

FAQS FOR NEW PHYSICIANS

A Guide to Your Career



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CONGRATULATIONS

You're ready to start your medical career, but you don't have to go it alone! TMA has many resources to help Texas physicians through this process. This program is your map for starting the exciting journey ahead.

TMA SPEAKERS

The speakers bring to these seminars many years of experience in myriad aspects of medical practice management, and an array of professional credentials. Their knowledge covers strategic planning, staff recruitment and training, credentialing, financial management and analysis, coding and billing, documentation, project management, and everything in between.

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WHAT ARE MY PRACTICE OPTIONS?



STRUCTURE

Your choice of structure and work environment for your medical practice involves several factors, including autonomy of decisionmaking, financial implications (including risk taking and income sharing), and professional considerations (including provision of after-hours coverage for patients). Here are some of the more common practice structures:

	ADVANTAGES*	DISADVANTAGES**
SOLO PRACTICE	Independence	Sole risk assumption
	Clinical autonomy	Financial responsibility
	Minimal staff	Time demands
	Personal satisfaction	Call coverage
SINGLE-SPECIALTY SMALL GROUP PRACTICE	Few competing interests	Less independence
	Governance role	Compromise on decisions
	Shared risk and overhead	Shared financial losses
	Consult accessibility	Less capital for purchases
MULTISPECIALTY LARGE GROUP PRACTICE	Shared responsibilities	No independence
	Referral opportunities	Implied expectations
	Clinical synergy	Office politics
	Negotiation leverage	Age hierarchy

*The advantages and disadvantages listed here are expressed in generalities and may not be reflective of each individual's experience.

RECRUITMENT

Consider working with a recruiting firm for possible placement with a hospital, medical group, or academic institution. These organizations pay the recruitment fees. Candidates will likely encounter recruiting firms that offer one of the following fee arrangements. As such, it may be helpful for candidates to familiarize themselves with both types of these fee arrangements

Contingency

This is a simple agreement between the recruiting firm and the hiring entity, whereby the recruiting firm provides the hiring entity with the names of qualified physicians, and the hiring entity interviews and selects the appropriate physician.

Retained

In this agreement, the hiring entity retains the recruiting firm and pays it on a monthly basis; the recruiting firm is paid whether or not the candidate takes the job. Under this dedicated arrangement, the recruiting firm visits the community, meets with key contacts, obtains practice information, designs the financial package, and establishes the overall strength of the opportunity. The recruiting firm then can provide the physician candidate with specific information relevant to current opportunities. The firm also can act as a consultant in arranging site visits as well as negotiating agreements.

Because of unprofessional practices by some recruiting firms, physician candidates should require any recruiter to get permission before forwarding their curriculum vitae to a prospective employer.



Recruiting firms offer possible placement with a hospital, medical group, or academic institution.

TOP 10 MOST REQUESTED PHYSICIAN SEARCHES

	Specialty	Average Salary
1	Family Medicine	\$271,000
2	Radiology	\$495,000
3	Psychiatry	\$285,000
4	Internal Medicine	\$271,000
5	Obstetrics-Gynecology	\$389,000
6	Anesthesiology	\$460,000
7	Hematology/Oncology	\$444,000
8	Gastroenterology	\$531,000
9	Cardiology – Non-interventional	\$396,000
10	Neurology	\$383,000

Source: AMN Healthcare 2024

LOCATION

When choosing a practice location, consider the following criteria:

Competition	Economic factors	Demographics of the area	Availability of space	Buildout
How many other primary care/ specialist physicians are in the area?	Does the area support large industries, schools, or government offices? What is the payer mix in the area (e.g., Medicare and Medicaid population)?	What are the population, age, sex, race, and educational factors of the area?	Is medical office space available, or will you have to lease nonmedical space?	Will you be responsible for funding the buildout of shell space? Will the landlord contribute?



TMA Celebrates Women Physicians

TMA’s Women Physicians Section was developed to strengthen female physicians’ engagement and representation in organized medicine. The section provides members with opportunities to network with peers, discuss important issues affecting women physicians, and influence TMA policy through representation in the TMA House of Delegates.

For more information, or to get involved, visit [texmed.org/WPS](https://www.texmed.org/WPS).

WHAT RELATIONSHIPS DO I NEED?

Establish relationships with certain professional entities who can help you with the details of starting your practice and maintaining smooth operations as your practice grows. Because of the unique nature of medical practice, you should ensure these professionals have relevant health care experience.

Banker

You may need to acquire a loan for start-up operations and working capital needs. Some banks have established departments that work only with physicians and other health care entities to start a practice. Typically, for the bank to consider you for a loan, you will need to provide your personal tax returns for two years and a business plan or financial proforma.

Health care attorney

In addition to helping you establish the legal organization of the practice, the attorney can interpret employment contracts, health plan contracts, and leases.

Health care accountant

Many physician practices hire a certified public accountant (CPA) for accounts payable, payroll, and quarterly/yearly tax preparation. The CPA also can develop physician compensation plans.

Practice management consultant

Practice management consultants are available to provide a variety of services to physician practices. For example, a health care consultant can handle all the details of starting in medical practice while you finish your residency. Consultants also can perform operations assessments, billing and collections assessments, coding and documentation reviews, and on-site staff training. Be sure to check the consultant's references before hiring.

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WHAT ARE MY OPTIONS FOR BUSINESS ORGANIZATION?

The decision regarding the business structure of a medical practice is one a physician should make should make in consultation with an attorney and accountant, taking into consideration issues regarding tax, liability, management, continuity, transferability of ownership interests, and formality of operation. Following is a brief description of the options for the structures of a medical practice.

SOLE PROPRIETORSHIP

PARTNERSHIP

NONPROFIT CORPORATION

PROFESSIONAL ASSOCIATION

PROFESSIONAL LIMITED LIABILITY COMPANY



Turn to TMA for support in your corner at every stage in your career.

You can survive residency and thrive afterwards with tools, information, and resources for TMA members. Plus, TMA works hard with physicians like you to help shape the environment in which you will practice medicine. No matter what the future brings, you'll be prepared and protected with TMA in your corner.

Questions? Contact the TMA Knowledge Center at (800) 880-7955 or knowledge@texmed.org.

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SOLE PROPRIETORSHIP

A one-owner, unincorporated business (includes spouses)

- ✓ Easy to form and dissolve;
- ✓ Not subject to Texas franchise tax;
- ✓ Owner pays all federal income tax;
- ✓ Owner subject to self-employment tax on net income;
- ✓ Owner fully liable for all business debts and liabilities; and
- ✓ Limited medical deductions allowed to owner.

TAX IDENTIFICATION

Once you have decided on the legal organization of your practice, you must obtain a federal tax identification number (TIN) or an employer identification number (EIN).

An EIN is required for any business organization type that employs someone and any business organization type in which the entity itself is legally required to pay taxes. However, some business organization types, such as sole proprietorships that don't employ anyone, may be authorized to file taxes and enroll in Medicare using the owner's Social Security Number.

Medicare and other health plans will use the TIN/EIN to identify you or your organization for tax purposes. You may [apply for an EIN online](#). If you have secured the services of an attorney, the TIN/EIN application can be completed upon incorporation.

Call for a price quote or to discuss specific matters:
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Michael Z. Stern Law Office of Michael Z. Stern, PLLC

- ✓ Contract Evaluation
- ✓ Practice Start-up
- ✓ Other Legal Services

Reviews new or existing employment contracts and managed care contracts for legal pitfalls, such as: Compensation, "Partnership Potential", Non-Competition, Contract Termination, "Hold Harmless", Recruitment, Access to Records, Buy-In and Buy-Out, and Other provisions that may affect your rights, obligations, and practice.

Mr. Stern also assists with the formation of PAs and PLLCs and other practice arrangements, drafts and reviews leases, contracts, and other agreements, advises about health law, business, and other legal matters, and prepares Wills, trusts, powers of attorney, guardian designations, and assists with other estate planning issues.

All attorneys at the Law Office of Michael Z. Stern, PLLC are fully licensed by the Texas Supreme Court in all areas. Not certified by the Texas Board of Legal Specialization.

