ADAM

Executive Decisions in
DERMATOLOGY

SPECIAL POST-MEETING EDITION | APRIL 2015

ADAM's 23rd Annual Meeting
Most Successful Ever!

From the networking to the Welcome Reception to the workshops . . . ADAM's 23rd Annual Meeting was our best yet! We had more attendees than at any other Annual Meeting, and we're looking forward to your constructive ideas for further improvement so we can continue the progress.

Congratulations to Alice Hyman,
practice manager with Advanced Dermcare of Danbury, CT, named ADAM's Practice Manager of the Year!

Stay tuned to the next issue of Executive Decisions in Dermatolory for an in-dept interview with Alice Hyman.

INSIDE:

Executive Decisions in Dermatology is a bi-monthly publication of the Association of Dermatology Administrators & Managers (ADAM). ADAM is the only national organization dedicated to dermatology administrative professionals. ADAM offers its members exclusive access to educational opportunities and resources needed to help their practices grow. Our 650 members (and growing daily!) includes administrators, practice managers, attorneys, accountants and physicians in private, group and academic practice.

To join ADAM, or for more information, please visit our Website at ada-m.org, call 866.480.3573, email adaminfo@shcare.net, fax 800.671.3763 or write Association of Dermatology Administrators & Managers, 1120 G Street, NW, Suite 1000, Washington, DC 20005.

From the President

If you were in San Francisco . . . you know how valuable the meeting was

By Pamela M. Matheny, MS/IO Psychology, MBA/HCM, CMPE

With record attendance, ADAM's 23rd Annual Meeting was a huge success!

We had nationally recognized speakers covering a wide range of topics to enhance the performance of both the new and experienced practice manager. Strategic planning and roundtable discussions focused around thriving in a continually changing healthcare environment.

Attendees had a complete educational experience with an in-depth review in the areas of compliance and regulatory, patient centered care, human resources, revenue, marketing and practice management.

In addition to the three full days of learning, we all had an excellent opportunity for networking specifically designed for ourselves and our peers in dermatology leadership.

At the Welcome Reception, we had many of ADAM's new and existing members together to build new relationships and a little recreation and relaxation.

Two nights of networking dinners provided additional opportunities for all attendees to build their resources and spend time with their peers.

And, the Exhibitor Reception offered a night full of surprises! Anticipation was high as the exhibitors provided a drawing for fabulous gifts including an Apple iPad, iPhone 6, Kindle Fire, skincare products and gift cards.

We especially appreciate ADAM's sponsors and exhibitors. Their generosity and support made ADAM's 23rd meeting possible and aided in attracting our great speakers.

I want to thank our board members who represent you; they do so much behind the scenes. Also, thank you to our committee members for their creative leadership toward continuous improvement and support. Thank you to everyone for volunteering your time and effort to support ADAM's success.

One more thank you to those of you who attended the annual meeting. We appreciate your constructive feedback and hope you will offer suggestions about the educational sessions and meeting agenda.

Hearing what you want and need on an ongoing basis is invaluable in helping ADAM prepare for an even better meeting next year to support your ongoing success.

In the Spotlight . . .

Alice Hyman named 2015 Practice Manager of the Year! Congratulations to each nominee

Congratulations to ADAM's 2015 Practice Manager of the Year Nominees

We are pleased to announce the 13 candidates for the 2015 ADAM Practice Manager of the Year Award. Each candidate received exceptionally high praise from the physicians they work with, and we commend them for their professional accomplishments.

DAVID BATAGOWER

David Batagower is Office Administrator for Bellaire Dermatology Associates in Bellaire, Texas. He has been with the practice for less than two years, having previously worked in multiple veterinary practices. Batagower brings innovative ideas to the practice: marketing, rebranding, staff development and teambuilding. One example of his work to build staff morale is developing an internal "Amazing Race" for the practice's physicians and employees.

SHERRI BERWICK

Sherri Berwick is Practice Manager for Dermatology Associates of the North County in Templeton, California. She has brought the practice to new heights through EMR implementation, bringing the practice billing back in-house via a new billing system, searching for a new Nurse Practitioner and designing a new office. Berwick achieved these new objectives while still maintaining a strong focus on effective patient care.

