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ACOs and the Proposed Rule

PS had our first of two webinars on accountable care organizations (ACOs) yesterday, and I appreciate many of you participating in this session. I am pleased that we were able to fill the available lines for the webinar, but at the same time I was somewhat surprised that there was not a long list of PPS members wanting to participate. Now, I realize the date and time are not going to be convenient for everyone; however, I have to wonder how the vast majority of our members are planning on preparing for ACOs?

Jerry Connolly, PPS lobbyist, presented for 1 hour. He provided an overview of ACOs and went into detail as to what we have learned from the proposed rule that was released at the end of March. Following Jerry, Helene Fearon, Chair of the PPS Government Affairs Committee, moderated a question-and-answer session with many great questions brought forward. For those who did not participate or access the program from our website, some very important points were discussed that you should be aware of as you prepare for ACOs.

First, you must understand that this is happening; ACOs will be implemented in January 2012. So you do not have a lot of time to try to prepare and have your practice in the best possible position as they develop. It is also important to understand what our potential role is. We are not, by statute, considered an ACO professional; we are a participant, and as a result we can contract and participate in but not form an ACO. It is critical that you review these specific details and understand how to best position your practice.

I think one of the most important points brought out on the webinar is that you need to know your cost to provide service. I realize that for many of our members, this is elementary; however, the consultants I know are often amazed at the number of private practitioners who do not know this. Many factors will be involved in the negotiating process for those who are considering participating with an ACO, and knowing these factors going in is critical to your success.

Another point that came out is to make sure you have a mechanism to document functional outcomes. Many simple, valid, and reliable tools are available, and I highly recommend that you look at these now and try to identify what fits your practice. In addition to knowing and documenting your outcomes, you have to be able to show that you can provide quality, cost-effective care. If you are good at what you do, get good functional outcomes, and can do so cost-effectively, then you will be in a better position to negotiate than practices that are not doing these things.

Finally, the point was made that there is no one model for ACOs. You will most likely see many different models that can vary considerably, and understanding these variations will be important as you look at possibly negotiating with any ACO. One thing that may prove helpful is making sure that you have good legal counsel that understands your business, as well as health care and ACOs. Because we do not yet know all the details of the ACOs (remember, what was released is the proposed rule), you may have to sift through some complex contractual arrangements—and you don’t want to end up in a position you regret.

As this is all developing, I encourage you to share what you are learning from your contacts and negotiations on the PPS message board. This is one of the best ways that we can help each other. The section will do everything we can to inform and educate the members; but we can also learn from you. Please help us in our efforts to assist all members as we enter this phase of health care reform.

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Take a look at the article by Kevin Hulsey on page 14. It will get your attention. The title is “$829,916.00.” This is the overpayment that Medicare initially required his practice to repay based on an audit.

The story has a happy ending. Kevin was able to negotiate the overpayment down to $22.65. That’s right—from $829,916 down to $22.65. Negotiate probably isn’t the right word. You’ll have to read the article to get the idea.

I am fortunate to know Kevin Hulsey pretty well. He’s a stand-up kind of guy, taking good care of his patients, doing it the “right way.” We would all do well to emulate his practice model. Kevin is far different from the typical Medicare fraud guys like the Dr. Wayne, aka the “Rock Doc” (pictured above), we read about in the Wall Street Journal back in February and in Tom DiAngelis’s February President’s Letter.

Nonetheless, it got me to thinking that if a guy like Kevin can get caught up in a mess, who among us isn’t susceptible to it as well? It appears that regulators and enforcement agencies are increasing their scrutiny of outpatient therapy. I heard someone say recently that it is not “if” they are going to show up at your practice, but “when.”

Okay, maybe there are some scare tactics at work, but it does get one’s attention. I recently attended a seminar on documentation and compliance. At one of the breaks, another attendee said, half-joking, that because of what he learned he was going to drive right to prison on the way home and check himself in! We discussed the feeling that if auditors look hard enough, they will find something we are doing wrong. Ugh! Not a comfortable feeling!

The good news is that planning, organization, and good information in terms of a compliance program are things we can control. Having controls in place will help mitigate those uncomfortable feelings. I have also found in my practice that compliance training and documentation auditing actually lead to better patient care. It sharpens the mind by getting physical therapists focused on outcomes, delivering skilled care, and medical necessity.

In this issue of Impact, you will read about the elements of good compliance programs. We make most of our living in a third party payment system, so we have to play ball by their rules. It is up to us to know the rules, enforce them in our practices, and stay on top of the changes that inevitably come about. I hope the material in this issue helps. Many thanks to Impact editorial board member Angela Wilson-Pennisi of Chicago for her help in bringing this valuable content to you.
Compliance Programs

PS continuously supports you in starting and following compliance programs. Such programs will help you avoid fraudulent activities and reduce your practice’s risk. Policies are written to guide behavior and although they are powerful tools, policies are most effective when used in the right way and for the right reasons.

Getting Started
Section resources are the first step:
View at www.ppsapta.org:

- Online store products, including the following:
  - Risk management—Reducing your exposure
  - Getting serious about security before you have a breach or government audit
  - Choose the right electronic medical records software for your practice
  - “How-to” manual
- Live Learning Center
  - 2010 Annual Conference educational sessions
  - 2009 Annual Conference educational sessions
- Practice Management
  - Compliance
  - Human resources
  - Forms and tablets
  - FAQs
- Payment Advocacy
- Government Affairs
- Member-Only Benefits

Website content is added regularly. Sign in weekly to access member-only information and receive a return on your investment in the section.

Corporate Compliance Benefits Practices and Patients
A formal compliance program is without a doubt a necessity for any practice regardless of size. Practices that do not utilize a compliance program are putting themselves at risk. Every practice must identify their areas of risk, have their own specific policies and procedures, and develop a compliance culture to ensure that the compliance plan will be taken seriously and implemented effectively.

A well-defined compliance program could be your organization’s life raft in today’s health environment in the face of the Medicare Recovery Audit Contractors, Zone Program Integrity Contractors, and Medicaid Integrity Contractors audits that are currently in process.

A compliance program can be developed in a few simple steps:

1. Recognize the importance of creating a practical approach to maintaining an effective compliance program.
2. Ensure that your practice management team is committed to implementing and maintaining a formal compliance program. The compliance program is a significant part of your practice’s policy and procedures.
3. Form a committee that can be solely devoted to the task of implementing and managing the compliance program. Assigning staff as committee members will ensure practice-wide cooperation.
4. Have the compliance program committee prepare and delegate responsibilities to involved staff.
5. Have the compliance program committee educate and train staff members on the purpose and goal of the policy or on how the practice should behave.
6. Determine when and how the training will be undertaken.
7. Recommend a practice “code of conduct.” This consists of the policy and procedure that dictates the ethical business processes within your practice. The compliance program must be a direct expression of the practice’s intention of conducting business in an ethical manner.

The creation of practice compliance programs is a large undertaking that PPS supports. Voluntary compliance programs provide benefits not only by helping to prevent erroneous or fraudulent claims, but also by showing that the practice is taking additional good-faith efforts to submit claims appropriately. A compliance program sends an important message to your practice’s employees that even though the practice recognizes that mistakes will occur, employees have an affirmative, ethical duty to come forward and report erroneous or fraudulent conduct so that it may be corrected.
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Part 1: Personal Data

Practice, Location: Sutton Place Physical Therapy in New York, New York

Practice specifics: 12 years old and going strong, we’re a single location with three full-time and three part-time physical therapists and a physical therapy technician. Our office staff includes one biller, three receptionists (one full-time and two part-time), and one part-time practice manager.

Most influential book/person/event that enhanced your professional career: Book: Getting to Yes: Negotiating Agreement Without Giving In by Roger Fisher and William Ury. After reading this book, I became more aware of the power I had to influence people in making decisions through education and challenging their decisions. My own consciousness was shifted to a place of “yes” as well, which has continued to enhance my ability to negotiate on whatever level is needed in my practice on a daily basis.

Person: My first mentor was Anne Saunier, whom I met when I held the position of chairwoman of the board of Planned Parenthood of Southwest Florida from 1994 to 1996. She taught me the leadership skills I needed to run a large agency with no previous experience and continued to mentor me after I moved to New York. When I was offered the opportunity to buy the practice I was working in, she believed in me enough to co-sign my loan.

Part 2: Business Philosophy

Describe your essential business philosophy: Clinically, I teach my patients that I want them to get better than they were prior to their injury. Businesswise, I have learned to look forward to the challenges that come each day and know I will continue to grow from each problem I solve and each mistake I make.

Describe your management style: I manage through a combination of ongoing individual and team development. We hold weekly staff and administrative meetings and in-services, taught by both outside resources as well as our physical therapists. I maintain an open door policy with our staff and let everyone know that no problem is too big or small. I lead by encouraging, educating, and inspiring.

How do you measure your success? Financially, I measure my success by my ability to continually grow my practice while operating within my budget. Personally, my success is measured by my ability to maintain a balanced life, which includes parenting my two sons, now 5 and 11, being a partner to my husband, and continually growing personally and professionally.

Best/worst/toughest decisions: My best decision was to buy my practice and have a child at the same time. Most people advised me I should not do the two simultaneously. However, upon reflection I can see that decision made me a better mother and business owner. Running a business, with its many challenges, while caring for an infant allowed me to develop my skills of prioritizing, delegating, and communicating. The same skills also helped me to develop as a parent, as well! In order for both parts of my life to work, I have had to “GET TO YES” quickly!