PARTNERSHIP

General partnership

A multiple-owner, unincorporated business

- ✓ Can be easy to form; however, the more time and expense spent during formation, the less time, expense, and potential litigation involved in dissolution;
- ✓ Not subject to Texas franchise tax (as long as all owners are individuals);
- ✓ Partnership files an annual federal information return to report the income, deductions, gains, and losses, but pays no tax; instead, it “passes through” any profits or losses to its partners;
- ✓ Partners pay tax on their shares of partnership income and loss (whether received or not);
- ✓ Partners subject to self-employment tax on their share of business income;
- ✓ Partners fully liable for all business debts and liabilities, including the partnership liabilities and the torts (malpractice/personal injuries) incurred by the other partners; and
- ✓ Limited medical deductions allowed to partners.

Limited partnership

A multiple-owner, unincorporated business

- ✓ Similar to general partnership, except has one or more general partners and one or more limited partners;
- ✓ *Limited partners* do not have personal responsibility for the limited partnership’s (LP) debts and legal obligations, but *general partners* are personally responsible for the LP’s debts and legal obligations. The trade-off is that limited partners cannot participate in the control of the business decisions of the LP—that is left to the general partner(s); and
- ✓ Partners subject to Texas franchise tax.

Limited liability partnership

A general or limited partnership, but with the following differences:

- ✓ The underlying LP or GP must file an application for registration of a limited liability partnership (LLP) with the Texas Secretary of State and pay any required fees. By registering as an LLP, the general partners of an LP or GP also receive the personal liability protection afforded to limited partners;
- ✓ Pays \$200 per partner per year to the secretary of state to shield the partners from liability for torts (malpractice/personal injuries) that others cause; and
- ✓ Subject to Texas franchise tax.

NONPROFIT HEALTH ORGANIZATION

162.001 corporation: a nonprofit health care corporation

- ✓ Established as a nonprofit corporation under state law and certified by the Texas Medical Board as a nonprofit health care corporation under Section 162.001, Occupations Code (formerly known as a 5.01[a] corporation); an exception to the Texas “corporate practice of medicine doctrine,” which ordinarily would preclude nonphysicians from owning an interest in a medical practice;
- ✓ Typically has one shareholder (member), which is a hospital; all of its directors must be Texas-licensed physicians actively engaged in the practice of medicine;
- ✓ While the nonphysician shareholder(s) may exercise decisionmaking authority over financial matters, physicians must make all medical decisions, including credentialing, quality assurance, utilization review, and peer review policies;
- ✓ Exempt from Texas franchise tax; and
- ✓ Also may qualify as a nonprofit organization for federal income tax purposes: If so, the corporation pays no federal income tax. Employees are taxed on their shares of corporate income and loss.

PROFESSIONAL ASSOCIATION

A highly restricted organization similar to a corporation that is formed for the purpose of providing a professional service and governed as a professional entity

- ✓ Professional services limited to those provided by a physician, podiatrist, dentist, chiropractor, optometrist, therapeutic optometrist, veterinarian, or licensed mental health professional; must be owned solely by licensees;
- ✓ May be co-owned and operated between medical specialties under certain circumstances;
- ✓ Can be jointly and severally liable for negligence of an owner, employee, or agent of the entity, but other owners (members) are not subject to that liability; and
- ✓ Subject to Texas franchise tax.
- ✓ For any professional association formed among persons with different licenses, each professional licensure type must practice within their own scope of practice.

PROFESSIONAL LIMITED LIABILITY COMPANY

A hybrid entity having attributes of partnerships and corporations that is formed for the purpose of providing professional services

- ✓ Complex to form and dissolve (plus filing with secretary of state and applicable filing fees);
- ✓ Must be owned by a physician or a professional organization;
- ✓ The professional association and an owner, employee, or agent who is negligent in providing a professional service for the professional association, are jointly and severally liable for the negligence of that particular owner, employee, or agent. However, any owners, employees, or agents of the professional association who were not negligent are shielded from personal liability for those acts;
- ✓ If structured as a partnership for federal income tax purposes:
 - Limited liability company (LLC) files “information federal income tax return,” but pays no tax; members are taxed on their shares of the LLC income and loss whether received or not (i.e., for federal income purpose, treated as a proprietorship);
 - Owner(s) pay federal income tax on their shares of LLC income whether received or not; and
 - As with proprietorships and partnerships, limited deductibility of medical expenses;
- ✓ If structured as a corporation for federal income tax purposes:
 - LLC pays federal income tax on LLC income;
 - Owners also taxed on the income and/or dividends received; and
 - As with corporations, medical expenses fully deductible;
- ✓ Greater flexibility than corporations in structuring distributions;
- ✓ Owners (members) not liable for LLC liabilities, including the torts (malpractice/personal injuries) and debts of others; and
- ✓ Owners (members) can be held liable for unpaid payroll tax liabilities.

(With current retirement plans options, deductions are very similar for all entity types.)

WHY IS INSURANCE IMPORTANT?



MEDICAL PROFESSIONAL LIABILITY INSURANCE

Medical professional liability insurance (aka “medical malpractice insurance”) is not typically required for licensure in Texas. But it is required, in varying limits of liability for each claim and in the aggregate, for hospital staff privileges. These limits typically will vary by specialty. Professional liability policies today also include an array of important ancillary coverages, such as cyberliability coverage (e.g., to cover data breaches) and disciplinary proceeding coverage (e.g., to cover the legal expenses for medical board investigations), as well as risk management and continuing medical education resources.

Claims-made policies

Claims-made policies cover claims arising from incidents that occur and are reported during the (in-force) policy period – provided the claim occurred on or after the policy inception (or retroactive date, if applicable). Claims-made policies typically are issued on a 12-month basis. A claims-made policy that is renewed each year will have continuing coverage for any claims that may arise from the inception date of the initial policy.

Occurrence policies

Occurrence policies cover claims arising from incidents that occur during the policy period, even if reported after the policy is canceled. Because it provides ongoing coverage for claims that occurred during the policy period, it’s not necessary to purchase extended reporting period or “tail coverage” (see below) when an occurrence policy is canceled.

Prior acts coverage

There is no coverage for claims that occur prior to the retroactive date of a claims-made policy. However, if you decide to change/switch from one claims-made insurer to another, often you can purchase prior acts coverage (also known as “nose

coverage”) from the new insurer to cover incidents that occurred prior to the inception date of the new policy. This provision would make the new insurer responsible for the payment of claims that have not yet been reported or are yet unknown from your prior professional acts.

Prior acts coverage is the preferable alternative to purchasing an extended reporting period or tail coverage from the former carrier. Employers typically will require you to purchase either tail or nose coverage to cover potential claims arising from prior professional acts. You should secure prior acts coverage from the new carrier before canceling your existing claims-made policy. Otherwise, any future claims that arose from services performed during the prior policy period will not be covered.

Extended reporting period

Claims reported after a claims-made policy is canceled are not covered unless an extended reporting period (or prior acts coverage) is purchased. This provision typically is known as “tail coverage.” Tail coverage is an additional premium option offered by the former carrier to provide an extended period for reporting claims occurring during

the policy period and on or after the retroactive date – but reported after the expiration of the policy. Without such a provision, you would have no coverage for future claims reported after the policy cancellation.

Medical director coverage

Physicians often are asked to be medical directors for surgery centers, nursing homes, hospital divisions, and the like. These positions often entail, along with direct patient care, a host of administrative duties including training and supervision of medical staff, drafting policies and procedures, and hiring and firing.

However, medical director duties are often excluded from professional liability policies unless endorsed/amended otherwise. So if you do act as medical director, make sure your professional liability insurance company has extended or will extend coverage for your medical director duties. It is best to purchase the medical director coverage from your current professional liability insurer to mitigate any potential coverage gaps.

You can find additional information from the Texas Medical Liability Trust, established by TMA, at www.tmlt.org.

Medical liability insurance can be complicated

Let TMLT help



Learn everything you need to know about purchasing medical liability insurance at our Buying Insurance site

<https://hub.tmlt.org/buying-insurance>

PROTECT YOUR CAREER AND FAMILY WITH ESSENTIAL INSURANCE COVERAGE

As you embark on your career, your future is bright. However, your future needs to be protected by securing essential insurance coverage.

Find more information from the Texas Medical Association Insurance Trust, established by TMA, at tmait.org.

Life

Life insurance is a fundamental part of any sound financial plan and is a cornerstone of any financial portfolio. It protects your family against financial difficulties in the event of your death. Life insurance has additional, valuable personal and professional applications to better protect your family and career.