RACHEL CHANES

Rachel Chanes is Practice Administrator for Pima Dermatology, PC in Tucson, Arizona. Since joining the practice in 2011, Chanes has played an integral part in improving the practice's operational effectiveness, building morale and promoting team unity. While facing significant challenges that required swift restructuring to stabilize the practice in 2014, she added an interim Mohs surgeon and a full-time RN while leading with strength and positivity. This year, Chanes added an expanded patient portal and new software.

ANGEL CUMMINGS

Angel Cummings is Vice President and Office Manager for University Dermatology Center in Muncie, Indiana. She began her career with the practice as Receptionist, rising to Billing Supervisor and Office Manager 10 years ago. Cummings was instrumental in starting the practice's dermatopathology lab, a medical/laser spa and Mohs services. In 2015, the dermatology practice became the first in Indiana to offer outpatient radiation brachytherapy.

REGINA CURRIMBHOY

Regina Currimbhoy is Billing Operations Manager for the Department of Dermatology, University of Texas Southwestern Medical Center in Dallas, Texas. She serves on three university committees working to create best practices for Front End Revenue. Currimbhoy 's department has been asked to pilot several new processes, and has been used an example for other clinics to emulate.

DIANA GONZALEZ

Diana Gonzalez is Practice Manager for Florida Skin Center in Fort Myers and Cape Coral, Florida. She has been with the practice since its inception. Gonzalez has implemented EMR and opened a second location, with a third location on the way, while providing patients with the highest level of care. She also has established core values, implemented accountability measures, and created teams and committees that encourage employee ideas and community volunteering.

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MADELYNN HUGHES

Madelynn Hughes is Practice Manager for Raymond C. Blackburn, M.D. in Dallas, Texas. She manages a staff of 15, including two Physician Assistants. She takes ownership of every aspect of the practice, and also has earned her Bachelor of Science in Healthcare Administration. Hughes' management style, notably her perseverance and discretion, has allowed the practice to grow very successfully.

ALICE HYMAN

Alice Hyman is Practice Manager of Advanced Dermcare in Danbury, Southbury, and Ridgefield, Connecticut. She has been with the practice for more than 15 years, guiding the practice's growth from four to eight providers with more than 50 staff members. Hyman implemented EMR, added a medical spa, relocated the office, and opened two satellite offices with a third office opening soon. She manages her staff effectively while taking a personal interest in each employee and treating each employee like a family member.

STACIA LAWRENCE

Stacia Lawrence is Practice Administrator of Kenneth Beer, MD PA in West Palm Beach and Jupiter, Florida. Although she has been with the practice for just nine months, in that short time Lawrence has improved morale, instituted a compliance program, trained staff, implemented financial safeguards and improved patient satisfaction.

GIBRAN LEESHA

Gibran Leesha is Practice Manager for William Kwan, MD in San Francisco, California. He joined the practice when it opened eight years ago, often filling in as receptionist, medical assistant and customer service representative since there was only one other employee. Leesha has grown the practice through effective marketing, developing specialty packages and holding office events, while gaining the trust and confidence of his fellow employees.

WENDY STOEHR

Wendy Stoehr is Practice Manager for Advanced Dermatology and Skin Surgery in Spokane Valley, Washington, and Coeur d'Alene, Idaho. With the practice for 16 years, Stoehr has grown the practice tremendously in that time, including purchasing a new office building, establishing a second office 30 miles away and leading the annual Strategic Planning session every January for 10 years. She has served as President of the Inland Medical Manager Association; recently the practice was named "Best Dermatology Practice in the Inland Northwest" by a local magazine.

BRENDA STUFFLESTREET

Brenda Stufflestreet is Practice Manager for Tri-Cities Skin & Cancer in Johnson City, Tennessee. With the practice for 11 years, Stufflestreet has overseen staff growth from two providers and 20 employees to seven providers and 70 employees. She leads with a "firm but fair" hand, and has managed many projects, including two building expansions, the addition of an operating room and pathology lab, and EMR adoption.