My worst decision was to avoid learning the billing part of my practice. After all, knowing the financial side of your practice can make or break you, literally. When I bought my practice, I was an employee and treating patients 13 hours per day. I never really learned the duties of billing since something else more important always seemed to come up. Due to a staffing change, I am now learning the billing, and find it funny that it is not as overwhelming as I had anticipated—I am actually quite good at collections!

How do you motivate your employees? Most important, I have learned to look for people who are inherently self-starters! I feel my responsibility is to energize them with new ideas, create an environment that is supportive to learning, and provide them with a career path within my practice.

Part 3: Your Practice

What sets you apart from the competition? We have differentiated ourselves from high-volume practices by providing one-on-one care.

Personally, my success is measured by my ability to maintain a balanced life... and continually growing personally and professionally.
Your best learning experience/s (mistakes) since inception of your practice: I have had so many experiences, but I will share only a few. Someone once told me to hire slowly and fire quickly. I have been guilty in the past of hiring too quickly when we really needed someone and not terminating someone when I knew in my gut that they were not a fit for my practice. Another mistake I have made is spending too much time working within the practice instead of reaching out and marketing the practice. Getting caught up in the day-to-day needs of the clinic is easy, and keeping up with marketing takes a lot of discipline, even though I love that aspect of owning a business.

What are the benefits of PPS membership to your practice? I would not have the successful practice I do now if it were not for PPS. When I was trying to buy my practice, I called one of the member mentors, Randy Johnston. Randy agreed to mentor me if I agreed to become a member and go to PPS meetings. I joined PPS and have attended meetings nearly every year since 1998. PPS is a wonderful organization with so many people from whom to learn. Members are willing to share, listen and inspire, and often are just a phone call away!

Part 4: The Future
What worries you about the future of private practice/what you are optimistic about: I am concerned about the power of health insurance companies, including the trend of rising copayments and deductibles, and the lowering rate of reimbursement. However, I recognize these things are out of my control, and I avoid dwelling on them. Instead, I focus on marketing my practice and working to make my staff the best available in physical therapy. I am generally optimistic about life and hold the philosophy that I can handle whatever comes my way! ■

Carole can be reached at cstillmanpt@aol.com.
Executive Summary
One practice owner’s experience in responding to a Medicare audit and how his practice navigated the appeals process to prepare practice owners for issues they might face in their own audits.

Now that I have your attention, I will share how Medicare arrived at the amount of this “overpayment,” requesting return by my midsize outpatient private practice—and how we survived the process.

The threats associated with a Medicare audit strike fear into the hearts of all physical therapists and may also be associated with nausea (I did vomit when I received the request for refund of the overpayment). For health care providers, this fear is possibly higher than that associated with life’s most notable stressors—death and taxes! Reports on Medicare audits are frequently associated with license disciplinary action, imprisonment, and monetary fines and penalties. Some of us might prefer death to fines, penalties, imprisonment, or “they took my license.” Although some may have survived a Medicare audit, most probably only fear the day. Just like an IRS audit, your turn to be audited may not be a matter of “if,” but “when.” However, I would like to share my audit experience and hopefully moderate the anxiety and frustration that are inherent to any audit process.

More than 2 years ago—specifically, on February 17, 2009—we received notice from the Western Integrity Center, a Centers for Medicare and Medicaid Services (CMS) Program Safeguard Contractor, that it would be performing a post-payment medical review to fulfill its “contractual obligation with CMS.” After appropriate Health Insurance Portability and Accountability Act disclosures, Western Integrity Center requested 88 patient charts from “a computer-generated sample of claims selected from the universe of our claims.” They provided the names and dates, and we promptly supplied the information.

On November 20, 2009, we received correspondence stating: “This is to let you know that you have received Medicare payment in error, which has resulted in an overpayment to you of $829,916.00 for services which Medicare paid on the attached list of claims.” They advised us to “please return the overpaid amount to us by 12/20/09, and no interest charge will be assessed. Please send a check or money order for the full amount due.” You may be confident that my practice does not have this amount of money lying around in the event of a request for repayment of an overpayment. To provide a frame of reference, my practice had received roughly $1.5 million in Medicare payments during the 3-year time period of this audit. The auditor was requesting more than half be returned. The request for repayment also included detailed information on their appeal process, which we gave our undivided attention.

As one might expect, our documentation may not have been perfect, but in my judgment, was not severely deficient. We initiated the audit process truly feeling we had nothing to hide. A deeper review of our response to the audit revealed that most of the initial mistakes were ours. We failed to send in all the information they requested, primarily signed plans of care. We responded by sending in another packet of information with more detail and including all requested information.

We received our appeal “response” dated November 13, 2009—the notice was dated 7 days prior to the initial...

I would like to share my audit experience and hopefully moderate the anxiety and frustration that are inherent to any audit process.
request for repayment. The determination stated “The additional information has been considered in this review and changes have been made, as appropriate, in the Medicare Record Review Findings Spreadsheet. We estimate that you have received an overpayment of $242,295.00.” This amount still represented a substantial amount of money for my practice, and we initiated another appeal. The audit and appeal process became more interesting as they revealed their specific findings, listed in Table 1.

Table 1. Audit and Appeal Findings

- Five dates of service did not meet the criteria for appropriate documentation
- Treatment flow sheets demonstrated incomplete documentation of services billed (because we did not list the time for each intervention)
- Plans of care were missing certification
- Eleven dates of service did not meet the criteria for the billing for electrical stimulation; specifically, the initial evaluation and the treatment notes did not document the need for electrical stimulation as described by the policy guidelines
- Use of vasopneumatic devices was not indicated

We responded by providing detailed information to dispute each of their audit findings. Interestingly, our appeal did not return to Western Integrity Center; it was reviewed directly by CMS. CMS, “based on the Medicare reconsideration decision, it is noted as partially favorable to the provider,” reduced our overpayment to $135,307.21. This was a vast improvement, but the request for overpayment still was not in an acceptable range. We became frustrated by our inability to obtain information. Western Integrity Center deferred all questions to CMS, but CMS would only offer us the opportunity to appeal. Therefore, we appealed again.

On May 2, 2010, we were advised that “Medicare hired First Coast Service Options to review our appeal and make a decision.” On September 30, 2010, we were advised “The appeal decision is UNFAVORABLE.” The capitalization for emphasis was added by CMS, not me. An UNFAVORABLE outcome meant we still owed $135,307.21. However, we were confused by the fact that First Coast Service Options ruled UNFAVORABLY for an entirely new set of reasons. They did not respond to the audit issues from Western Integrity Center that were the basis of our appeal (eg, the flow sheets, the electrical stimulation, the vasopneumatic devices). Instead, First Coast based their denial on a new set of infractions. When we voiced our concern to CMS, they advised us our only option at this point would be to request a hearing with an Administrative Law Judge and voice our concerns, which we then pursued. On December 8, 2010, we really began to feel life was unfair when we received notice of a second audit, directly from CMS. “Data analysis…finds you are the top payee in the state billing 97110. Four individuals within your group are among the top 20 providers in the state billing codes 97110. One Provider’s frequency per patient is higher than the peer group mean for the code as well.”

CMS requested 10 charts for each of the four therapists listed. Each of the charts was for patients who had exceeded the therapy cap and were being billed using the -KX modifier. Happily, on February 1, 2011, we were advised that “based on this review…we have determined that you have been overpaid $158.26. We also found you were underpaid in the amount of $135.61.” Since we owed them $158.26, and they owed us $135.61, our net repayment to CMS for this audit was $22.65. I found this to be an acceptable request for refund.

The appeal on our original audit was heard on February 15, 2011. The judge did allow a few opening remarks from me. I explained that we were trying to do things right, but that our audit had been reviewed by three different groups, we were $829,916.00, continued on page 16
having difficulty obtaining information, and our frustrations with the process. The judge stated that this was standard operating procedure, and that his responsibility was simply to rule on the information from the most current audit. He was essentially stating that we could assume our other appeals had been favorable and further clarified that his ruling would be final and only address the audit by First Coast.

The judge’s comments made me feel warm and fuzzy on the inside! My impression was that since he was an employee of neither Medicare nor the auditors, he would give an impartial hearing. We reviewed each of the items in the appeal, one by one, and the judge dismissed each of the audit findings. As of this writing, I do not yet possess the final letter absolving us of any overpayment; but I am very confident in the judge’s verbal ruling and anticipate that the dismissal of all the audit findings will be upheld. The judge also offered excellent advice: Appeal. He advised us to never trust the initial findings of auditors.

My advice to practice owners is to document defensibly, bill accurately, and when providing services to Medicare beneficiaries, play the game by their rules. Though we found the audit and appeal process frustrating, this frustration was largely the result of our own ignorance of the process and the difficulty obtaining information. Though costly in terms of time spent and jars of antacids ingested, the rulings were appropriate at each stage of the appeal and the end results demonstrated that our desire to do things right was ultimately adequate to support our billing practices.

Kevin Hulsey is CEO of RehabAuthority, with locations in Idaho and Nevada. He may be reached at kevin@rehabauthority.com.
PT Billing Solution has worked hard to keep its reputation of the most robust practice management software for over 10 years. By listening to customer’s feedback and releasing new features on a constant basis, we have been able to provide the most complete product on the market, PT Practice Pro. PT Pro allows you to handle documentation, scheduling, billing and reports all in the same system without the need for double data entry.

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Elements of Compliance
An Audit and Monitoring Plan Based on Risk Assessment

By Nancy J. Beckley, MS, MBA, CHC

Executive Summary
This article is a guide to assist practice owners in developing their own compliance plans for their practices. The author also includes sample forms and charts to help jumpstart implementation of a compliance plan.