Disability

Protecting your ability to earn a good living is of utmost importance. This coverage provides protection against the devastating financial implications of an illness or injury that strips you of your ability to make a living. Coverage options are available to provide you with an income for a period of time, such as three months or until you retire. Pregnancy coverage is available.

Health

Private practice, employed in a hospital setting or locum tenens, your employment situation typically dictates if you receive health insurance as a benefit or if you need to secure coverage yourself. Short-term and comprehensive health care coverage with many options to choose from, including individual HMO and group HMO and PPO plans are available – even special group options for physicians in private practice or partnerships without employees.

Business Overhead Expense

Help cover your practice overhead in the event you can't treat patients due to illness or injury. Like personal disability insurance, this coverage helps replace lost revenue for your practice so you can retain staff, pay your expenses and even cover the cost of a locum tenens, helping to maintain the financial viability of your practice.



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WHERE DO I GO FOR LICENSES AND REGISTRATION?

State medical license

The Texas Medical Board issues licenses to practice medicine. The license application fee is \$817. Once your license is approved, you'll need to pay an initial registration fee (for either 12 or 24 months, as assigned by the board), in addition to the application fee.

- Initial registration of 12 months – \$283.48
- Initial registration of 24 months – \$469.48

To maintain current status, physicians must complete at least 48 continuing medical education credits every 24 months. At least half of these credits must be in formal Category 1 courses, of which:

- Two credits must be medical ethics and/or professional responsibility;
- Two credits must address pain management and the prescription of opioids;* and
- An HHSC-approved course in human trafficking prevention must be completed.*

* When renewing a license on or after September 1, 2020.

For more, visit <https://www.tmb.state.tx.us/page/physician-before-you-apply>.

Federal DEA registration

The U.S. Department of Justice Drug Enforcement Administration (DEA) issues the federal narcotics registration for a three-year period at a cost of \$888. All prescriptions for controlled substances must contain the prescribing physician's DEA number. To order Schedule II controlled substances for office use, you must use [DEA Form 222](#). To register online, use DEA Form 224, found [here](#), or to find the DEA office nearest you, visit [here](#). Requests for paper forms and any change of practice address should be directed to your local DEA office. Contact: (800) 882-9539 or DEA.Registration.Help@usdoj.gov.

State prescription monitoring program

To prescribe Schedule II controlled substances, physicians must use special, secure, single-copy prescription forms displaying their preprinted U.S. DEA registration number or through an e-prescribing software/EHR application that complies with the DEA's Electronic Prescriptions for Controlled Substances (EPCS) rule. Printed copies of Schedule II controlled substance prescription forms are available only through the Texas State Board of Pharmacy. Additionally, as of March 1, 2020, physicians must set up an account with the Texas Prescription Monitoring Program (PMP) and check the PMP prior to prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. Learn more about the PMP at www.pharmacy.texas.gov/PMP/.

WHAT VENDORS AND SUPPLIERS DO I NEED?

PRACTICE MANAGEMENT SYSTEM

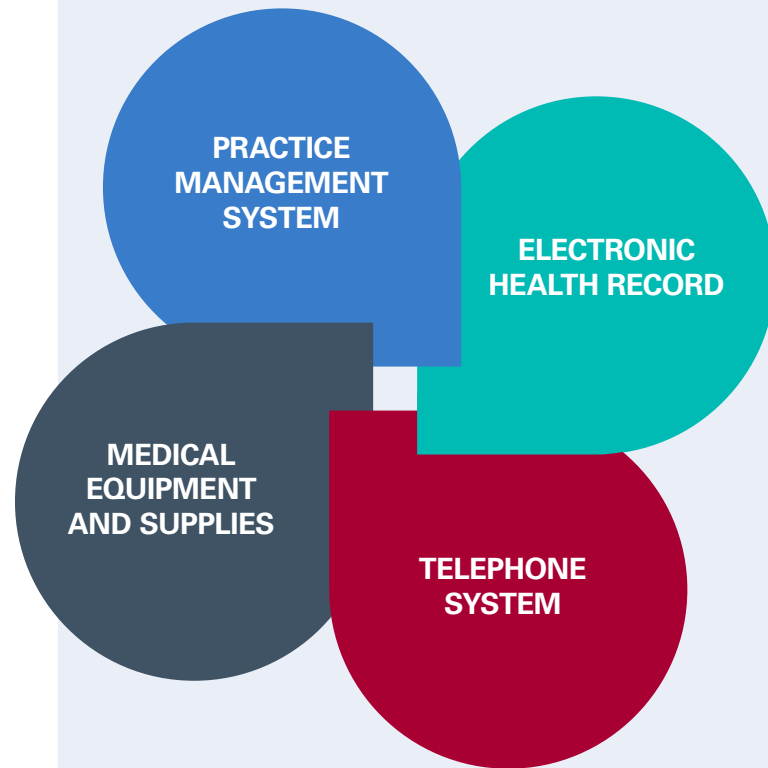
The key to selecting the right practice management software system for a physician practice is ensuring that the software meets the specific needs of the practice – “one size fits all” does not apply. You must research and plan your system carefully to avoid the pitfalls of system software incompatibility. This will be a high-cost purchase, so pay special attention to your projected needs. If you buy or lease a system that does not have the expansion capability or modules, e.g., electronic health record (EHR), that your practice may need in the next five years, you could end up having to convert all your data to a new system. This will be costly, time-consuming, and disruptive to practice operations.

Staff training

The purchase price of your system should include training specific to the software. Ideally, the training should allow multiple users to become familiar with both the mechanics of the system and the integration of the system with day-to-day practice procedures. The software vendor is the best candidate for software-specific training including system setup and customization, daily functions (from scheduling to charge entry to billing), reports, and electronic health record (if included). Depending on the system selected, ongoing maintenance costs may include additional training services, or you may have to purchase them separately. Some systems also have local or regional user group meetings for networking with other practices to maximize system efficiencies.

Purchase/lease options

You can lease or purchase practice management systems. Leases should contain end-of-lease financial requirements that may include a fair market value assessment. To take advantage of various tax benefits, consult your practice CPA before making the decision to lease or purchase.



Practice management software system features should include:

- Patient registration
- Appointment scheduling
- Appointment reminders
- Appointment tracking
- Multiprovider scheduling
- Eligibility and benefit verification
- Patient billing
- Statement generation
- Patient portal
- Claims filing and management
- Reporting features
- Practice performance measure tracking
- Document management
- Data security

ELECTRONIC HEALTH RECORD

As with practice management software, selecting an appropriate EHR system depends on the needs of the practice. When researching an EHR and EHR vendor, some important questions to consider are:

- ✓ What functions are available?
- ✓ Does the vendor guarantee in the contract that the software will comply with all current and future federal and state mandates?
- ✓ Does the software include or interface with your practice management system?
- ✓ Is the software appropriate for your specialty?
- ✓ Does this system work over the internet, or will you need to purchase a server?

Terminology

EHR and EMR are sometimes used interchangeably. There is a slight distinction between the two terms.

- An electronic medical record (EMR) is comprised of a patient’s health information within a single practice or health care organization.
- An electronic health record (EHR) is the patient’s health information that includes data from multiple sources as information is shared across organizations where the patient seeks care.

EHR Selection

With hundreds of EHR products, the marketplace offers a robust choice, and selecting the system that is right for your practice depends heavily on understanding the practice’s needs before meeting with vendors. It is important to consider an EHR that is certified so that you are assured that the EHRs functionality has been verified by an authorized testing body. For more information on certification, visit www.chpl.healthit.gov.

Additionally, TMA has resources such as how to create a request for proposal for an EHR, questions, for vendor references, and much more on the TMA EHR resource page which can be found at www.texmed.org/EHR.

Vendor demonstrations

Vendor demonstrations are extremely important in the selection process. To get the most benefit from this step, schedule demonstrations with three to five EHR vendors. Expect demonstrations to last approximately two hours. Because the purchase of an EHR system involves a substantial financial commitment by the practice, all physicians who are partners in the practice and their practice manager should attend these demonstrations. Prepare a case study for the demonstration that mirrors the way a patient will move through your practice so the vendor can demonstrate the product in a way that matches set workflows.

Cost

When a practice acquires EHR software, it is actually acquiring licenses to use that software. The most common metric for pricing is the number of licensed professionals in the practice whose services can be billed. Those professionals include not only physicians but also advanced practice nurses, physician assistants, and physical therapists who are employed by the practice.