NATHAN WESSELLS

Nathan Wessells is Practice Manager for Mountaintop Dermatology in Colorado Springs, Colorado. Two years ago, he helped launch the practice, and has since doubled the staff, and has seen 24 months of continued financial growth for the practice, thanks to a successful Web marketing campaign. Wessels focuses on exceptional customer service, and his meticulous management of the practice schedule has resulted in a no-show rate lower than the industry standard.

Q&A: Ask the Lawyer

Are practices liable if employees or patients are injured on the way to the office during inclement weather, like ice or snow?

By Michael J. Sacopulos, JD, Medical Risk Institute

Q: Is the practice liable if we choose to stay open during inclement weather, like a snowstorm, and an employee is injured in an accident on the way to work? While we give employees the choice to come to work or stay home and use a vacation day during inclement weather, if the employee chose to come to work and had an accident, we are wondering if we still would be liable.

A: Just a guess, but is your practice is located in Boston, MA or Portland, ME? The 2014/2015 winter has been brutal for some parts of the country, especially the northeast U.S., and I certainly understand why this question is on your mind.

First, your question seems to be focused on employees and not patients. Just in case you're also interested in the question from the patient standpoint, in terms of getting patients out in inclement weather, here are my thoughts: when it comes to patients, your potential risk exposure for keeping your office open in bad weather comes down to 'slip and fall.'

There is no liability for your practice simply for being open if a patient is traveling to you and experiences problems. Your liability begins and ends on the physical premises of the practice.

What we should be concerned about are the 'slip, fall, and sue' type of cases that often occur from snow and ice. These cases are covered by your premises liability insurance policy. Obviously, you should, to every extent possible, have the snow and ice removed for the general public, to reduce the chance of someone falling.

Where I think your question is really going relates to employment law. You said you would allow employees to decide whether or not they could make it into work. I think that is a smart idea. But let's assume one of your employees has an accident on the way to work in the morning. Your practice is not liable. Going to and from a place of employment is not considered to be within the scope of employment. Therefore, it is outside the scope of worker's compensation and outside the scope of the practice's liability.

The only exception is if you have asked the employee to do something on his or her way to and from work. For example, if I ask a staff member to drop off the mail at the post office on her way home and she is injured en route, I am on the hook. As long as you are not asking the employee to do anything on his or her way to and from work, your practice will have no liability for any injuries suffered due to bad weather.

Are you ready for the 2015 Audits?

By Suze Shaffer, Aris Medical Solutions

Let's dive in by first addressing the Centers for Medicare and Medicaid (CMS). If you adopted Electronic Health Records (EHR) and applied for the Meaningful Use incentive money that was offered, you may be subject to an audit. CMS hired Figliozzi and Associates to audit the recipients of the incentive funds. In 2014 the pre-payment audit system was begun; they request your documentation before they send you your incentive payment. This includes your EHR documentation and a dated risk management plan that explains how you have mitigated vulnerabilities.

Most medical practices are busy learning the new EHR/EMR software. While making sure they meet all the percentage requirements of the Core Measures, sometimes practices forget to read the requirement for the measure that simply states Protect Electronic Health Records. When you answer "Yes" to this question, you are attesting that you have performed a Security Risk Analysis, implemented security updates as necessary, and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure. If you have not performed these very important tasks, your money can and will be recouped by CMS if you are audited. These audits are random, so do not think if you are a small practice they will not audit you.

Next, the Office for Civil Rights (OCR) is also interested in how you protect patient data. While the Security Rule has been around since 2005, it has not really been enforced until now. CMS reintroduced this rule with the Meaningful Use criteria as we mentioned above. A Security Risk Analysis (SRA) is required under the Security Rule. However, they are interested in so much more than just your network. A true SRA must include a review of the administrative, physical and technical safeguards you have in place to protect patient data. The SRA should also include a review of your policies and procedures. The Security Rule is about 75 percent policies and procedures on how you protect patient data.