Corporate compliance plans were introduced as a “voluntary” concept in the Balanced Budget Act of 1997, and the first model compliance guidance for hospitals was issued by the Department of Health and Human Services Office of Inspector General (OIG) in 1998. Since that time, OIG has continued to issue model compliance guidances, including updates to existing guidances. In 2000, the OIG issued the Model Compliance Program for Individual and Small Physician Practices. The model program specifically mentioned the applicability to physical therapists, noting that: “Much of this guidance can also apply to other independent practitioners, such as psychologists, physical therapists, speech language pathologists, and occupational therapists.”

Fast forward to 2010, with the passage of the Patient Protection and Affordable Care Act (PPACA) and the requirement of mandatory compliance programs for all providers billing federal healthcare programs by 2014. Although theoretically “voluntary” in the past, compliance professionals have long recognized the importance of compliance programs, even for small practices. The final rules have yet to be proposed for mandatory compliance programs under the PPACA; however, the model program for individual and small physician practices provides an excellent starting point for mitigating practice risk for those who do not currently have a compliance program in place. In addition, an annual auditing and monitoring program will help detect, correct and prevent improper payments.

The Seven Elements of a Compliance Program
The model program for individual and small practices provides an insight into the government’s view that compliance elements for smaller providers may differ in design and dimension than those programs for larger providers such as hospitals, allowing for an adjustment in financial and staffing resources. The seven essential elements laid out in the compliance guidances issued by OIG are as follows:

1. Conducting internal monitoring and auditing through the performance of periodic audits.
2. Implementing compliance and practice standards through the development of written standards and procedures.
3. Designating a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards.
4. Conducting appropriate training and education on practice standards and procedures.
5. Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities.
6. Developing open lines of communication, such as (a) discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct and (b) community bulletin boards, to keep practice employees updated regarding compliance activities.
7. Enforcing disciplinary standards through well-publicized guidelines.
Compliance planning begins with a thorough assessment of the risks associated with the practice. Generally known risks associated with the delivery of physical therapy services and specific risks associated with the practice’s contracted Medicare and Medicaid payers should be included. For example, a general physical therapy risk for private practice is the billing for therapy services beyond the annual therapy cap, as identified in the 2011 OIG Work Plan. For 2011, OIG will review outpatient physical therapy services provided by independent therapists to “determine whether they are in compliance with Medicare reimbursement regulations,” particularly for independent therapists who have a high utilization rate for outpatient physical therapy services. OIG also plans to compare physical therapy in counties with high utilization rates with the national averages.

A more specific risk would be associated with your Medicare contractor’s announced widespread review of specific codes, such as a review of aquatic therapy that is provided consistent with the published Local Coverage Determinations guidelines. However, the most specific risk would be associated with the results of your practice’s internal review activities or findings by outside parties. For example, you may have received denials for codes associated with the Correct Coding Initiative edits, or your own chart reviews may have indicated that documentation of timed codes was inadequate to support the use of the code.

Auditing and monitoring activities should be differentiated as separate and distinct processes or functions in your practice. A monitoring activity relates to constant surveillance of an identified risk factor or function. For example, Medicare has published signature guidelines for the purposes of medical review. Verifying compliant signatures and correcting them on a daily basis is an example of a monitoring activity that can prevent denials during medical review. Obtaining the initial certification on the plan of care, as well as subsequent re-certifications, is another example of risk-based monitoring activity that should be employed in every physical therapy practice.

An audit activity, in contrast to a routine monitoring activity, is designed to address topics of risk in a more formal format against a pre-established set of standards and guidelines. Audit topics arise from the risk assessment, and allow an opportunity to address these areas either concurrently or retroactively.

The example in Figure 1 depicts a line-item, detailed review of claims for a specific date of service in a discovery sample of 50 charts. The audit is scheduled for the first month of the third quarter.

<table>
<thead>
<tr>
<th>Audit Control #</th>
<th>Risk</th>
<th>Audit Category</th>
<th>Audit Method</th>
<th>Type of Audit</th>
<th>Venue</th>
<th>Payer</th>
<th>Clinic Division/Region/State</th>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(assigned by Compliance)</td>
<td>✓ High Medium</td>
<td>Medical Necessity</td>
<td>✓ Discovery Sample Peer Review Concurrent Chart Audit Database Query</td>
<td>Internal ✓ External Validation</td>
<td>Onsite Remote</td>
<td>✓ Medicare WC Commercial Medicaid</td>
<td>✓ Division 1 ✓ Clinic 1 ✓ Clinic 2 ✓ Clinic 3 Division 2 Clinic 1 Clinic 2</td>
<td>Line Item Detail Match (per DOS)</td>
<td>A discovery sample of 50 claims (defined as a single date) will be used to verify that the codes billed match the medical record documentation and coding requirements. The results of the discovery sample will be examined to determine refinement of the audit topic and/or to evaluate whether further auditing or an expansion of the sample size is needed. The discovery sample will be generated through the billing system, with sampling elements and claims record data provided in a spreadsheet for calculation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Claims Coding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Identify internal or external resource for the audit</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. Physical Therapy Audit Plan Face Sheet

Auditing and monitoring activities should be differentiated as separate and distinct processes or functions in your practice.
quarter, conducted by an external auditor, and cites the applicable section of the Medicare manual. The audit reviews all charges billed for a specified date of service to determine if the documentation supports the number of codes being billed. Because this particular audit is labeled as a claims audit, the review does not involve medical necessity but rather focuses on the documentation (including minutes) to support the codes billed on that date of service.

Figure 2 provides a sample of an audit program for a small physical therapy practice based upon a risk assessment, including industry risk, Medicare contractor risk, and specific identified practice risk. The list is a sample of the categories that can be used, the variation on topics, and the audit method. For each item identified, an audit face sheet should be developed detailing the specific parameters of the audit. In Figure 2, the audit method includes internal review, peer review, and supervisory review, in addition to the use of an external auditor for one of the topics. The list is not all-inclusive, but it demonstrates the process by which a private practice can begin to implement compliance activities based on documented risk.

**Figure 2. Sample Outpatient Rehab Audit Plan**

<table>
<thead>
<tr>
<th>Category</th>
<th>Topic</th>
<th>Assessed Risk</th>
<th>Audit Method</th>
<th>Scheduled</th>
<th>Comments – Including Recommendations &amp; Re-audit</th>
<th>Completed – Findings to Audit Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees</td>
<td>Excluded provider verification against sanctions list</td>
<td>High</td>
<td>Query databases and match</td>
<td>1. On employment</td>
<td>Q1/2010</td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td>Licensure verification</td>
<td>High</td>
<td>Query databases and match</td>
<td>1. On employment</td>
<td>Q1/2010</td>
<td></td>
</tr>
<tr>
<td>Coding</td>
<td>RAC Topic – billing of untimed codes &gt;1</td>
<td>High</td>
<td>Claims history research</td>
<td>Q1/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coding</td>
<td>Compliance with 8 minutes rule for billing</td>
<td>High</td>
<td>Concurrent Chart Audit</td>
<td>Q4/2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coding</td>
<td>Claims audit—line item claim to chart review</td>
<td>High</td>
<td>External Auditor</td>
<td>Q1/2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POC Certification</td>
<td>MD dated certification w/in 30 days per CMS</td>
<td>High</td>
<td>Internal Peer Audit</td>
<td>Q2/2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POC Re-Certification</td>
<td>POC recertified within time-frame (up to 90) per CMS</td>
<td>High</td>
<td>Internal Audit</td>
<td>Q2/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily Note</td>
<td>Does note support LCD recommendations for manual therapy documentation?</td>
<td>High</td>
<td>Clinical supervisor audit</td>
<td>Q3/2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td>Verify legible signature per CMS requirements</td>
<td>High</td>
<td>Concurrent Chart audit</td>
<td>Q4/2010</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Author’s Note: Readers are encouraged to review a copy of the physician compliance guidance for discussion of the various elements (readily available on the OIG website at http://oig.hhs.gov/authorities/docs/physician.pdf). Caution should be exercised to reference the most current versions of criminal and civil laws and statutes.

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**References**

3. Ibid.
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Executive Summary
Read about one facility’s experience with Medicare audits and the lessons learned in the process.

As Director of Rehabilitation for a 378-bed regional referral hospital in southern Oregon, I administer a staff of 100, including therapists and support personnel. Our outpatient therapy services were subject to several audits a few years ago, and in sharing my experience I hope to provide some “preventative medicine” to help keep you from financial distress. For more in-depth information, I encourage you to utilize the many resources that are available to you, including attorneys and consultants who specialize in these areas.

An individual provider, practice, or facility could be subjected to several types of Medicare and Medicaid audits, but your risk for being randomly audited by the Centers for Medicare and Medicaid Services (CMS) might be compared to your risk of personally being audited by the Internal Revenue Service (IRS). However, just as the IRS has flags to help it determine its targets for auditing, CMS also flags areas of particular interest to determine subjects of auditing. Each year, the Office of the Inspector General (OIG) issues a work plan that outlines areas of focus to drive the audit process. In addition, because much of the “savings” envisioned in the Affordable Care Act is in the form of recovery of inappropriate or inaccurate payments by the government for healthcare services, we are all more likely to be audited through their efforts to eliminate waste.