There are several pertinent questions when researching EHR system costs:

- ✓ Will your practice require interfaces with a practice management system, lab, radiology center, hospital, or health information exchange?
- ✓ What are the ongoing price considerations such as annual fees, upgrades, or technical support?
- ✓ Are there charges for additional features such as reporting tools, e-prescribing and e-prescribing of controlled substances, voice recognition, scanning software, or a patient portal?
- ✓ What are the costs associated with having current records converted into the new system?
- ✓ What are the hardware needs?
- ✓ What are the training costs?

Be aware that some expected costs are merely estimates. Health information technology (HIT) is a highly competitive industry, and in some cases, vendors may attempt to close sales by using estimates that are unrealistically low. Implementation costs have been reported to be 5%, 10%, and sometimes 50% more than vendor estimates. Be sure to confirm the actual cost and check the vendor’s history in working with other practices before signing a contract. If the salesperson makes promises not listed in the contract, be sure those promises become an addendum to the contract. The salesperson may be long gone when issues arise, and your contract is your protection.

TELEPHONE SYSTEM

Purchase telephone hardware and software only after determining the following needs of the practice:

- ✓ Number of voice and data lines;
- ✓ Number and type of telephone sets (i.e., display, nondisplay, cordless);
- ✓ Voicemail availability, with or without outgoing messaging;
- ✓ Message or music on-hold capabilities; and
- ✓ Remote programming for call forwarding.

Because the needs of a practice change, the phone system should have some expansion capability in terms of the number of sets, the number of voice and data lines, and system features. Maintenance agreements from the manufacturer or vendor typically are available beyond the original purchase; compare them with local service plans for price and response time.

MEDICAL EQUIPMENT AND SUPPLIES

Medical equipment and supplies are available through a number of sources. You can purchase them directly from sales representatives, or through mail order catalogs or internet sites. The prices usually are competitive, so you should monitor them frequently.

Although a supplier may offer an exclusive purchasing agreement, be aware that association with a single supplier can be either a hindrance or an advantage. If the medical supplier doesn't think you have received any better offers in terms of price or payment terms (such as "dating," delayed payment terms without accruing interest or financial charges), your practice may end up paying more than the market price for equipment, supplies, or biologicals. When figuring your costs, include the time spent negotiating prices in addition to the actual costs of the supplies and normal inventory levels. Pay careful attention to changes in the cost of supplies to ensure the office fee schedule covers increased costs.

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HOW DO I FIND THE RIGHT STAFF?

Personnel management is critical to the success of a medical practice. However, finding qualified staff for your office in the first place can be difficult at times because of market saturation, low unemployment rates, and other factors. You will be more successful in hiring if you first develop accurate job descriptions and determine the qualifications needed for each position on your staff. This also will help ensure you adhere to appropriate interviewing, hiring, and annual staff evaluation policies.

Be sure you understand the legal regulations for interviewing, hiring, and dismissing staff. In the absence of a written employment agreement, Texas law is considered employment-at-will, which means employees may leave the practice voluntarily or be terminated for any nondiscriminating reason. Employees serve at the will of the practice; any provision, written or implied, regarding a disciplinary process is procedural in nature and creates no guaranteed right of continued employment. Covenants not to compete can be enforced if they meet Texas statutory requirements.

Refer to [Appendix A](#) for federal laws that affect employment practices.

ADVERTISING FOR AND SELECTING CANDIDATES

Take your practice to the next level and recruit qualified health care candidates along with physicians across all specialties. The TMA Career Center is designed with physicians and medical professionals in mind. Visit www.texmed.org/CareerCenter to post open positions on TMA's Job Board or sign up as an exhibitor at TMA's Virtual Career Fairs.

To avoid discrimination complaints, design your selection procedures to produce job-related information about each applicant's qualifications (i.e., knowledge, skills, and abilities needed to perform the job).

INTERVIEWING

Interviews can be a valuable source of job-related information about applicants, giving the interviewer a chance to fill any gaps on the application form, gauge the applicant's job-related knowledge and abilities, and describe particular features of the job and practice. Like other components of the employee selection process, interviews are subject to scrutiny under federal and state equal-employment-opportunity rules. The safest interview course to follow is to identify the basic requirements of the job and develop a standard set of questions designed to reveal each applicant's ability to perform the specific requirements.

Refer to [Appendix B](#) for guideline questions to ask during an interview.

TOP 10 TOOLS FOR HIRING SUCCESS

- 1 Create an accurate job description
- 2 Advertise wisely
- 3 Develop a consistent interview process
- 4 Conduct reference/background checks
- 5 Hire the right person
- 6 Orient the new hire
- 7 Train, train, train
- 8 Provide feedback
- 9 Conduct exit interviews
- 10 Develop retention strategies

BACKGROUND CHECKS

Performing background checks on potential employees before making a job offer is essential to selecting a quality candidate. Employee screening companies can perform the following individual background checks:

Statewide criminal background search

A search of the official state repository for crimes that may include felony, misdemeanor, and traffic offenses for the past seven years.

National criminal offender profile summary

A nationwide search of state and county criminal records databases. For most states, the reporting period covers the past 10 to 15 years.

County criminal search

A criminal records search in any U.S. county and some Canadian provinces of felony and misdemeanor offenses for the past seven years.

Social Security validation

A background check that validates a Social Security number, provides information on past addresses and movement patterns, and verifies the candidate’s full name, date of birth, and phone numbers.

Education and employment verification

A service that verifies the highest educational level attained by the candidate and information regarding employment history.

Motor vehicle report

A report of motor vehicle violations, suspensions, and revocations as well as the type of driver’s license the candidate holds and any restrictions on its use. Note that in some Texas counties, convictions for driving under the influence of alcohol and drugs may not appear in county criminal records but will appear on this report.

Consumer credit report

For staff with a high level of fiscal responsibility, a report of credit history, current account status, payment histories, collection items, bankruptcies, and other public records, but no credit score.

NOTE: Check for local “ban-the-box” ordinances that limit when an employer may permissibly ask about an individual’s criminal history during the interview process.

Refer to [Appendix A](#) for federal laws that affect employment practices.

PERFORMANCE APPRAISALS

Performance appraisals should be one of your main tools for making salary and promotion decisions in your practice. They also help improve employee performance and morale, identify training and development needs, promote better communication between supervisors and staff, and reduce absenteeism and turnover. A well-designed appraisal system can provide solid documentation of performance, accomplishments, or problems your practice can use to justify a wide range of personnel actions or decisions.

TOP 10 MISTAKES TO AVOID

- 1 Believing job descriptions aren’t necessary
- 2 Hiring too quickly
- 3 Not equally emphasizing skills, behaviors, and cultural “fit”
- 4 Doing most of the talking in an interview
- 5 Waiting until review time to assess performance
- 6 Basing performance appraisal on opinion, not documented fact
- 7 Performing one-way appraisals
- 8 Believing turnover is a fact of life and out of your control
- 9 Not involving physicians and staff in the retention program
- 10 Failing to recognize the power of praise and recognition

WHY ARE POLICIES AND PROCEDURES IMPORTANT?

Developing personnel policies and office procedures for your practice will help streamline its operations and improve efficiency. You can use your policies and procedures manual as a training and orientation guide, an ongoing reference and training resource for staff, and a risk management tool. Be sure to keep it current, and always share it with new staff members at orientation. All employees should sign a statement indicating they have read and understand the practice's policies and procedures. Finally, it is imperative that your practice actually implement and enforce all policies and procedures.

Key elements of a policies and procedures guide:

- ✓ **Human resources:** Dress code, vacation and holidays, hiring, performance evaluations;
- ✓ **Front desk:** Scheduling, telephone protocols;
- ✓ **Business office:** Billing and collections, health plan requirements, claim forms;
- ✓ **Management responsibilities:** Facility maintenance, accounts payable and receivable;
- ✓ **Clinical:** Medication distribution, patient consent and education;
- ✓ **Medical records:** Retention, release, maintenance;
- ✓ **Safety:** Exposure control, patient/staff injuries, emergency evacuation plan, safety officer;
- ✓ **Compliance:** Patient rights and responsibilities, compliance officer; and
- ✓ **HIPAA:** Patient privacy and security, privacy officer.