You may be wondering what this has to do with the OCR? It only takes one patient complaint to trigger an audit from the OCR. If you do not have a full set of Privacy and Security Policies and Procedures, you could be found in willful neglect. If you have a data breach, that will trigger an audit as well. The fines can be substantial, up to $1.5 million per violation per year.

The OCR also has trained the States' Attorneys General on HIPAA Compliance. Each state is handling this in its own way. Some states hired their own HIPAA staff and are sending these employees into practices as patients and documenting violations as they go through the triage. Others are surfing websites of practices looking for your Notice of Privacy Practices to ensure they have been updated to meet the Omnibus Rule requirements. So you see, you need to prepare for audits. It is no longer "if" you get audited, it is "when".

Here are some helpful hints to help you prepare for the upcoming audits:

1. Covered Entities and Business Associates are both required to conduct a Security Risk Analysis. There are free tools available, including one from the Department of Health and Human Services (HHS). Keep in mind no matter which tool you use, it is only a starting point.
2. Create a Risk Management Plan based on the findings from your Risk Analysis. Review Health and Human Services' Security Matrix to understand what is required and what is addressable. Keep in mind addressable does not mean optional. Addressable means you must have reasonable and appropriate safeguards in place, based on the size of your organization.
3. All covered entities must have the ability to monitor their audit logs from either their EHR/EMR software or a device which connects a user to Electronic Protected Health Information (ePHI). The purpose behind this requirement is to monitor for abnormal activity. This abnormal activity could be the result of a rogue employee or a cyber-attack.

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4. Make sure you have assigned a HIPAA Privacy Officer and a HIPAA Security Officer. Everyone in the practice needs to know who these people are by these titles. In a small practice it could be just one person. If an auditor calls your office, they will ask for your Privacy Officer, your Security Officer, or possibly your Compliance Officer.
5. Every practice needs to have in place a Breach Notification Plan in the event of a Data Breach. Most importantly, you must have an IRT (Incident Response Team) in place that includes an IT Professional, a Forensic IT Company, and a Healthcare Attorney along with your own personnel. After you suffer from a Data Breach is not the time to put this team together. Time is of the essence when notifying your patients. Federal law states you have 60 days to notify your patients involved in a Data Breach. However, some states are much more stringent, therefore State law would trump Federal law. Some states now even require the State Attorney General be notified as well. Know your State law!
6. Contingency planning is a must whether you have a server-based or a cloud-based EHR. You must have a plan in place to protect and restore ePHI in the event of an emergency or disaster. Your plan will be very different based on where your ePHI is located. This Security Standard has three required and two addressable components.
7. Business Associate Agreements are a must. If your Business Associate (BA) has a data breach and you do not have an agreement in place and do not have any documentation that your BA is HIPAA-compliant you could be faced with the same fines and penalties as the BA. Even though a practice may not be responsible for a BA's Subcontractor, if the Subcontractor or the BA has a Data Breach, the practice is ultimately responsible for the cost of the Data Breach. Make sure anyone who accesses, creates, maintains or stores YOUR ePHI is HIPAA-Compliant.
8. Protected Health Information is obviously located within your EHR, but since more and more equipment now stores ePHI, it is necessary to review your workflow to determine where ePHI is located. This is required since you must have procedures in place when you replace your computers and other office equipment to ensure ePHI is properly removed or the device is destroyed.
9. Technical Safeguards has several categories in the Security Rule. Some are required standards while others are labeled addressable. With that said you could be fined and penalized a large sum of money if you do not have what are considered reasonable and appropriate safeguards in place. For instance, even though encryption is addressable, if your server, computer or laptop is stolen and it is not encrypted, you could be faced with a $1.5M fine.
10. Policies, procedures and documentation are the backbone of HIPAA Compliance. You are required to have up-to-date privacy and security policies and procedures that cover all the requirements of the Security Rule. Last but certainly not least, be sure to document everything. The Office for Civil Rights (OCR) is famous for saying . . . "If it's not documented, it didn't happen and doesn't exist." Documentation must be stored for a minimum of six years; however, it can be stored digitally, instead of paper storage.

For more information on audits or any other HIPAA matter, contact Aris Medical Solutions at 877.659.2467.

