana's twenty-four (24) hours nurse call program, HumanaFirst, or any such successor program.

E. **Hospitalist Programs**

Physician agrees to cooperate with and participate in Humana's hospitalist programs where applicable, as they are developed and implemented.

F. **Transplant Programs**

Upon request by Humana, Physician agrees to cooperate with and participate in Humana's organ and tissue transplant programs as they are developed and implemented.

G. **Health Improvement Studies**

Physician agrees to participate in Humana's health improvement studies as they are developed and implemented.
H. Quality Improvement Activities

Physician agrees to cooperate with Humana's quality improvement activities and, upon request by Humana, to participate in Humana's quality improvement activities as they are developed and implemented.
PAYMENT ATTACHMENT

1. REIMBURSEMENT

A. Commercial Plan(s)

Physician agrees to accept as payment in full from Humana for Covered Services rendered to Members covered by this Agreement the lesser of Physician's billed charges or the amount specified below, less any Copayments due from Members.

<table>
<thead>
<tr>
<th>Physician</th>
<th>Service</th>
<th>Reimbursement</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Drugs &amp; Biologicals</td>
<td>105% of Humana’s 201-544 fee schedule</td>
</tr>
<tr>
<td></td>
<td>All Laboratory</td>
<td>100% of Humana’s 008-782 fee schedule</td>
</tr>
<tr>
<td></td>
<td>Evaluation &amp; Management Services</td>
<td>120% of Humana’s 008-782 fee schedule</td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
<td>115% of Humana’s 008-782 fee schedule</td>
</tr>
<tr>
<td></td>
<td>Radiology Services</td>
<td>120% of Humana’s 008-782 fee schedule</td>
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<tr>
<td></td>
<td>HCPC, Physical Therapy</td>
<td>100% of Humana’s 008-782 fee schedule</td>
</tr>
<tr>
<td></td>
<td>All Other Services</td>
<td>115% of Humana’s 008-782 fee schedule</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Extender</th>
<th>Service</th>
<th>Reimbursement</th>
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</thead>
<tbody>
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<td>100% of Humana’s 008-782 fee schedule</td>
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<tr>
<td></td>
<td>All Other Services</td>
<td>85% of Humana’s 008-782 fee schedule</td>
</tr>
</tbody>
</table>

B. Medicare Advantage Plan(s)

Physician agrees to accept as payment in full from Humana for Covered Services rendered to Members covered by this Agreement the lesser of Physician’s billed charges or the amount specified below, less any Copayments due from Members.

Medicare HMO (MHMO), Medicare PPO (MPPO), and Medicare Private Fee for Service (PFFS)

<table>
<thead>
<tr>
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<th>Reimbursement</th>
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<tbody>
<tr>
<td></td>
<td>DME, Radiology, All Laboratory Services</td>
<td>70% of Humana’s 005-795 fee schedule</td>
</tr>
<tr>
<td></td>
<td>All Other Services</td>
<td>100% of Humana’s 005-795 fee schedule</td>
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</tbody>
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</tr>
<tr>
<td></td>
<td>All Other Services</td>
<td>85% of Humana’s 005-795 fee schedule</td>
</tr>
</tbody>
</table>

C. Fee Schedule Description
201-544 Fee Schedule:

Humana's injectable fee schedule (201-544) uses a percentage of the CMS Average Sales Price (ASP) or another industry standard as the basis of the 201-544 fee schedule. The fee schedule includes the following administration codes: 90465, 90466, 90467, 90468, 90471, 90472, 90473, and 90474. Notwithstanding anything to the contrary in the Agreement, in the event the basis for the schedule is changed from a percentage of ASP to another basis, then Humana will provide ninety (90) days advance notice to Physician, of the new basis. The list of codes and associated fees are reviewed and updated quarterly to reflect market pricing. These quarterly updates, if any, as well as any change in the basis may result in fees being adjusted either upwardly or downwardly. These updates shall be incorporated in the Humana injectable fee schedule (201-544) without notice to Physician, but will be made available to Physician, upon request.

008-782 Fee Schedule:

Humana's (008-782) fee schedule is based upon a modified version of the 2008 Medicare Resource Based Relative Value Scale ("RBRVS") fee schedule and payment systems, including the site-of-service payment differential. Various percentages are applied by Humana to the fees in the schedule for specific Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS") codes or ranges of CPT and HCPCS codes.

Humana may modify schedule 008-782 to include codes and/or fees for services that are not included in this fee schedule (hereinafter "Gap Codes"). In most cases, the Gap Codes are adjusted by Humana using the relative value unit ("RVU") multiplied by Medicare's conversion factor and geographic factor to assign the fee at the same percentage applied by Humana for other codes within that code range.