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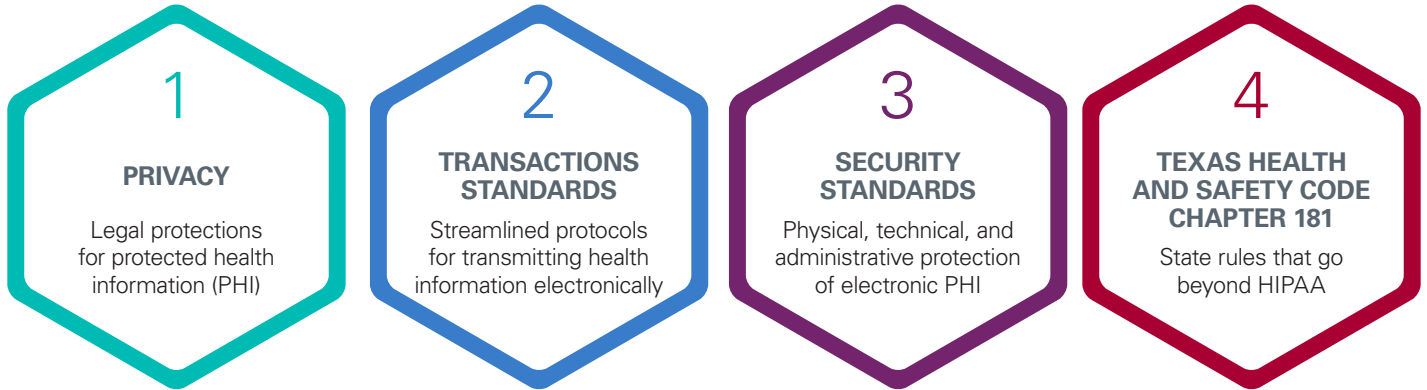
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WHAT DOES HIPAA ENTAIL?



PRIVACY

The Health Insurance Portability and Accountability Act Privacy Rule provides legal protections for personal health information held by covered entities and gives patients a collection of rights with respect to that information. Every physician and every health care provider regardless of size that electronically transmits health information is considered a covered entity. Using electronic technology, such as email, does not mean a physician is a covered entity; the transmission must be in connection with a standard transaction. These transactions include, but are not limited to, claims, benefit eligibility inquiries, and referral authorization requests. The Privacy Rule covers physicians and health care providers who electronically transmit these transactions directly or use a billing service. HIPAA also imposes a number of duties regarding physicians' use and disclosure of patient information, including:

- ✓ Adopting appropriate physical, technical, and administrative safeguards to protect health information;
- ✓ Having written confidentiality policies for the practice to follow;
- ✓ Designating a physician or staff member in the practice to be accountable for implementing and enforcing those policies;
- ✓ Posting a notice of those policies in a public area where patients can read them; and
- ✓ Making a good-faith attempt to get patients' acknowledgement they have received the notice of privacy practices.

For more information, visit the website for the [U.S. Department of Health and Human Services Office for Civil Rights](#).

TRANSACTIONS STANDARDS

HIPAA regulations cover a large range of issues. First among the act’s purposes is an assurance for Americans that their insurance will be “portable.” A person may change employers without fear that the new employer’s health plan will exclude preexisting conditions.

HIPAA also contains penalties for embezzling funds meant for health care, strengthens federal fraud and abuse laws, and introduces administrative simplification. Administrative simplification is the federal government’s effort to eliminate the hundreds of electronic claim forms required by insurers and health maintenance organizations. The government has replaced differing formats with a single standard electronic claim form that the U.S. Department of Health and Human Services adopted for financial transactions related to health care delivery. The regulations require physicians to submit transactions in the federally mandated standard format or be subject to sanctions.

Of course, most of this is invisible to the physician who relies upon vendors to ensure that claims sent to carriers are in the standard format. Most physicians send claims either through a clearinghouse or through software purchased from a vendor who, according to contract, will send HIPAA-compliant claims on the physician’s behalf.

SECURITY STANDARDS

HIPAA security standards go hand in hand with the HIPAA privacy rules. These regulations lay out the physical, technical, and administrative safeguards a practice should have in place to protect the confidentiality of medical information that is transmitted or stored electronically. While the privacy standards apply to all medical information, the security standards apply only to electronic medical information. Within the Department of Health and Human Services, the Office for Civil Rights has responsibility for enforcing the Privacy and Security rules through voluntary compliance activities and civil monetary penalties.

A major goal of the Security Rule is to protect the privacy of patients while allowing physicians and health care providers to adopt new technologies to improve the quality and efficiency of patient care. The Security Rule is designed to be flexible and scalable so that physicians can implement policies, procedures, and technologies that are appropriate for the practice’s size and structure. Rather than lay out exact actions that physicians must take in regard to electronic privacy, the regulations require you to engage in a risk assessment of your practice. Based on the risks identified, you must act as your judgment dictates. The regulations focus more on this assessment than actual methods of protecting information.

TEXAS HEALTH AND SAFETY CODE CHAPTER 181

Texas extends the federal HIPAA rules in a couple of ways. First, the definition of a covered entity is much more expansive:

- A “covered entity” is any person who:
- (A) for commercial, financial, or professional gain, monetary fees, or dues, or on a cooperative, nonprofit, or pro bono basis, engages, in whole or in part, and with real or constructive knowledge, in the practice of assembling, collecting, analyzing, using, evaluating, storing, or transmitting protected health information. The term includes a business associate, health care payer, governmental unit, information or computer management entity, school, health researcher, health care facility, clinic, health care provider, or person who maintains an Internet site;
 - (B) comes into possession of protected health information;
 - (C) obtains or stores protected health information under this chapter; or
 - (D) is an employee, agent, or contractor of a person described by Paragraph (A), (B), or (C) insofar as the employee, agent, or contractor creates, receives, obtains, maintains, uses, or transmits protected health information.

In addition, the Texas Health and Safety Code adds requirements for covered entities related to employee training, patient access to protected health information, sales and marketing of, and the definition of a security breach.



HOW DO HEALTH CARE CONTRACTS AND CREDENTIALING AFFECT ME?

Participation in health care payment contracts requires credentialing, a process that includes verifying the physician’s education, licensure status, medical liability insurance status (including a claims history), and hospital privileges. Credentials usually will be renewed biannually to make updates and to verify that all licenses and registrations are current. The initial credentialing process typically takes 120-180 days.

As you open your medical practice, various health care payment organizations will approach you to contract for a defined patient population under an arranged fee schedule. Some of these organizations include:

Health maintenance organization (HMO)

HMOs offer comprehensive health coverage for both hospital and physician services. They may contract for either capitated or fee-for-service payments. Typically, HMO patients have restricted access to out-of-network services. To manage the cost of care, HMOs usually require primary care physicians to act as gatekeepers of medically necessary care.

Affordable Care Act (ACA) marketplace exchange plans

At their core, the ACA exchange plans are products offered by private health insurance companies and are subject to all state laws and regulations, including prompt pay laws. The insurance companies may or may not establish separate networks for each plan. Depending on the insurance company’s business plans and physician contracts, individual physicians

may or may not have the option to participate in particular plans while opting out of an unwanted plan. It is possible the only way a physician can avoid the terms of a plan offered on the exchange is to terminate the entire insurance contract.

One major difference between a typical state-regulated plan and a plan offered on the exchange (also called the insurance marketplace) is that insured individuals who receive a government subsidy through the exchange have a 90-day grace period to pay their premiums in full. Federal regulations require the health plans to cover the cost of services provided to patients in the first 30 days of nonpayment by an insured person.

However, for care provided during the last 60 days, the ACA and its regulations allow health plans to rescind the coverage and later recoup from doctors payments for services provided to patients who end up delinquent.

Preferred provider organization (PPO)

PPOs are created by purchasers of care (e.g., employers, insurance companies) and providers who offer patient benefits at a reasonable cost by offering incentives (such as lower deductibles and copays) to use in-network providers. Physician payment usually is in the form of a fee-for-service agreement and also may have restrictive utilization review guidelines. Patients who wish to access physicians outside the network usually may do so at a higher out-of-pocket expense.

Medicare/Medicaid

Currently Medicare and Medicaid have traditional delivery systems and managed care models in some areas. The latter are contracted through various health care payment plan organizations and may require additional contracts and credentialing. One of the biggest distinctions with Medicaid is physicians “enroll” with Medicaid FFS. They are not credentialed.