ADAM Access Pass:

Wish you could attend all of the great webinars ADAM has to offer throughout the year, but can't make them work with your schedule?

The ADAM Access Pass is for you! For just $149 (members only), you'll have access to all of the recorded webinars through 12/31/15. You can watch them at your leisure, share them with your staff or use them to brush up on the information. Purchase in the online store under the "MyADAM" tab or email ADAMinfo@shcare.net for more information.

Benchmarking an Effective Tool for Ongoing Practice Evaluation

By Tony Davis, CPA CMPE
Executive Director, Dermatology Specialists, Edina MN

Now that 2014 is in the rearview mirror and the winter months are passing by (well, for most of you, I do live in Minnesota!), most of us are ready to reflect and make sense of the year-end financial and productivity reports before us on our desks.

These reports cover a wide range of financial information. Some are the basic accounting reports generated internally or by our accounting advisors, and others are supplied by practice staff, the business office, front desk, lab or nursing, to name a few.

The key question, once we receive these reports, is how to convert a bunch of numbers into meaningful analysis. On their own, the numbers tell a small story, but when compared with other data (historical, industry or budgeted), this benchmarked financial information becomes a useful management tool.

This financial information can be broken down into two main categories: Financial Reports and Productivity Reports.

FINANCIAL REPORTS

Typically, we are used to seeing a Balance Sheet and Income Statement (or a Profit and Loss Statement). These statements provide excellent insight into the health of the corporate entity on a particular date or for a particular period of time. They also can be useful in comparing the financial results of the clinic over a number of years and with budgeted projections.

The Income Statement often is used to calculate overhead percentages on key costs such as human resources (salaries and benefits), office space (rent), medical supplies, technology expenses, depreciation of medical and office equipment, and office costs such as telephone/copiers, utilities and general supplies. There are helpful industry statistical norms available from groups like the Medical Group Management Association (MGMA) and the American Medical Group Association (AMGA) that can help a manager understand where the overhead percentages line up compared with other independent medical clinics.

PRODUCTIVITY REPORTS

There are many different ways to track and measure clinic productivity and, similar to accounting reports, it is important to establish base years of information in order to track performance and establish benchmarks against results.

Productivity reports can cover many components of a dermatologist's practice. Some of my favorite reports include:

- **Net Charges**—calculated as Gross Charges minus contractual adjustments
- **Net Collections**—actual cash collected from medical procedures minus patient refunds
- **Work Relative Value Units (WRVU)**—calculated by using the work component of the CPT code charged by the dermatologist multiplied by the number of times that code is used (volume)
- **Evaluation and Management (E/M) codes**—tracking on a bell curve the number of times a dermatologist bills the CPT code in the New Patient office visit—99201, 99202, 99203 and 99204 compared with the Established Patient visit – 99211, 99212, 99213 and 99214. This is a particularly useful report for identifying any outlier behavior among doctors.

Gathering relevant benchmarking data can be a challenge. As I previously wrote about in the November/December 2013 issue, there are many different resources available to managers, and careful research is required to determine where and what kind of benchmarking data is most useful.

Some resources you might consider are three breakout sessions at our upcoming ADAM Annual Meeting in San Francisco from March 18—20. On Wednesday, March 18 at 2:30 p.m., we offer *How to Manage Your Practice in One Hour a Week With Benchmarking* presented by Judith Aburmirghan. On Friday, March 20, we offer *Top Financial Benchmarks to Monitor Your Practice* with Jackie Coult at 10:50 a.m. and *Inventory—It's All About Cost* with Kathy Hargreaves at 4 p.m.

Within the ADAM family, we continue to pursue the idea of creating our own financial benchmarking data specific to dermatology. This will require the cooperation and organization of the membership of our association—are we up for the challenge?

Melanoma Monday®: Statistics, History and Getting Ready for May 4

By Jill Sheon, Children's Dermatology Services of Children's Community Pediatrics, UMPC Children's Hospital of Pittsburgh

Established by the American Academy of Dermatology (AAD) in 1995, Melanoma Monday® falls on the first Monday in May every year, and was established to raise awareness of melanoma and other skin cancers. Melanoma Monday® officially kicks off Melanoma/Skin Cancer Detection and Prevention Month®. This year's event is Monday, May 4.