Although nearly everyone has heard of Recovery Audit Contractor (RAC) audits, you might be less familiar with Comprehensive Error Rate Testing (CERT) audits. In very simplistic terms, a CERT audit occurs pre-payment, and a RAC audit occurs up to 3 years post-payment. In addition to the audit flags identified by OIG, individual contractors have some freedom to pursue their own areas of interest, especially for identifying targets for CERT audits.

The audits on our facility were CERT audits, but many of the same principles apply to RAC and other audits. Specifically, the auditors are reviewing for two broad categories of error: “technical” and “medical necessity.” Finally, providers can make mistakes in how they react to the audit, which I’ll call “response error.”

Technical Errors
In theory, identifying a technical error would not require the reviewer to have a medical background. For example, because most of the Speech/Language Pathology (SLP) billing codes are untimed, no more than one unit of these SLP codes should be charged per day. If a facility bills two units of an untimed code, a technical error is identified and classified as an automatic take-back. In our case, the most common technical errors focused around use of improper Current Procedural Terminology codes. For example, our providers were unclear about the proper codes for certain procedures and followed guidance from our commercial insurers regarding the most appropriate codes to bill. However, the advice from our commercial payers was not consistent with CMS guidelines and therefore resulted in technical errors.

The most common technical error identified by our CERT audit was the failure of the therapists’ documentation simply to match the charges submitted.
Lesson #1: Make certain you have carefully reviewed the CMS and Medicare audit contractors’ publications about therapy and which codes properly describe the procedure or modality performed. If you are uncertain, the audit contractor or carrier may have contact persons who can provide assistance. Your billing must conform to their standards to pass an audit.

However, the most common technical error identified by our CERT audit was the failure of the therapists’ documentation simply to match the charges submitted. As a result, we have completely changed our workflow to eliminate that error source. Common examples of these types of errors include (1) the date of the visit in the chart documentation did not agree with the date of the charge submitted, and (2) the time-span of the visit in the chart did not agree with the number of units billed.

Lesson #2: Implement procedures that eliminate the potential for disconnect between clinical notes and charges. They must match.

Medical Necessity Errors
Identifying medical necessity errors is a completely different animal. The critical thinking skills of a medical professional will typically be involved to make the judgment of an error related to medical necessity. However, most of the medical necessity errors found by our auditor were amazingly straightforward. For our facility, the most common errors were the following:

1. Unsigned or otherwise inadequate plan of care.
2. No physician certification (or re-certification if needed) in the chart. In the eyes of Medicare at that time, the physician certification was clearly considered to be evidence of medical necessity.
3. Rarely, language in the clinical progress notes implied that the patient was no longer benefitting from therapy. If a patient has reached a point of no further benefit from therapy, he or she should be discharged. If the patient has hit a temporary setback, the therapist should be very clear in the documentation about their strategy to regain progress.

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Lesson #3: Make sure each chart is complete with all the required elements in place and includes language that supports the need for the skills and training of a licensed therapist.

Response Errors
The last area of risk in a Medicare audit is our response to the audit! Larger organizations may be more at risk for this type of error, such as failing to quickly respond to requests for individual charts. In our organization, multiple separate requests were delivered to our facility over several weeks and received an inadequate response from the person receiving the request. Everyone in your organization must understand that any government request for charts be directed to someone who can handle the request! Of all the denials that we experienced, the majority occurred simply because we failed to return the requested materials by the deadline or failed to include all the documents requested.

Each request for a chart will detail the exact information requested. Read the request carefully. In our second round of audits, we created a checklist of documents and attached a cover letter to each chart detailing why each of the charts met Medicare criteria.

Lesson #4: Have a game-plan and a clearly delineated process for responding to audits. Check and double-check that you have complied with the details of the request. Communicate with the contact person at the requesting agency if you have any questions; if you miss a deadline, recovering the take-back becomes far more complicated.

Our first audit took us by surprise, and we had already experienced several denials before we realized what was happening. Once we became organized, we made sure we understood exactly what contributed to the denials that were occurring, and we immediately provided that information to our staff. We changed procedures repeatedly and rapidly to address some of the issues and increased our own internal audits to catch problems before the payers did. Therapists were provided with real-time feedback if they continued to display problematic habits.

Lesson #5: Leverage your communications with the auditor to make yourself compliant with regulations, and in the process build mutual trust with the auditor’s staff. Auditors are incentivized to focus on the “problem” providers where they can find errors most easily.

Audits are costly, and follow-up audits are more costly because they encompass a broader scope. The consequences of continued high error rates can be drastic and severe. In the case of CERT audits, the carrier’s goal is to determine if there is an unexpectedly high error rate. If it is too high, it will conduct a follow-up audit with a much larger sample size. If the second audit still has a high error rate, it may utilize several punitive tools, the least palatable of which is to simply apply that error rate to future payments and discount them appropriately. For example, if your error rate is 15%, it could discount future payments by 15% across the board. In our case, I am happy to report that our error rate was about 2% by the second audit. Although we have had a few probe CERT audits since then, we have managed to keep the error rate low and avoid any costly repercussions.

Bob Perlson is Director of Rehabilitation at Rogue Valley Medical Center in Medford, Oregon. He may be reached at bperson@asante.org, and he blogs on rehabilitation and health care issues at http://bpsrehabblog.blogspot.com/

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Using Treatment-Based Classifications to Raise the Bar on Medicare Compliance

By Tim Richardson, PT

Executive Summary
Considering using treatment-based classifications to improve clinical quality and enhance compliance with Medicare documentation requirements.

The words treatment-based classification and Medicare compliance are unlikely partners in the same sentence. Perhaps few therapists have considered treatment-based classification (TBC) in the context of Medicare compliance, as the former is cutting-edge science and the latter is the lowest possible standard of physical therapists’ clinical documentation.

TBC is a method of categorizing physical therapy patients according to their essential characteristics, rather than their physicians’ pathologic diagnosis. TBC uses a parsimonious set of four to six questions and physical exam items to predict the likelihood of success for particular treatments for individual patients. The treatment groups have an expected outcome, usually a standardized self-report questionnaire, and a recommended frequency and duration of the plan of care.

The Medicare Benefit Policy Manual Chapter 15—Covered Medical and Other Health Services describes the minimum standards by which physical therapists should document the care they provide their patients:

The plan of care shall contain, at minimum, the following information as required by regulation,

- Diagnoses
- Long term treatment goals
- Type, amount, duration and frequency of therapy services

The plan of care shall be consistent with the related evaluation, which may be attached and is considered incorporated into the plan. The plan should strive to provide treatment in the most efficient and effective

The poor quality of typical physical therapists’ documentation and the rising prevalence of revenue-seeking government auditors require a rapid shift in how physical therapists document their findings. TBC data sets can provide the security that clinicians and administrators seek.
manner, balancing the best achievable outcome with the appropriate resources.¹

I propose that physical therapists use TBC to generate the Medicare-compliant physical therapists’ plan of care, usually within the first 15 minutes of the patient evaluation. The remaining time can be utilized to assess additional risk reduction strategies, such as fear, falls, or pathology screening.

To date, initial work in TBC has been done for the following high-volume treatment groups, summarized in Table 1.

Can TBC Data Sets Provide a “Bulletproof” Medicare Chart?
TBC is typically to assist in physical therapists’ decision making or as a surrogate for the physical therapists’ diagnosis. To my knowledge, no literature or regulation exists advising physical therapists to use TBC as a Medicare plan of care. The poor quality of typical physical therapists’ documentation and the rising prevalence of revenue-seeking government auditors require a rapid shift in how physical therapists document their findings. TBC data sets can provide the security that clinicians and administrators seek. However, some questions regarding this approach should be considered:

1. Preliminary TBC derivation-level studies may reflect associations between predictor variables and the outcome that are due to chance. The investigators set statistical filters to minimize the risk of discarding valuable test findings. Therefore, their initial results may include some false-positive test variables.
2. Predictors may be specific to the study setting or patient demographics. For instance, the preliminary lumbar stabilization rule was derived on a set of 54 patients between the ages of 29 and 55 years living in Pennsylvania and Mississippi. This rule may not apply to older, Medicare-aged patients.⁴
3. Clinical workflows in different settings may impact the implementation of the rule. For example, paper templates were used in all of the validation studies. If an electronic decision support system embedded in a smartphone were used instead of paper templates, this workflow change could affect data collection because of data completeness bias. Data completeness bias occurs if the clinician’s memory is used to recall data points important in the study. If a smartphone with prompted questions is used in subsequent settings, the differential collection of data sets will bias the subsequent setting.
4. Most TBC derivation-level studies used single-armed designs, which may identify only the variables predictive of a nonspecific, good outcome. A single-arm design may not be able to demonstrate that one particular treatment is superior to an alternative treatment.¹⁴,¹⁵
5. All TBC outcomes are measured using self-report questionnaires, but some Medicare auditors still conclude that self-report measures are “subjective”; that is, biased by the patients’ experience or expectations.