Independent practice association (IPA) and physician hospital organization (PHO)

IPAs and PHOs are more recent physician-contracting vehicles. Typically, groups of like specialists and/or primary care physicians form IPAs, whereas PHOs link hospital services with physician services to form a contracting group. These types of contracts are referred to as Delegated Contracts

Revalidation/recredentialing

Health plans require this every 3-5 years. The dates of completion are specific to each physician. Some health plans will use the physician’s Council for Affordable Quality Healthcare (CAQH) so they must keep CAQH updated.

Potential Roadblocks:

1. The license expires in less than 30 days. It must

2. Knowing when revalidation/recredentialing is required to be completed can be unclear. Pay attention to the date and know if the date is “submitted by” or “completed by.”
3. A group National Provider Identifier (NPI) is required, and physicians have not obtained one.
4. The NPI/Taxonomy submitted on the application does not match what is in the NPPES system, Texas Medical Board, and/or CAQH.
5. Health plans have had an influx of applications, and are behind on processing, which may cause delays.

As you consider the various physician networks, pay careful attention not only to the fees they offer but also to the administrative time and staffing required of you and additional risks the practice will incur. Consider also the legal implications of participating. If you choose to accept an insurance plan with which the practice is not currently contracted to “build a rapid patient base,” you also should establish policies that address out-of-network issues. A competent health care attorney can provide insight into the legal language of the contract and help you define the risks of participation. Once the concerns are defined, they can become points upon which to negotiate.



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WHAT SHOULD I KNOW ABOUT FINANCIAL MANAGEMENT?



Be prepared to play an active role in the financial management of your practice and stand behind the practice's established policies. Financial policies should address monthly and yearly reports, billing and collections, and embezzlement controls.

REPORTS

Good business planning requires ongoing, overall financial evaluation of the practice, including regular audits of critical financial reports. At a minimum, your practice should generate and review the following reports on a monthly and annual basis:

- ✓ Accounts receivable aging;
- ✓ Procedure analysis by physician;
- ✓ Billing summary;
- ✓ Collections analysis;
- ✓ Unpaid insurance claims; and
- ✓ Charges, collections, and adjustments.

Pay careful attention to the following areas:

Physician production

Monitor individual physician production for overall consistency. Unless a physician has been out of the practice for an extended period (such as vacation), physician production should not vary greatly from month to month. A drop in production may signal failure to bill on a timely basis or a decline in service volume.

Charges, payments, adjustments, write-offs

Track charges, payments, contractual adjustments, and bad debt write-offs so you can compare them from year to year and identify any significant changes. Pay careful attention to any increases in contractual adjustments, which may indicate a shift in payer mix. Should this occur, the practice may need to develop a strategy to shift to a more profitable payer mix.

Amount of collections

A drop in collections from one year to the next could indicate a change in payment patterns, such as a decrease in office visits, increased payer adjustments, or a problem with billing and collections.

Rate of collections

Review the gross collection percentage, net collection percentage, and accounts receivable ratio to determine whether these are reasonable. Track these data for a year-to-year comparison, and analyze the cause of any significant changes.

Contractual adjustments

Review contractual adjustments by carrier to determine whether any particular carrier makes up the majority of practice revenues. Heavy reliance on a particular carrier could put the practice at financial risk if the plan were to pull out of the market or terminate the contract with the practice. To decrease the contractual adjustments, the practice will need to renegotiate health plan contracts and/or shift the practice payer mix by accepting fewer of those patients or by terminating the contract for carriers whose adjustments are higher in comparison with other contracts.

Accounts receivable

Track accounts receivables more than 90 days old and compare them from one 12-month period to the next. Watch for a gradual increase in accounts receivable aging (bracket creep), which could signify a problem with collection procedures.

Fee schedule

Conduct a regular spot audit of the practice fee schedule against HMO and PPO explanations of benefits. This will help identify practice fees for particular Current Procedural Terminology (CPT) codes that may be set too low. Set up a spreadsheet listing most frequently billed CPT codes, the practice charge, the contracted fee, patient copayments and deductibles, and the amount paid to the practice. If the billed charge is too close to or lower than the amount paid, this could indicate that the practice's fee schedule for this particular code needs to be adjusted.

THE NATIONAL PROVIDER IDENTIFIER

What is an NPI?

The National Provider Identifier (NPI) is the standard unique identifier for physicians and health care providers. Any physician (individual or organization) who sends electronic health care claims to a health plan(s) is a covered entity and must obtain an NPI. Physicians who are not covered entities may elect to apply for NPIs but are not required to do so. An NPI is required for Medicare enrollment.

Is a sole proprietor considered an individual or organization?

A sole proprietor/sole proprietorship is an individual, and as such, is eligible for a single NPI. Sole proprietors must apply for the NPI using their own Social Security number, not an employer identification number, even if they have an EIN. Because a sole proprietor/sole proprietorships are individuals, they cannot be a "subpart" and cannot designate subparts.

How does a sole proprietor apply for an NPI?

Sole proprietors apply for NPIs online at <https://nppes.cms.hhs.gov>, or they may call the NPI Enumerator to request a paper NPI Application/Update Form at (800) 465-3203.

For the latest information regarding NPIs, visit www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand.

BILLING AND COLLECTIONS

The goal of any medical practice is to provide quality care to patients; however, the practice of medicine also is a business that involves billing and collecting money for medical services. Establishing and enforcing billing and collections policies that are equitable for all patients is critical to financial success.

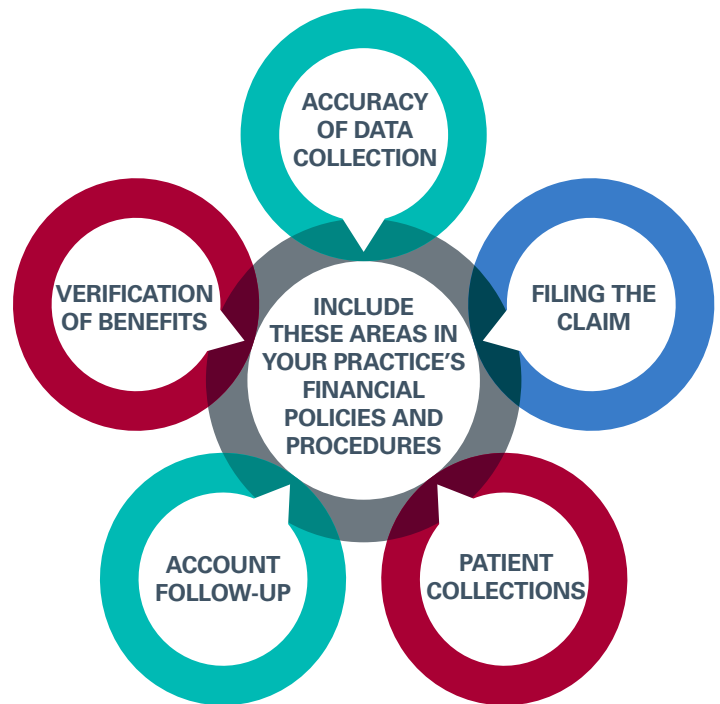
Include these areas in your practice's financial policies and procedures:

Accuracy of data collection

Well-designed forms make the process of gathering financial data easier. At times, the accuracy of the data depends on the skill of the staff member entering the information into the practice management system; your practice can conduct spot audits to check the accuracy of data input. Many practice management systems track each staff member's activity. This feature also can serve as a training tool and a measure for performance evaluations.

Verification of benefits

It is recommended that a practice verify benefits and eligibility for all patients prior to the patient's appointment. A valid referral is not a guarantee that the patient is eligible when you deliver services. Verification of benefits should help the office determine the patient's financial responsibility (any coinsurance due) and allow for financial counseling and collection at the time of service.



Filing the claim

Many practices are using clearinghouses to file their claims electronically so the claims are processed and payments generated more rapidly. Inaccurate data input can cause claims to be rejected or returned for further information – another good reason you should establish policies for data accuracy.

Account follow-up

Maintain a detailed accounts receivable aging report, and adopt a systematic approach – based on age and dollar amount criteria – for follow-up of unpaid claims and outstanding patient balances. A chronic problem for many practices is a carrier saying it has no record of the claim. By starting calls at 30 days old, the practice will find out as soon as possible whether the carrier received the electronic claim and entered it into the system. If not, then the practice can refile such claims early enough to meet filing deadlines. The sooner staff start follow-up, the more quickly the claims will be paid. Your practice goal should be to obtain carrier payment within 30 to 45 days. If calling all carriers with unpaid claims at 30 days is not feasible, then staff should set specific dollar amount criteria and call these carriers first.