Melanoma facts from the American Academy of Dermatology

- On average, one American dies from melanoma every hour.
- In 2015, it is estimated that 9,940 deaths will be attributed to melanoma - 6,640 men and 3,300 women.
- Melanoma is the most common cancer for young adults 25 to 29 years old and the second most common form of cancer for adolescents and young adults 15 to 29 years old.
- When caught early, skin cancer, including melanoma, is highly treatable. The five-year survival rate for people whose melanoma is detected and treated before it spreads to the lymph nodes is 98 percent.

2014 American Cancer Society facts regarding melanoma in the United States

- About 76,100 new melanomas will be diagnosed annually (about 43,890 in men and 32,210 in women).
- About 9,710 people are expected to die of melanoma annually (about 6,470 men and 3,240 women).
- Melanoma is more than 20 times more common in whites than in African Americans.
- Overall, the lifetime risk of getting melanoma is about 2% (1 in 50) for whites, 0.1% (1 in 1,000) for blacks, and 0.5% (1 in 200) for Hispanics.
- The risk of melanoma increases with age. The average age at the time it is found is 61 years old. But melanoma is not uncommon even among those younger than 30 years old. In fact, melanoma is one of the most common cancers in young adults (especially young women).

When was melanoma first identified as a disease?

News-Medical.net reports a number of facts regarding early detection and identification of melanoma. John Hunter is reported to be the first to operate on metastatic melanoma in 1787. Although not knowing precisely what the condition was, he described melanoma as a "cancerous fungous excrescence." The tumor he excised was preserved in the Hunterian Museum of the Royal College of Surgeons of England. The French physician René Laennec was the first to describe melanoma as a disease entity. His report was initially presented during a lecture for the Faculté de Médecine de Paris in 1804 and then published as a bulletin in 1806.

The first English language report of melanoma was presented in 1820 by William Norris, an English general practitioner. In a later work in 1857, Norris remarked there is a familial predisposition for development of melanoma ("Eight Cases of Melanosis with Pathological and Therapeutical Remarks on That Disease"). The first formal acknowledgment of advanced melanoma as untreatable was made by Samuel Cooper in 1840. Cooper stated the only chance for benefit depends upon the early removal of the disease. It was not until 1968 that microscopic examination of the specimen revealed it to be metastatic melanoma.

Now that we've armed you with some stats and history about melanoma, what will you do? Get ready for May 4. The American Academy of Dermatology Melanoma Monday® website has everything you need, from free cancer screening tools to the ABCDE's of Melanoma and other educational guides, to mole mapping tools. Spread the word to your family, friends and community about Melanoma Monday®.

The more you participate, the more you grow as a leader

By Janice Smith, Office Manager, Spencer Dermatology Associates, LLC, Crawfordsville, IN

Joining a committee is the best and quickest way to get more from your ADAM membership. Not only can you help guide ADAM to make it a stronger organization, getting involved in a committee is also a great way to network, gain more knowledge about practice management, and get to know your fellow members on a more personal basis.

COMMUNICATIONS COMMITTEE

Ever wondered how the newsletter is produced? This Committee's main focus is developing Executive Decisions in Dermatology, our bimonthly newsletter. Communications meets once every six weeks to set the theme and brainstorm article ideas for the next issue. Members are also directly involved with the website content and design, social media, email blasts and other communication tools focused on connecting ADAM internally and externally.

EDUCATION COMMITTEE

Want direct input on the type of education ADAM provides to members? This Committee brainstorms topics and speakers for monthly webinars and assists the Annual Meeting Program Chair with building the Annual Meeting program. Getting involved with the Education Committee is a great way to make your voice heard on topics you'd like to learn more about.

MEMBER SERVICES COMMITTEE

Do you have a new member benefit idea? Would you like to help ADAM grow? The Member Services Committee develops potential member benefits, creates additions to the My ADAM section of the website, and works on recruiting and retaining our members.