Most validated self-report measures show superior reliability to many commonly used performance tests, such as the Timed Up and Go test. In addition, most validated self-report measures show superior reliability to many commonly used impairment-level tests, such as range-of-motion and manual muscle

### Table 1: Treatment-Based Care in High-Volume Treatment Groups

<table>
<thead>
<tr>
<th>Condition/body region</th>
<th>Treatment group</th>
<th>Duration</th>
<th>Frequency</th>
<th>Expected outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower back pain</td>
<td>Lumbar manipulation²,³,¹⁰</td>
<td>1 week</td>
<td>2 visits</td>
<td>50% improvement in Oswestry</td>
</tr>
<tr>
<td></td>
<td>Lumbar stabilization⁴</td>
<td>8 weeks</td>
<td>2x per week</td>
<td>6-50% improvement in Oswestry</td>
</tr>
<tr>
<td></td>
<td>Lumbar traction⁵</td>
<td>9 days</td>
<td>3 visits</td>
<td>50% improvement in Oswestry</td>
</tr>
<tr>
<td>Referred leg pain</td>
<td>Lumbar manipulation⁷</td>
<td>immediate</td>
<td>1 visit</td>
<td>+4 on the Global Rating of Change scale</td>
</tr>
<tr>
<td>Neck pain</td>
<td>Thoracic manipulation¹²,¹³</td>
<td>6 days</td>
<td>3 visits</td>
<td>+5 on the Global Rating of Change scale</td>
</tr>
<tr>
<td></td>
<td>Cervical traction⁵</td>
<td>3 weeks</td>
<td>2x per week</td>
<td>+6 on the Global Rating of Change scale</td>
</tr>
<tr>
<td>Referred arm pain</td>
<td>Thoracic manipulation⁹</td>
<td>4 days</td>
<td>3 visits</td>
<td>+4 on the Global Rating of Change scale</td>
</tr>
<tr>
<td>Knee pain</td>
<td>Hip joint mobilization¹¹</td>
<td>2 visits</td>
<td>—</td>
<td>+3 on the Global Rating of Change scale</td>
</tr>
<tr>
<td>Ankle pain</td>
<td>Ankle mobilization⁶</td>
<td>8 weeks</td>
<td>2x per week</td>
<td>+6 on the Global Rating of Change scale</td>
</tr>
</tbody>
</table>

RAISE THE BAR, continued on page 28
testing. If validated, “subjective” tests demonstrate superior reliability to traditional, “objective” tests, then the use of self-report questionnaires as an outcome measure may be rejected on a limited basis.

The physical therapist should consider at least four factors when using TBC for individual patient decisions and Medicare compliance:

- Is there risk of harm to the patient with the use of preliminary TBC rules?
- Is there an alternative decision making model that could replace the use of a preliminary rule?26
- Is the alternative decision-making model a naturalistic, intuitive, or “gestalt” model? Does this model have an evidentiary basis?
- Is there supplemental evidence that would bolster the recommendation of the preliminary rule (eg, patient preference, physician request)?

Traditional physical therapists’ treatment notes have been described as “meaningless drivel” by some physical therapist authorities, and as a “black hole” by others.17,18 In an unlikely combination of necessity (audits) and invention (TBC), TBC data sets can provide physical therapists the opportunity to improve both their clinical quality and their documentation quality.

Tim Richardson is a physical therapist in private practice in Palmetto, Florida. He is the author of Bulletproof Expert Systems: Clinical Decision Support for Physical Therapists in the Outpatient Setting. He may be reached at timrichpt@medicalartsrehab.com.

References
13 Cleland JA, Mintken PE, Carpenter K, Fritz JM, Glynn P, Whitman J, Childs J. Examination of a clinical prediction rule to identify patients with neck pain likely to benefit from thoracic spine thrust manipulation and a general cervical range-of-motion exercise: Multi-center randomized clinical trial. Phys Ther. 2010;90(9):1239-1250.
17 Amato A. Value purchasing in outpatient physical therapy. IMPACT Private Practice Section. 3(10):8-12.
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The following questions are routinely asked by private practitioners. Noncompliance places the physical therapist at significant risk:

**Q:** Can I discount my charges for cash-based services?  
**A:** In general, it is best not to offer discounts on a regular basis. Your practice should have a standard fee schedule for services and be able to demonstrate a consistent pattern of charges that reflect their demonstrated value. Your practice should have a procedure in place to describe the collection process for copays and deductibles. These procedures should be contained in a policies and procedures manual that is reviewed and updated annually. The manual should also include a policy to be used in the exceptional case when discounting is offered. Consistent policies will be much easier for administrative staff to enforce.

Discounting and waiving of copays or deductibles may be viewed as inducements, which are not permitted under the Medicare program. Also, submitting a claim that does not reflect the waiving of copays would be considered intentional misrepresentation of charges.

Last, it is important to remember that patients and caregivers may discuss their care with others in the community. Inconsistent policies on discounting could be problematic for your practice’s reputation.

**Q:** How can I structure a discounted fee schedule for “same-day” cash payment of services?  
**A:** It is recommended that any design of a discounted fee schedule used for “same-day” payment of services be consistently applied regardless of the patient’s insurance coverage, condition, or the services provided. Once the cost per visit is determined and a reasonable profit margin is considered, it is then possible to calculate a rate for “same-day” payment. One example is to have a uniform percentage discount applied to the practice’s published fee schedule.
It is preferable that any discount applied to a practice’s published fee schedule be based on prompt payment, because there will be no costs associated with billing and collecting fees from a third party.

Policies that discriminate between individuals who have insurance and those who do not are not recommended. It is preferable that any discount applied to a practice’s published fee schedule be based on prompt payment, because there will be no costs associated with billing and collecting fees from a third party. This policy would prevent any accusation of discrimination against an insurance company, or being caught in a situation where, knowingly or not, a contract has been signed with an insurance company that contains a “most favored nation” clause, which would then require that insurer be offered the same discounted rate.

It would be prudent to include a policy on discounts for same-day cash payment for services in any policies and procedures manual, and to verify that there are no state laws that limit a provider’s ability to provide multiple fee schedules.

Q: May a physical therapist collect out-of-pocket payments from a Medicare beneficiary for a service that is not a covered benefit (eg, fitness programs or services that are provided once the therapy cap has been reached and no exceptions process is in place)?

A: Yes. In specific circumstances, a physical therapist may collect out-of-pocket payments from a Medicare beneficiary. Cash may be collected if the service is not a covered benefit or when the therapy cap has been exhausted and no exceptions process is in place. In this situation, it is strongly recommended that the beneficiary sign an Advanced Beneficiary Notice.

Helene Fearon, PT, and Steve Levine, PT, DPT, MSHA, are partners in Fearon & Levine, a national practice management consulting firm, and development partners in Optimis PT, an EMR product. They can be reached at helenefearon@fearonlevine.com or stevelevine@fearonlevine.com, or through www.FearonLevine.com.
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The world is becoming an increasingly complex place, and nowhere is that more true than in health care and practice management. Each payer requires different documentation and procedural standards, clinical practice guidelines and evidence-based practice establish a standard of care, and we are required to perform our work under significant time pressure. Besides managing our clinical caseloads, we also must integrate the mandates of the Health Insurance Portability and Accountability Act, comply with the requirements of state and federal programs, and adhere to state and federal laws in managing our employees. In his book *The Checklist Manifesto: How to Get Things Right*, Gawande examines how other professions and systems have responded to complexity and pressure with the use of checklists and is a proponent for their implementation in health care.

Gawande argues that the ideal checklist is not a “to-do” list for simpletons. Instead, it is a fail-safe to ensure that critical steps are not missed in complex, overwhelming situations. The checklist functions as a kind of “cognitive net,” catching our lapses in focus and attention. He argues that medicine has become too complex for the historic model of the physician as king, with other players following his or her supreme direction. Instead, the implementation of a checklist system empowers all members of the health care team to draw attention to errors or missed steps and enhances communication amongst team members.

Gawande explores the use of the checklist in other industries to make his case. Specifically, aviation has moved from relying on the experience of the pilot as “rock star” and instead uses evidence and investigation to determine the most appropriate procedure. The checklist is used in the construction industry among the different trades involved in constructing a building. The checklist does not provide a step-by-step guide on how to build the building, but instead facilitates communication by the critical parties at the right times. As Gawande describes it, “[Y]ou push the power of decision making out to the periphery and away from the center.”

In physical therapy practice, I anticipate that checklists can be useful in confirming that critical steps are completed during the first patient visit. Was insurance verified and communicated to the patient? Was the patient oriented to the clinic so that all follow-up visits go smoothly and keep the physical therapist running “on time”? Did the patient receive information on our cancellation policy and do we have a credit card on file? Checklists can be used to ensure compliance with Medicare, HIPAA, the Occupational Safety and Health Administration, and employment laws. No practice owner I know wakes up in the morning and says “I think today is the day I should test our computer backup files, make sure the employee training has been completed for the year, and test the disaster recovery plan.” A checklist can help make sure it happens—and document that it did happen.

Clinically, checklists can be used to promote and equalize a standard of care among your physical therapists. Such checklists can leave plenty of room for creative problem-solving by the therapist, but should also help him or her to build those evidence-based guidelines into the care of every patient. Checklists can help guide your employees in their decision-making processes, empowering them to address situations without unnecessarily involving the practice owner.

If checklists are as effective as Gawande asserts, why are we so resistant to using them? Gawande attributes our reluctance to a sort of “maverick” mentality that we have been hesitant to abandon in health care. We maintain the ideal of the genius or guru who diagnoses and solves the toughest cases; such a hero is above using a tool as simple as a checklist. In health care, we are continually chasing the best equipment, techniques, and methods, but pay little attention to how they fit together to truly improve care for the patient. Checklists enable the clinician or practice owner to integrate these parts into a “system of excellence.”

Finally, one of the greatest benefits of the checklist is the practice of studying our failures to identify patterns of recurrent mistakes and refine both the solutions and the checklist. The checklist is not about continually working harder, but working smarter and freeing the practice owner’s mental energies to tackle the bigger issues facing our practices.