Patient collections

Implementing a patient collection procedure that complies with all applicable state and federal laws will help ensure more payment collection at the time of service. Assign staff to handle past-due accounts on a monthly basis, using a combination of telephone calls and collection letters. The practice should keep a log, either manual or generated from the practice management system (if possible), of all patient contacts, giving the status of the account and when a payment can be expected



REVENUE GETTING AWAY FROM YOU?

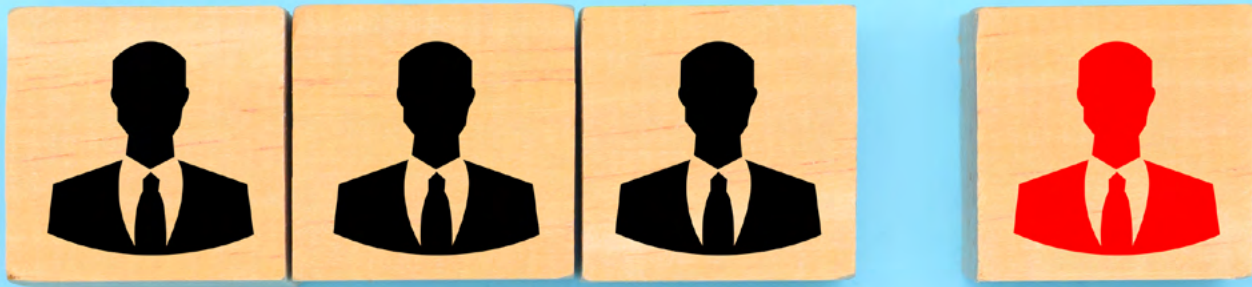
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EMBEZZLEMENT

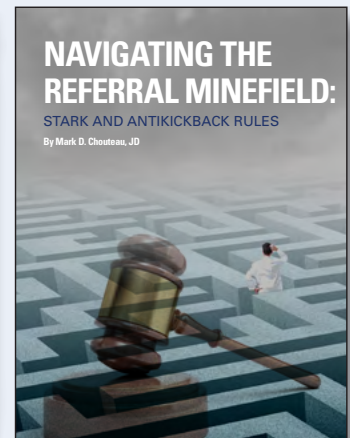
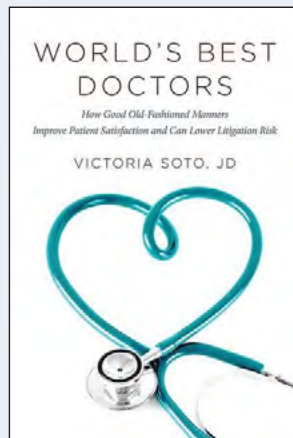
Effective use of cash is essential to the operation of any practice. Internal control procedures can promote efficiency and reduce the risk of errors and fraudulent activities. The following policies can assist a practice in reducing the potential for embezzlement:

- ✓ Do not give any one employee complete control over the entire sequence of cash transactions.
- ✓ Give only key employees access to cash.
- ✓ Segregate financial transactions so that employees who keep practice accounting records do not handle receipts or perform cash disbursements. If this division of labor is impractical, arrange for a review of all work at least quarterly.
- ✓ Consider requiring business office employees to become bonded.
- ✓ Hire an outside accounting agency to perform periodic financial audits.

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WHAT SHOULD I KNOW ABOUT CODING AND DOCUMENTATION?

Coding is the responsibility of you, the physician. The government and other payers hold the physician accountable for incorrect coding that is not government-compliant. While a staff member may aid you with coding, the physician must review the codes for accuracy prior to submitting them for billing.

Due to the fear of overcoding, undercoding is prevalent. Undercoding means lost revenue that is rightfully due to the practice. Learning to code to the correct level offers a significant opportunity for revenue enhancement for many practices. The American Medical Association has reported that the average physician loses 10% to 30% of potential revenue by incorrectly coding the services provided. This equates to between 25,000 and 75,000 for a physician earning \$250,000 annually.

An annual audit of a physician's coding and documentation is recommended to ensure accuracy and appropriateness based on the most current evaluation and coding guidelines adopted by the Centers for Medicare & Medicaid Services. Practice management consultants can perform coding and documentation reviews and provide recommendations for improvement as well as train your staff to conduct internal audits on a regular basis.

According to the 1995, 1997, and 2021 CMS Documentation Guidelines for Evaluation and Management Services, the following are general principles of medical record documentation:

- ✓ The medical record should be complete and legible.
- ✓ The documentation of each patient encounter should include reason for the encounter and medically appropriate history, and physical examination findings, prior diagnostic test results, assessment, clinical impression or diagnosis, plan for care, and date and legible identity of the observer.
- ✓ If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- ✓ Past and present diagnoses should be accessible to the treating and/or consulting physician.
- ✓ Appropriate health risk factors should be identified.
- ✓ The patient's progress and response to treatment, changes in treatment, and any revision of diagnosis should be documented.
- ✓ The CPT and ICD-10-CM* codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

**International Classification of Diseases, 10th Revision, Clinical Modification*

WHAT TRIGGERS AN AUDIT?

- Within a group setting, inconsistent coding among partners
- Excessive use of a code
- Coding level 5 services and not preventive medicine codes for annual physicals
- Upcoding on stable chronic conditions
- Missing physician signatures for lab and/or test results ordered by a physician assistant, nurse practitioner, or physician
- Use of words such as "maybe," "perhaps," "probably," or "rule out" instead of signs and symptoms
- Use of symbols or shorthand. (Be sure to have a list of what the symbols or shorthand means in your office. Negative symbols without elaboration are not considered sufficient documentation.)
- Lack of specificity about what you are reviewing. (Review of systems as "unremarkable" is insufficient to support that a review was completed.)



HOW CAN I MARKET MYSELF?

Successful marketing plans are long-term investments supported by a sufficient budget and a commitment to continuing the plan, even though results are not immediate.

To market effectively to your target population, you must understand it. Area hospitals and the local chamber of commerce may be able to provide demographic information about your area's population and employment trends, including changes that have occurred over the past five years. In addition, you should identify your practice's main competition, who your referral base is, and which insurance companies have the largest market share in the area.

Marketing your practice begins the minute a patient calls your office or walks in the door. The office decor and signage, the behavior of the staff (and you, the physician), and the policies of the practice must create a friendly and professional impression on your patients and referring physicians – the first time and every time they interact with the practice.

PRACTICE WEBSITES

Websites are a successful marketing and patient education tool for medical practices. Your practice site can include your basic office policies, information about you and your staff, your philosophy of care, patient education material prepared by medical specialty societies, the latest medical news, and even a secure system by which you can communicate with patients over the internet.

Information covered can include office hours, phone number, address with map, availability and types of appointments, call coverage instructions, billing and payment options, referral policies, and how to obtain medical records and prescription refills.

SOCIAL MEDIA

Social media platforms like Facebook, Twitter, and Instagram as well as blogs also can be effective vehicles for promoting your practice. Public health messaging, healthy behavior reminders, and photos of you and your staff doing community outreach are ways to establish yourself as a trusted professional. However, it is important to be mindful to comply with all state and federal privacy laws (e.g., HIPAA).

MEDICAL STAFF NETWORKING

Notify medical staff at hospitals where you have privileges that you are accepting patients at your new practice. Send them announcements that provide your name, specialty, practice address, and phone number. This will start word-of-mouth advertising that will help your practice grow. To develop an ongoing relationship with other physicians in your area, write thank-you notes for referrals, send holiday and/or thank-you gifts, and make donations to charitable and community events on behalf of the referring physicians.

PATIENT SATISFACTION SURVEY

Patients who are given an opportunity to share their views about the practice through patient satisfaction surveys feel a stronger commitment to the patient-physician relationship. By asking for and receiving patient input about the practice, you can establish a "we care what you think" relationship. Patients are more likely to recommend the practice to others who are looking for a similar type of relationship with a physician.

WHAT WEBSITES SHOULD I BOOKMARK?