Additionally, Humana may incorporate new CPT and HCPCS codes into schedule 008-782. The fee attributable to such code(s) will be determined by applying the same percentage as Humana applied to other codes within such code range to that code's RBRVS which is current as of the date of creation of the code.

Periodic updates for new CPT codes, HCPCS codes and/or Gap Codes, or for modifications of fees resulting from adjustments to a code's RVU as specified above, shall be incorporated into schedule 008-782 without notice to Physician, but will be available to Physician upon request. Humana may make other adjustments and modifications to this fee schedule. In such cases, Humana will provide Physician a ninety (90) day written notice prior to implementation of any other modifications and adjustments to schedule 008-782.

005-795 Fee Schedule:

Humana's 005-795 fee schedule is based on the RBRVS fee schedule and payment systems, including the site-of-service payment differential, in effect as of the effective date of this Agreement and will change thereafter to reflect the annual updates to the schedule made by the Centers for Medicare and Medicaid Services ("CMS"). Additionally, Humana will adjust the schedule to include and assign fees for services which are not covered by RBRVS. A list of those Humana adjusted codes and fees will be available to Physician upon request.

Such annual updates by CMS and any corresponding adjustments by Humana shall be incorporated herein without notice to the Physician, but will be available to the Physician upon request. Humana may make other adjustments and modifications to the fee schedule. In such cases, Humana will provide to Physician a ninety (90) day written notice prior to implementation of any other modifications and adjustments to the fee schedule.

D. Unlisted Codes

Claims filed with an "unlisted" service or procedure code must include documentation of the service provided. The documentation must include a written description of the service and the appropriate medical reports related to the service, including the NDC number for drugs or a copy of the invoice for
equipment, if applicable. Unlisted procedure codes are defined as CPT or HCPCS code descriptions that include one of the following: "NOC, NEC, NOS, unlisted, not specified, miscellaneous or special report". Each claim will be reviewed manually and Humana will assign the allowable fee based on established fees for comparable services. In the event that a comparable service cannot be determined, the allowable fee will be the lesser of a discounted percent of the billed charge amount, the Average Wholesale Price for drugs, or invoice cost plus 10% for supplies or equipment.

E. Fee Schedule Samples

Humana has provided a representative sample of these fee schedules to Physician prior to Physician's execution of this Agreement, and thereafter will supply a sample upon written request by Physician. Physician hereby acknowledges receipt of fee schedule sample.

2. PHYSICIAN EXTENDERS

Physician agrees that in the event that Physician employs, subcontracts or dependently contracts with or uses the services of a physician extender (that is a physician assistant, advanced registered nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, certified surgical assistant, certified registered nurse first assistant or such other similarly situated individual) who will be providing services to Humana Members under the supervision of Physician, Physician shall notify Humana in writing, upon execution of this Agreement and at any time during the term of this Agreement when such physician extenders are employed, subcontracted, or independently contracted with Physician, and the specific services that such physician extenders will be performing, prior to the provision of services to any Humana Member. Physician represents that physician extenders employed by or under contract with Physician will comply with the terms and conditions of this Agreement, maintain professional liability coverage and are appropriately licensed as required by applicable state and federal laws, rules and regulations. Physician acknowledges and agrees Humana retains the right to approve, suspend and/or terminate participation under this Agreement of any physician extender who will be providing services to Humana Members.

3. SPECIFIC REFERRALS

Physician and other Participating Providers acknowledge and agree that certain referrals are required to be made to specific providers designated by Humana. The specific referral providers include but are not limited to:

<table>
<thead>
<tr>
<th>Services:</th>
<th>Vendor Entity:</th>
</tr>
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<tbody>
<tr>
<td>HMO</td>
<td>Renal Associates</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Professional Vision Care</td>
</tr>
<tr>
<td>Optometry: Ophthalmology</td>
<td>LifeSynch</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Clinical Pathology Laboratory, Quest Diagnostics, Lab Corp</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>LifeSynch</td>
</tr>
</tbody>
</table>

Physician and other Participating Providers further acknowledge and agree that such specific providers may be changed or added to upon written notice by Humana to Physician.

4. MISCELLANEOUS

Physician understands that Humana may market or administer products that contain variable Copayment amounts due from the Member for Covered Services based on the medical specialty of certain physicians and the unit costs or reimbursement rates provided for in provider participation agreements. Physician agrees to participate in such products and to bill and accept as payment in full for Covered Services rendered to Members in such products the reimbursement rates set forth above less any Copayment amounts due from the Member.

In circumstances where the Member's Copayment for a Covered Service is equal to or greater than the rate set forth herein for that service, Physician agrees to accept as payment in full for the service the Member's
Copayment, not to exceed the rates set forth herein. Furthermore, in such cases, Physician agrees to refund to Member the difference, if any, between the Copayment collected from the Member and such rate.