Angela Wilson Pennisi, PT, MS, OCS is President of Lakeshore Sports Physical Therapy, PC, and Physioview, LLC in Chicago, Illinois. She can be contacted at awp@lakeshoresportspt.com.
A common mistake that many private practices make is not having a written plan to guide their business. Unfortunately, our practice of 25 years had fallen into that category. As a result, we found ourselves experiencing difficulty in working through issues that were challenging our business. Recognizing this shortcoming, we went to work on putting together a business plan. A business plan can suit two purposes. It can be used as a document to assist in obtaining external financing or, as in our situation, to serve as a master guide to running our practice. The purpose of this article is to share with you our experience and to provide you with guidance on how to find and analyze the information necessary to complete a business plan specific to your practice.

The first step we took was to complete an online search for background information about developing a business plan. Our comprehensive search revealed that there is minimal information directly devoted to business plan development for physical therapy practices. Our internet search did result in a number of sites that offered to sell us software that would walk us through the process of writing the business plan. The most useful site that we were able to find was for the Small Business Administration (SBA), www.sba.gov. The SBA website provides a number of resources and links that will assist in writing a business plan, including an online training tutorial for completing a business plan as well as a template that may be used in writing the plan. Although you can purchase a business plan software program, the information provided by the SBA will give you an adequate basis to start developing your business plan without any additional cost.

The typical business plan is going to include the following components: a description of your business along with a statement of your mission and vision, definition of the market, description of your products and/or services, discussion of your organization and management structure, presentation of your marketing and sales strategy, and relevant financial data. An executive summary that provides a snapshot of your practice and essentially summarizes your business plan is also included. The appendices contain supporting documentation for your business plan.

The business description component of the plan is probably the most straightforward part of the business plan. It will include a statement of your company’s mission, vision, goals, and objectives; a history of the business; and key principals of the organization. The mission and vision statement are critical components of the plan, as they will be the driving force behind your organization. If you do not already have a mission and vision statement or wish to update your existing ones, an internet search will provide you with multiple resources (ie, www.managementhelp.com, www.missionstatements.com) that you can use to develop them. Business goals and objectives should be specific, measurable, and attainable. Keep the history of the company brief, highlighting how the business started and how it has evolved. The background information should also identify the founders and the current key individuals in the business.

Defining the market is somewhat more difficult. There is no readily available data that will provide you with the information that you need; it takes a fair amount of investigative work. In performing our business plan, we found several websites that provided information that we could use to describe our market. The SBA will provide links to census, demographic, and economic data. The Kaiser Family Foundation (www.statehealthfacts.org) will provide state and local health, demographic, and economic data. The Centers for Disease Control and Prevention at www.cdc.gov and the National Institutes of Health at www.nih.gov or www.nihseniorhealth.gov provide information on health data and trends. General health industry trend reports are provided by PriceWaterhouseCoopers (www.pwc.com), Bain and Company (www.bain.com), and the Kaiser Family Foundation (www.kff.org).

Describing your products will be one of the easiest parts of your business plan to complete. However, as you go through the process, you will have the opportunity to analyze and justify

The mission and vision statement are critical components of the plan, as they will be the driving force behind your organization.
your services. In this section, you should identify your services, describe how you price your services, and explain your pricing. You may also want to review constraints on pricing or expected trends in pricing. Most important, you should be able to describe why you provide these services and how they make you competitive in your marketplace. If you can’t do this for a product or service, you may want to reconsider the value of your practice providing these services.

In the section on organization and management, you will provide information on the company’s overall organizational structure, discussing the legal form of ownership as well as how the organization functions on a day-to-day basis. It is here that the actual process on how the practice completes its day-to-day operations will be described. Finally, the decision makers in the organization and what types of support and consultative services are available are identified. These data can also be used to evaluate your structure and operations. Our analysis resulted in a change of our corporate structure and a conversion from a rehab agency to a group private practice.

Depending on the primary purpose of your business plan, the section on marketing and sales strategy can vary in depth and detail. As an in-house document to guide our business, a more comprehensive approach was taken. An analysis of potential trends, a strengths-weakness-opportunities-and-threats analysis, analysis of competitors, and the formulation of a strategy to address the findings were included. A review of national and regional health care trends was completed by searching health care trend reports at PriceWaterhouseCoopers, Bain & Company, the National Institutes of Health, the Centers for Disease Control and Prevention, and the Kaiser Family Foundation. Because utilization data for private companies are generally not available, a competitive analysis is difficult to complete using objective data. Public companies may report their utilization data in their annual reports. Completing our competitive analysis, we identified all organizations that advertised that they provided therapy services and classified them based on the type of organization they represented (ie, private practice, physician owned, hospital based), location and scope of services provided, and personal knowledge of their operations. These data were used to subjectively assess their competitive impact on our practice.

The financial management component of your business plan typically will consist of copies of balance sheets, income statements, and cash flow statements. If you are using your business plan to obtain financing, you will normally need at least 3 years of balance sheets and income statements and a 12-month cash

MANAgEMENT, continued on page 36
flow statement. The entity that is providing financing may also require copies of your personal financial statements and federal tax returns. If you are not using the plan to obtain financing, the cash flow statement is probably the most important part of the financial component section. Here is where you will be incorporating revenue and expense changes that you expect to see through the implementation of your business plan. Working with your accountant, you can set up a spreadsheet and perform a “what if” analysis to look at what the impact these changes may make on your cash flow under different scenarios.

The appendixes section will simply include any supporting data or additional information that you feel is appropriate for your business plan. It could include copies of research reports, data analysis, charts, and marketing materials.

The final component of completing your business plan will be the executive summary. This section provides you with the opportunity to synthesize your findings and to develop a concise document that can be shared with staff, board members, consultants, and financial agencies. In general, it should include a brief overview of the company along with key highlights, findings, and conclusion of the plan.

Once you have completed your business plan, remember that it is not a static document. It is a dynamic tool that will be constantly evolving and will require periodic review and updating. At minimum, you should be reviewing and updating this document annually. Realistically, it should never leave your desk, as it will give you the tool you need to focus your energies to ensure your practice’s future success.

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Introducing the Administrator’s Certification Program

By Jay Jones

“Wouldn’t it be nice if there were a comprehensive program for practice administrators that focused on the running of a private practice business? Somewhere administrators could obtain reliable and current information and guidance on how to do it right?” It was that question that led to the development of an Administrator’s Certification Program.

This new program is being offered at the PPS Annual Conference & Exposition in Seattle, Washington, November 2–5, 2011. Modeled from the Medical Group Management Association’s comprehensive resource for practice administrators, a workgroup of nationally recognized contributors within PPS was assembled to develop and implement this top-notch certification program for practice administrators. Similarly, it is formatted as a collection of modules, each representing a key administrative area of a physical therapy practice. Using case applications and key concepts, a comprehensive presentation will be provided during the course of the PPS Annual Conference & Exposition, which will result in participants being more efficient and profitable administrators.
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- Financial Management
- Marketing and Customer Service

Each module will be presented by a nationally recognized expert in their respective fields. Running concurrent with the 2011 PPS Annual Conference & Exposition, participants will be able to attend any or all modules for their class time. If you have an interest in a specific module and want to attend only that, the module will be available to you. However, individuals who have demonstrated attendance and participation at all modules will be eligible to test for the certification. Testing will be internet-based and at a later date following the Annual Conference & Exposition. Successful passage of the certification test will result in the award of the designation CPPA, Certified Private Practice Administrator. CPPA designees will be able to maintain their annual certification by completing continuing education hours, which will be offered by PPS through additional educationally blended venues.

PPS is pleased to present this program as a significant value afforded to membership. Although numerous courses are available to enhance one’s clinical abilities, courses designed especially for the administrator—who needs to fully understand and demonstrate superior competency of the business process—have been more difficult to find. Understanding the road map to success has been difficult at best. This course provides understandable directions and easy-to-read signposts to help administrators stay on course to greater efficiency and enhanced profitability. It is the first of its kind, and seeks to provide a level of competence that has not been available in any other venue.

The certification program was designed with the nonclinical practice administrator or office manager in mind, but is more than suitable for any individual responsible for the successful operation of a private practice physical therapy practice.

The Administrator’s Certification Program is open to all PPS members and nonmembers, and to their staff. Substantial discounts are provided to PT members and to members of the Administrators Council, for which membership costs are only $50 a year. If you are not a member of PPS or the Administrators Council, you can join by contacting the PPS office at 1-800-517-1167.

Register for the PPS Annual Conference & Exposition today by going to www.ppsapta.org and clicking on 2011 Annual Conference tab. And have a blast in Seattle!

Jay Jones is CEO at Southern Physical Rehab Network in Birmingham, AL, and Chair of the PPS Administrators Council. He can be reached at jaypllx@bellsouth.net.
“I have always felt like I should get my tDPT but I just could not justify the time out of the office... Then I found the Executive Program. This program is actually an investment. I have made much more income from the knowledge gained than I spent on time, effort and money on the course. I grew from 5 locations to 8 last year and realized a 12% increase in my profit margin...Oh yeah, it is also a blast!”

-Brett Tice, DPT, CEO/President, Back To Action, Harlingen, TX
Ludwig Wittgenstein once said, “A picture is a fact.” In an environment of declining reimbursement and increasing audit frequency, practice owners might consider repurposing the video analysis software initially purchased for sports and running analysis to enhance documentation of patients’ impairments and functional limitations.