Professional Affiliations

- TMA at: www.texmed.org

Licenses and Registration

- Texas Medical Board at: www.tmb.state.tx.us
- Texas Prescription Monitoring Program at: www.txpmp.org
- U.S. Drug Enforcement Administration, Diversion Control Program, at: www.deadiversion.usdoj.gov

Promoting Interoperability Programs

- Quality Payment Program at <https://qpp.cms.gov>

Personnel Management

- Civil Rights Act of 1964 at: www.eeoc.gov/laws/statutes/titlevii.cfm (includes sexual harassment and religious discrimination)
- Americans With Disabilities Act at: www.ada.gov
- Age Discrimination in Employment Act of 1967 at: www.eeoc.gov/laws/statutes/adea.cfm
- Equal Pay Act of 1963 at: www.eeoc.gov/laws/statutes/epa.cfm
- Occupational Health and Safety Administration at: www.osha.gov
- Employee Retirement Income Security Act of 1974 (ERISA) at: www.dol.gov/general/topic/retirement/erisa
- Consolidated Omnibus Budget Reconciliation Act (COBRA) at: www.dol.gov/general/topic/health-plans/cobra
- Family Medical Leave Act at: www.dol.gov/whd/fmla

HIPAA Privacy/Security Standards

- Texas Medical Association at: www.texmed.org/HIPAA
- U.S. Department of Health and Human Services, Office for Civil Rights, at: www.hhs.gov/hipaa/index.html

Coding and Documentation

- Novitas Solutions: www.novitas-solutions.com
- TMA Physician Payment Resource Center: www.texmed.org/physicianpaymentresourcecenter/

Sources for FAQs for New Physicians:

Policies and Procedures: A Guide for Medical Practices, Texas Medical Association, 2021.

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APPENDIX A

A REVIEW OF FEDERAL LAWS THAT AFFECT EMPLOYMENT PRACTICES

NAME	PURPOSE
Title VII of the Civil Rights Act of 1964	Employers cannot discriminate on the basis of race, color, religion, sex (which, after the U.S. Supreme Court’s decision in <i>Bostock v. Clayton County</i> (2020), includes sexual orientation and gender identity), or national origin.
Americans With Disabilities Act	Employers cannot discriminate against qualified disabled individuals. Applies to employers with 15 or more employees.
Age Discrimination in Employment Act of 1967 as amended (ADEA)	Employers cannot discriminate on the basis of age against any individual 40 years of age or older. Applies to employers with 20 or more employees.
Sexual harassment under Title VII	Employers must promulgate a comprehensive policy to ensure that sexual harassment complaints are promptly and thoroughly investigated, complaints are held in confidence and disclosed only to those authorized, and no retaliation is permitted against employees filing bona fide complaints. Appropriate disciplinary action must be taken against the offender.
Religious discrimination provisions of Title VII and E.O. 11246	Prohibits religious discrimination. Employers must reasonably accommodate religious beliefs of their employees and ensure that employment decisions are made without regard to religion.
Equal Pay Act of 1963	Requires employers to pay men and women equally for doing substantially the same work at the same workplace.
Pregnancy Discrimination Act of 1978	Amendment to Title VI prohibits discrimination in all areas of employment on the basis of pregnancy and pregnancy-related conditions. Employers must not discriminate against a qualified pregnant employee.
Employment and reemployment rights of members of the uniformed services	Prohibits discrimination against persons based on their service in any uniformed service.
United States Bankruptcy Code	Prohibits private employers from terminating employment or otherwise discriminating against any individual who is or has been a debtor or has filed bankruptcy.
Consumer Credit Protection Act	Employers are prohibited from discharging an employee because his or her earnings have been subjected to garnishment for any single debt.

APPENDIX A (continued)

A REVIEW OF FEDERAL LAWS THAT AFFECT EMPLOYMENT PRACTICES

NAME	PURPOSE
Fair Credit Reporting Act	If an employer will use a consumer report to make employment decisions, the employer must advise the applicant that it might use information in their consumer report. The employer must receive written permission from the applicant before requesting their consumer report. Before an employer rejects an applicant based on the information in their consumer report, the employer must provide the applicant with a pre-adverse decision notice, which must include a copy of the report and summary of their rights under the Fair Credit Reporting Act. After that, an adverse decision notice is also required if the decision is finalized based on the contents of the report. This second notice must include the name, address, and phone number of the consumer reporting agency, a statement that the consumer reporting agency did not make the adverse decision, and notice that the applicant may dispute the accuracy or completeness of any information in the consumer report.
Drug Free Workplace Act of 1988	Employers must take specific steps to maintain a drug-free workplace. Applicable to all employers receiving federal grants and those entering into federal contracts of \$100,000 or more to be performed in the United States.
Occupational Safety and Health Act	Mandates strict record-keeping and reporting requirements regarding occupational injuries and illnesses.
Employee Polygraph Protection Act	With limited exceptions such as professions involved in national defense or security, the use of polygraphs (lie detectors) is prohibited for employment purposes.
Employment Retirement Income Security Act of 1974 (ERISA)	Governs all employee pension, health, and welfare benefit plans. Plan administrators must provide employees summaries of their benefit plans, updates of major changes, and reports on financing certain plans.
Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)	Employees and eligible dependents must receive a temporary extension of health insurance at group rates in certain cases in which coverage otherwise would end. Applies to employers with 20 or more employees.
Fair Labor Standards Act of 1938 (FLSA)	Establishes the minimum wage, maximum hours, and overtime pay provisions employers must provide for covered employees.
Immigration Reform and Control Act (IRCA)	Prohibits employment of aliens and nonimmigrants not legally authorized to work in the United States.
Jury System Improvement Act	Employers cannot discharge, threaten discharge, intimidate, or coerce an employee because of jury service.
Family and Medical Leave Act of 1993 (FMLA)	Employers must provide qualified employees leave of absence for the birth or adoption of a child, the care of a seriously ill family member, or an employee's own serious health condition. Applies to employers with 50 or more employees.

APPENDIX B

GUIDELINE QUESTIONS TO ASK DURING AN INTERVIEW

SUBJECT	DON'T ASK	DO ASK
Name	Have you ever legally changed your name? What was your original name?	Do I need additional information about use of an assumed name or nickname to check previous employment?
Age	What is your date of birth? What is your age?	If hired, can you provide proof that you are at least 18 years of age?
Birthplace	Where were you born? Where were your parents born?	Will you be able to provide a birth certificate, resident alien card, or other proof of employment eligibility upon being hired?
Residence	Do you own or rent your residence? What are the names and relationships of persons residing with you?	What is your present address, and how long have you resided there? What is your former address, and how long did you reside there?
Race/Color	What is your race? What color is your hair, eyes, or skin?	None.
Religion	What is your religious affiliation? What church do you belong to? What's the name of your pastor, minister, or rabbi? What religious holidays do you observe?	None.
Sex	Are you male or female?	None.
Photographs	Submit a photograph with your application form or after the interview.	A photograph may be required after hire for an ID card or other identification purposes.
Education	List the dates you attended or graduated from high school or college.	List your academic, vocational, or professional education and the public and private schools attended.
Citizenship	Of what country are you a citizen? Are you or other members of your family naturalized citizens? If so, when did you or they become citizens? Do you intend to become a U.S. citizen?	Are you a citizen of the United States? If not, are you prevented from becoming legally employed because of visa or immigration status?
National origin	What is your lineage, ancestry, national origin, descent, parentage, or nationality? What is your native language? What are the nationalities of your parents/spouse?	What languages do you read, speak, or write fluently (only if another language is necessary to perform the job)?

APPENDIX B (CONTINUED)

GUIDELINE QUESTIONS TO ASK DURING AN INTERVIEW

SUBJECT	DON'T ASK	DO ASK
Height/Weight	What is your height and weight?	None, unless employer proves that a bona fide occupational qualification is involved.
Arrests	Have you ever been arrested? Have you ever been charged with any crime?	Have you been convicted of any crime? [Check local ban-the-box ordinances.]
Family status	What is your marital status? What was your maiden name? How many children do you have? Are you pregnant or do you plan to have children? Do you have day care provisions for your children?	None.
Military record	What type of military discharge did you receive? Were you ever disciplined while in the service?	Are you a veteran of the armed forces? If yes, what type of training or education did you receive while in the military?
Groups	List all organizations, clubs, societies, and lodges to which you belong.	List any professional, trade, or service organizations of which you are a member or have been a member.
References	What is the name of your pastor, minister, or rabbi?	Who referred you for a position here? List the names of persons willing to provide professional or character references for you.
Handicaps	Are you handicapped?	Are you capable of performing the necessary assignments of this position in a safe manner? [Define any special requirements, such as lifting 50 pounds or reaching six feet.]