MENTORING & NETWORKING COMMITTEE

Do you love to help others? Want to share your ADAM experience with new members? Each month Committee members are assigned new members to welcome to ADAM and answer any questions they may have. This Committee also plans networking events at the Annual Meeting, such as Networking Dinners and the Welcome Reception.

Don't put it off! Today, contact ADAM Executive Director Pam Kroussakis today at ADAMinfo@shcare.net and let her know what committee you'd like to connect with. The more you participate, the more you will grow as a leader.

ADAM Webinars

Save the Date: ADAM Webinars Coming Up

BEHIND THE SCENES OF AN AUDIT PROCESS: HOW TO PREPARE AND RESPOND

Wed., May 27, 2 p.m. EST

Sean M. Weiss, CPMA, CPC, CPC-P, CCP-P, ACS-EM

Vice President and Chief Compliance Officer | DoctorsManagement, LLC

With more than a dozen entities waiting to audit your practice at any given time, it is crucial tyou understand the common theme used in each of their audit processes. Your key to successful compliance is to understand the similarities and differences across audits such as RAC, OIG, ZPIC, MIC or MAC.

In this one-hour session, Sean M. Weiss walks you through the steps every practice needs to know should they become the target of any audit. You will gain an in-depth view of what happens behind the scenes of an audit, including notification, review and determination. You will also learn preparation and response strategies that can help avoid a number of common mistakes and mitigate potential damages.

INSURANCE ADJUSTMENTS: DOES YOUR CASH FLOW HAVE HIDDEN LEAKS?

Wed., June 3, 2 p.m. EST

Gene Good, J.D., CPA, MAcc

Senior Management Consultant, Partner | DoctorsManagement, LLC

How do you know when your practice is losing too much revenue to insurance adjustments?

The sad truth is that DoctorsManagement has never completed an assessment of a medical practice where the management team knew if their insurance adjustments were too high, too low or even what level of adjustments are expected. Without this knowledge, your practice is flying blind when it comes to collecting appropriate revenue and protecting itself from embezzlement.

Attend this one-hour webinar to learn the mathematical formulas used by DoctorsManagement to calculate insurance adjustments for your practice. Using data you already have, you can determine whether your practice is giving up revenue it has rightfully earned and what level of insurance adjustments are appropriate for your practice. You will also learn the steps you need to take to stop this revenue leak.

The content covered in this webinar is intended for the experienced practice manager, administrator, billing manager or managed care specialist.

MASTERING THE RVRBS – LEARN TO DEVELOP YOUR OWN RBRVS ANALYSIS

Wed., May 20, 2 p.m. EST *(may qualify for CEUs)*

Frank Cohen, *Director of Analytics and Business Intelligence* | DoctorsManagement, LLC

The RBRVS has become the industry standard for financial and statistical benchmarking for medical practices. Payers use it. CMS uses it. OIG uses it—and so does just about everyone else looking to gain an upper hand on performing complex medical practice analyses. It is the most important tool in the toolbox. Used for everything from benchmarking to reengineering to process improvement strategies, knowing how to use it is no longer an option. In this session, you will go from the basics of understanding the difference between resource- and cost-based relative value scales all the way through the process of developing a full-blown RBRVS analysis. You will learn about the different RVU components, how to make adjustments for your specific geographic area, techniques to calculate conversion factors, how to factor the data for modifiers and how to use that information to perform a cursory examination of your practice's overall health.

When this session is complete, attendees will be ready to develop their own RBRVS analysis and apply it to other practice models. Attendees will receive a complete tool box, including documentation, worksheets, templates and everything else necessary to conduct a comprehensive RBRVS analysis of their practice.

Learning Objectives

- Understanding relative value scales
- Discussion of benchmarking techniques
- Defining the different RVU components
- Developing the RBRVS analysis
- Factoring RVU values for modifiers
- Demonstration of practical RBRVS applications

Standing Ovation

We couldn't have done it without each of you! Special thanks to each of our outstanding sponsors and exhibitors who made ADAM's 23rd Annual Meeting possible.

We value each organization's ongoing commitment to ADAM and to the individual practices, managers and leaders we engage across the country.

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