Be creative in your use of digital video analysis software and consider recording and analyzing functional outcome measures, such as the 10-m walk, Timed Up and Go, and Berg Balance Test. Analyzing movements frame-by-frame can help determine the primary and secondary impairments that are limiting safe mobility. This type of analysis could also help a therapist determine and document whether the patient’s deficit with the Timed Up and Go test is related to transferring, turning or gait limitations.

Kristi Link, PT, ATC, a physical therapy resident at Sports Medicine of Atlanta, may be reached at 703/585-3751.
Learn to gather and use information to operate each aspect of business. That is what we primarily learned from our experience, as we placed a physical therapy clinic onsite at United Parcel Service (UPS) in Cleveland, Ohio, in the late 1990s. The plant of 3,200 employees was sustaining 100 new injuries per month. We were brought in to help them solve this massive problem.

During our work with UPS, we learned the value of having immediate access to accurate information and learned how to consolidate information to most clearly solve problems. We watched them as they devised and continually improved methods of organizing and reporting their data. It was fascinating, and it made us realize how far away from that we were in having a grasp of our own business information. At that time, we had no means and no plan. It certainly raised a few questions like, “What information do we need to gather, and how can we use it to strengthen our business?”

To get to the most essential information, the first step is asking the right questions. Then, determine what is needed to provide the answers. Here is the primary question we sought to answer in our practice: “What is it that we, as business owners, have to do to increase the payment rates for physical therapy service?”

The second report (see page 47) compares the top 20 payers to Medicare and again to our costs. This consolidated report answers the question asked earlier. The cost to operate that clinic is $1.89 per charge minute. As you can see, Medicare pays at 2.4% over costs. The second payer, which is 11.4% of the business, pays us at a rate that is 71.2% of Medicare and 27.1% below our costs. Overall, this clinic lost 6.9% in 2011 (bottom right in chart). This is powerful information, and it is used in each negotiation. Telling this to someone most often stimulates a “Really?” response.

The third report (see page 47) drills down into the multiple plans inherent in the second payer in the second report. This is an example of a report that we send to the top four payers (74% of total business) twice per year. They pay us at a rate of $1.39 per charge minute. The most disturbing aspect of this information is that this company is fully aware that they pay us at this rate, yet do nothing about it. They call their payment rate “market value.” We have drafted legislation asking our state to give the Department of Insurance jurisdiction to inquire about payment methodology that defines market value based on costs of providing services.

In our opinion, practice owners must accurately determine costs and use that information in negotiation with the payer. When we present our costs, most payers’ first comment is that the business expense is too high. To counter, we report our expenses to this general business standard: the salaries should be 48–50% of the operation expense, and the rent and utilities 9%. The top four payers to whom I report this information know exactly what my costs are and how they compare with that cost. What we are looking for is a fair deal, and once the payer recognizes the cost savings and controlled spending, as
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the result of physical therapy intervention, then our negotiation capability becomes stronger. By compiling and analyzing data in a meaningful way, we improve our ability to negotiate with payers and operate our practices profitably.

Thanks, UPS, for the business education.

James A. Porterfield PT, MA, ATC, is the owner of Rehabilitation and Health Center, Inc. in Akron, Ohio, and is CEO of Venture Practice Services, LTD, www.venturepractice.com and CEO, Acadaware, www.acadaware.com. He can be reached at porterja@aol.com or 330/701-9694.

| Date: 03/21/11 | Percent Payer\Cost | Report #2 |
| Service Date | Insurance Name\Code ranked by # of Charged Visits | 01/01/2010 | 12/31/2010 |
| Facility | | Total Visits | % Tot Visits | Avg Pay/Min | MED00 Pay/Min | % of MED00 | Cost/Min | Pay as % Cost |
| Insurance Name\Code | | | | | | | | |
| 848 | 23.9 | 1.94 | 1.94 | 100.0 | 1.89 | 2.4 |
| 387 | 10.9 | 1.38 | 1.94 | 71.2 | 1.89 | -27.0 |
| 366 | 10.3 | 2.12 | 1.94 | 109.7 | 1.89 | 12.4 |
| 254 | 7.2 | 1.98 | 1.94 | 102.5 | 1.89 | 5.0 |
| 187 | 5.3 | 1.40 | 1.94 | 72.2 | 1.89 | -26.0 |
| 167 | 4.7 | 2.28 | 1.94 | 118.0 | 1.89 | 20.9 |
| 160 | 4.5 | 1.47 | 1.94 | 76.1 | 1.89 | -22.1 |
| 116 | 3.3 | 1.85 | 1.94 | 95.5 | 1.89 | -2.2 |
| 96 | 2.7 | 1.04 | 1.94 | 54.0 | 1.89 | -44.7 |
| 85 | 2.4 | 1.78 | 1.94 | 91.7 | 1.89 | 6.0 |
| 82 | 2.3 | 1.36 | 1.94 | 70.0 | 1.89 | -28.3 |
| 81 | 2.3 | 0.90 | 1.94 | 46.4 | 1.89 | -52.5 |
| 78 | 2.2 | 1.41 | 1.94 | 72.8 | 1.89 | -25.4 |
| 44 | 1.2 | 2.74 | 1.94 | 141.7 | 1.89 | 45.1 |
| 44 | 1.2 | 1.37 | 1.94 | 70.8 | 1.89 | -27.4 |
| 42 | 1.2 | 2.68 | 1.94 | 138.4 | 1.89 | 41.7 |
| 41 | 1.2 | 1.27 | 1.94 | 65.4 | 1.89 | -33.0 |
| 38 | 1.1 | 1.10 | 1.94 | 57.0 | 1.89 | -41.6 |
| 32 | 0.9 | 1.08 | 1.94 | 55.8 | 1.89 | -42.8 |
| 31 | 0.9 | 2.88 | 1.94 | 148.6 | 1.89 | 52.2 |
| Top 20 | 3179 | 89.5 | 1.77 | 1.94 | 91.3 | 1.89 | -6.5 |
| Totals | 3550 | 100.0 | 1.76 | 1.94 | 90.9 | 1.89 | -6.9 |

| Date: 03/28/11 | Percent Payer\Cost | Report #3 |
| Service Date | Insurance Name\Code ranked by # of Charged Visits | 01/01/2010 | 12/31/2010 |
| Facility | | Total Visits | % Tot Visits | Avg Pay/Min | MMO14 Pay/Min | % of MMO14 | Cost/Min | Pay as % Cost |
| Insurance Name\Code | | | | | | | | |
| 387 | 84.0 | 1.38 | 1.55 | 88.7 | 1.89 | -27.0 |
| 21 | 4.6 | 1.36 | 1.55 | 87.3 | 1.89 | -28.2 |
| 21 | 4.6 | 1.55 | 1.55 | 100.0 | 1.89 | -17.7 |
| 20 | 4.3 | 1.32 | 1.55 | 85.0 | 1.89 | -30.1 |
| 12 | 2.6 | 1.46 | 1.55 | 94.1 | 1.89 | -22.6 |
| Totals | 461 | 100.0 | 1.39 | 1.55 | 89.1 | 1.89 | -26.7 |
EMR and HIT: Defining Key Terms

Stephen M. Levine, PT, DPT, MSHA and Helene M. Fearon, PT

The potential for information technology to have an impact on health care safety, cost, and quality has never been greater; however, realizing these benefits requires an underlying infrastructure that can support the use of patient-focused electronic health information, including the process of sharing health-related information in a secure manner. The recent surge of activity from both public and private sectors to use and share health-related information has proceeded, even though myriad meanings for terms used to define the electronic medical records (EMR) landscape have emerged and the relationships among terms are inadequately defined. There was, and continues to be, no clear, consistent language underlying health information technology (HIT) adoption. To ensure that physical therapists develop and use a consistent language when discussing electronic medical records (or electronic health records), it is important that providers have a clear understanding and consistent application of various terms used in HIT.

The National Alliance for Health Information Technology (NAHIT) was hired by the Office of the National Coordinator of Health Information Technology (ONCHIT) to create key HIT definitions, which were released in a report in April 2008. The executive summary of the report explains why defined terms are needed:

“The ambiguity of meaning created by not having a shared understanding of what these key terms signify becomes an obstacle to progress in health IT adoption when questions about a term’s definition and application complicate important policy expectations or directives, contractual matters, and product features. Differences in how a term is used can cause confusion and misunderstanding about what is being purchased, considered in proposed legislation, or included in current applicable policies and regulations.”1

As we continue in this series focused on successful transition to EMR, physical therapists should become familiar with several key terms. The following list is not exhaustive, but provides short definitions of key terms that health care providers in general and private practice therapists specifically should understand in order to enhance HIT:

- **Electronic Medical Record (EMR)**—An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.
- **Electronic Health Record (EHR)**—An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.
- **Personal Health Record (PHR)**—An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.
- **Health Information Exchange (HIE)**—The electronic movement of health-related information among organizations according to nationally recognized standards.
- **Health Information Organization (HIO)**—An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.
- **Regional Health Information Organization (RHIO)**—A health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among

**Note:** PPS members are encouraged to submit questions on this or other EMR topics, and we will publish these questions, and our responses, in this column as space permits. The authors will not publish questions and answers on specific products or EMR vendors, but will focus on information that can be used to assess the EMR product landscape. Submit questions to compliancepps@apta.org.
them for the purpose of improving health and care in that community.

- **Clinical Decision Support (CDS)**—Programs designed to assist health professionals with decision-making tasks, linking health observations (signs and symptoms) with health knowledge (best practices and current research) to influence choices made by clinicians to improve care.

- **Client/Server Application**—The relationship between two computer programs in which one program, the client, makes a service request from another program, the server, which fulfills the request. In this environment, a facility will view and document information in an EMR while it resides on the hard drive or server located within that facility or a facility-owned network.

- **Application Service Provider (ASP)**—A business that deploys, hosts, and manages access to software applications for multiple parties from a central location. The ASP charges a subscription fee to users of the applications, which are delivered over the Internet or other public or private networks. The application software resides on the vendor’s system and is accessed by users through a web browser or by special purpose client software provided by the vendor.

- **Integrated (End-to-End) EMR**—An integrated practice management and EMR system (often heard discussed as an “end-to-end” system) developed by the same vendor, sharing a single database or development platform, and designed to share complex data between applications.

- **Interoperability**—The ability of software and hardware on multiple pieces of equipment made by different companies or manufacturers to communicate and work together. This need is essential for sharing of health-related information. Established systems must meet standards to enable systems to exchange information reliably and securely. It also requires critical mass of HIT adoption within the delivery system to create and share health-related information electronically.

Like all other industries that have moved to electronic communications and transactions, the process begins with standards. The HIT industry was no different. In 2004, the ONCHIT was established not only to initiate and promote adoption of EMR, continued on page 51
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Steve Levine, PT, DPT, MSHA, and Helene Fearon, PT, are partners in Fearon & Levine, a national practice management consulting firm, and development partners in OptimisPT, an evidence-based, compliance-focused EMR. They can be reached at stevelevine@fearonlevine.com or helenefearon@fearonlevine.com, or through www.FearonLevine.com.

Reference
1 Defining Key Health Information Technology Terms; Department of HHS; April 28, 2008
Legislation that would repeal the arbitrary caps on therapy services for Medicare beneficiaries has been introduced in both chambers of the 112th Congress. In April, representatives Jim Gerlach (R-PA) and Xavier Becerra (D-CA) and senators Ben Cardin (D-MD) and Susan Collins (R-ME) introduced The Medicare Access to Rehabilitation Services Act (H.R. 1546/S. 829). Once again, our patients face an unreasonably hard therapy cap if Congress does not act by the end of 2011.

Many consumer groups have joined the professional therapy associations and other provider groups to call for the demise of these caps. And it is heartening to know that there is such a broad base of grassroots patient and provider support for repealing this peculiar policy. Although the current dire fiscal environment renders the likelihood of achieving full repeal this year extremely challenging, introducing these bills is the right advocacy strategy. We must continue to pressure Congress to remedy this flawed policy that is bad for beneficiaries. After all, eliminating the therapy caps would be consistent with the insurance reform contained in the Patient Protection and Affordable Care Act (PPACA), which protects patients by prohibiting annual and lifetime caps in insurance policies.

Prospects for full repeal improve significantly if and when a major reform of the Medicare payment mechanism (the sustainable growth rate, or SGR) is undertaken and accomplished. But that is not likely this year either. The cost of reworking the SGR is staggering and so far, no evident plan—or sentiment—has materialized for “writing off” the debt that has accumulated under the flawed formula. So we are probably looking again at a short-term Medicare payment patch, the specifics of which are far from being identified.

In examining repeal of the therapy caps, Congress will be looking for alternatives—in particular, looking for provisions to guard against overutilization. Although the original statutory language enacting the caps called for the limits to be temporary until an “alternative payment method can be developed,” after 14 years no such concrete alternative has emerged from the Centers for Medicare and Medicaid Services.

Perhaps this void can be filled by proposals emerging from the therapy professions following the leadership of APTA. Not only do we deal perennially with the therapy caps, but last year a new onerous and unfortunate payment policy was foisted upon the therapies. The Multiple Procedure Payment Reduction (MPPR) calculates a stepped-down rate for second and subsequent procedures delivered to the same patient on the same day. So, while the therapy cap limits the aggregate dollar amount of therapy a beneficiary can receive in a calendar year, the MPPR decreases reimbursement to the therapist for individual therapy sessions. In the payment policy arena, it can be said that the MPPR has become the therapy cap of the 21st century.

The therapy cap was legislation that was misguided from the outset. But the MPPR was regulatory action gone amiss, only to be opportunistically vacuumed up by the legislative branch in search of “savings” that could be used to help extend the SGR patch for the remainder of 2010. Doesn’t this sound like inventing a new flawed policy to temporarily remedy an old one?

Nevertheless, both the therapy cap and MPPR provisions (not to mention the 8-minute rule) point to the prospect that physical therapy could benefit from the development of a coding
schema that more accurately describes the services provided to and the benefits derived by the patient. Perhaps the time is right to explore a coding system more uniquely suited to physical therapy: one that more accurately reflects the evaluation and intervention skills of the physical therapist; one that corresponds to the severity of involvement of the patient; or one that incorporates outcomes measurement and objectively captures and quantifies the patient’s response to physical therapy. Or perhaps one that provides all of the above.

The stars do appear to be aligning favorably for a more appropriate method of coding physical therapy services, namely a descriptive payment system that incorporates the patient’s severity, the clinician’s skills, and the resultant outcome. Identifying and operationalizing these attributes could provide better outcomes for the patient and greater cost effectiveness for Medicare and other payers by recognizing the profound clinical contribution of the professional physical therapist.

Until those beams of light converge, members are urged to push for full repeal of the therapy caps in an effort to make this policy consistent with the other cap prohibitions included in ObamaCare. Contact your members of Congress by clicking the "Take Action" button on APTA’s website and tell your legislators to cosponsor legislation to repeal the therapy cap (H.R. 1546/S. 829) once and for all.

How can you improve your ability to hear the needs of those around you and maintain productivity during non-patient care time? First, don’t attempt to multi-task when someone is talking to you. There is nothing more limiting in a conversation than having someone doing something else at the same time. Set down your pen, stop working on your computer, and focus on making eye contact. Not only will looking at the source of conversation engage your involvement, it will provide a connection that encourages the sharing of information efficiently.

Once the connection has been established and is productive, compliment the conversation by restating questions or reinforcing the topics at hand. This provides the speaker with the opportunity to clarify and confirm information if needed.

Take the listening session to the next level by taking a few notes (specific to the topic), establishing timelines for follow-up, and thanking the speaker. This can create an efficient and productive opportunity, as information can be shared faster and without distraction.
Publications

A concise, easy-to-use guide that offers practical, step-by-step advice to physical therapists who are considering starting a private practice or may have just opened a practice. Experienced practice owners will also find valuable information throughout this manual.

Private Practice: Strategies for Everyday Management
This guide contains vital information needed to start up and manage a private practice. Chapters include planning, financial management, personnel management, marketing, reimbursement, office management, and customer service.

The Valuation of a Physical Therapy Practice
Understand the financial and strategic issues involved in valuing your practice and learn how to advance the overall value of your practice.

Transitions: How to Position Your Physical Therapy Practice and Create Your Succession Plan
It is the goal of this manual to assist private physical therapy practice owners in creating succession plans that are beneficial to both buyers and sellers of practice equity. Learn from the authors’ experiences of owning and exiting three practices and their work as consultants.

Impact Magazine
Published 11 times per year, Impact provides a wealth of information for the private practice owner. Issue themes include legislative updates, need-to-know tips about managing your practice, the latest resources from the section, and more. (Impact is a PPS member benefit. Nonmembers may purchase an annual subscription.)

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We all get frustrated that consumers often confuse physical therapists with chiropractors, massage therapists, or personal trainers. Few members of the public realize the depth of our knowledge and extent of our training. Some clinics, including mine, still get referrals for ultrasound, massage and Williams flexion exercises for a patient with low back pain. And how many times have you heard us referred to as “physical terrorists” or “pain and torture”?

With changes occurring everyday with rules and regulations being published regarding health care reform, it is time we step forward and teach the country how private practice physical therapy can make the difference in reducing cost, improving quality, and increasing the function of today’s society. The Private Practice Section Board of Directors is committed to tackling the challenges brought on by health care reform and helping our members promote our value to consumers, legislators, third-party payers, other health care providers, and other organizations by creating a public relations (PR) and marketing committee to develop strategies and materials to lead the way.

The new committee, which was formed in May, will brainstorm with a marketing firm to develop a targeted message to use across the board in all marketing and PR initiatives. This is necessary to prevent knee-jerk reaction to any negative publicity that may occur. One example that will be discussed is “Physical therapy is an incredible part of the health and wellness system. Physical therapists help people stay independent, help people stay fit, decrease the use of medications, decrease surgeries while offering a more cost-effective, long-term solution with few side effects.”

Public advocacy PR is also going to be a vital part of this committee in determining the best ways to educate consumers on what private practice physical therapists have to offer and what benefits they will gain from choosing a private practice PT over other options. In addition to public advocacy, we plan to develop opportunities for advertising and PR partnerships with similar service demographics, such as AARP, the Arthritis Foundation, Easter Seals, and many more.

We will need the help of many of you as we also hope to create a team of media “first responders” to constantly supply a positive message for all markets regarding private practice physical therapy and to act as “watch dogs” to monitor and report opportunities for PR, editorials, and responses to health care articles. We hope to serve as a communication pipeline by utilizing blogs, social media, and other means of communication.

These are just a few of the initial ideas and hurdles for this new committee; but to be successful, we will need the help of many members as we create a unified voice and get the word out on why we should be the first choice.

If you are interested in being a part of this committee, have suggestions for the committee or want to be included as a “first responder,” please contact the PPS office. As this committee moves forward with its work, updates will be posted on the PPS website.

Amanda Somers, DPT, is a PPS Director and can be reached at amanda@ssi-physicaltherapy.com.
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