Embracing a Culture of Constant Change

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Imagine a world in which nothing changes. We cannot, of course, because change is central to the human fabric.

Given that change is inevitable, it seems obvious that we want to be innovative by embracing change early, rather than being reactive to change and perpetually a step behind. The challenge arises with assuming some risk in order to be in the forefront.

How, then, does your clinic strike such a delicate balance?

1. *Assess.* Maintain an ongoing plan to examine your occupational health products, operational systems, staffing relationships, and sales/marketing initiatives on an annual basis.

   For example, routinely ask external clients for their opinion and suggestions for change. The more bluntly you ask the question, the more likely you will get direct answers that reveal valuable change opportunities.

2. *Balance the new with the old.* There should be a little change each and every year, rather than stability over many years followed by major and often reactive change. Your clinic should try out at least one major new initiative every year. Over the course of a decade you will try 10 or more initiatives. Although many will far short, you will hit a few home runs.

3. *Align on the culture of change continuum.* View change as a continuum with aversion to change on one end and constant change and upheaval on the other.

   Where should your clinic be on this continuum, and how will you determine this?

   It begins with your organizational culture. Some organizations are slow to innovate; at best, you can only buck this slightly at the program-level.

   Also consider clinic age. A newer clinic needs to work out the kinks and is unlikely to innovate in the short term. Conversely, a long-established program is more likely to have settled into old habits that need to be refreshed with new innovations.

4. *Be flexible.* Change works if processes are in place to monitor the impact of that change and modify the change plan as realities dictate.

   A new marketing scheme might look appealing, but face unexpected complications. Your clinic can A) proceed with the plan, B) drop the plan at the first sign of disappointment, or C) constantly tweak the plan in response to market reactions.

   Option A is the easy choice, option B the panic-induced choice, and option C usually the right choice.

5. *Do many small things.* Hedge your bets by introducing several small changes rather than a single major one. When it comes to marketing, try three new ideas every year. If even one of the new innovations works, you have something to build on during your next marketing cycle.

6. *Think "three."* Why three? Because of span of control and as a buffer for under-performance. That is, four or more initiatives (or divisions) are invariably unwieldy and difficult to monitor. One area usually fails to receive sufficient attention or is ignored altogether.

   On the other hand, do not put all of your eggs in one basket to protect yourself against unanticipated erosion in a single area. You might divide your efforts—

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and your client's attention—among injury management, prevention services, and consulting. Your services would, therefore, be somewhat insulated against, for example, a change in the state's fee schedule.

Likewise, a marketing initiative could include educational programs, one-on-one contact, and e-mail contact. If one area failed to meet expectations, the other two could carry it for a year while the first area was re-invigorated or replaced.

7. *Recognize synergisms*. Be certain that each of your three areas feeds one another. At my company, for example, our educational programs provide us with information for our publications and members, which converts to more consulting clients, which provide us with more insights to share in our educational programs.

   Likewise, the major components of your marketing plan should seldom be a "stand-alone" idea; rather, every idea should be connected to another in order to feed your program in multiple, synergistic ways.

8. *Embrace change-speak*. Embracing change means more than proactively introducing new products and marketing techniques every year. It also means embracing "change-speak" into your vocabulary. You should make judicious use of such words as "new," "modern," and "updated" in your sales and marketing discussions, literature, and personal contacts. You need to *project* constant change and improvement as much as you need to *effect* it.

9. *Keep abreast of technology.* When I established my company some 25 years ago, fax machines were considered cutting-edge technology, and there was no Microsoft Word, Excel, or PowerPoint. Nor was there much of an Internet, e-mail, or cell phones. Yet today, virtually all are central to my professional life each and every day. Looking back, I was probably a bit late in understanding and adopting virtually all of these technological advances.

   The message: stay a step ahead of the posse by keeping abreast of emerging technologies and using them to your advantage.

Status quo—so pervasive in healthcare management—quickly becomes old, tired and counter-productive. It is better to get *beyond* the status quo by asking yourself, "What can I do differently each year?" ■

emergency basis in the office), the answer would depend on the clinical situation.

Based on the definition of the code, it should be used only for patients seen in a physician office. It should not be used in conjunction with emergency department visits or for care rendered during a hospital admission. This code should be used as an add-on code. It is intended to compensate the physician for the interruption in the office schedule when the physician, based on the emergent nature of the patient visit, must leave another patient immediately to render services to the patient in question.

If a patient visits a physician with a chief complaint of chest pain, it is very likely that the physician was called from the care of another patient in order to evaluate the seriousness of the patient's chest pain. Thus, in many cases, CPT code 99058 could be used properly in conjunction with the ICD-9 for chest pain.

Q. Can a nurse practitioner bill under E&M codes?

– *Question submitted by April Knight, claims representative, AMCO Nationwide Insurance Company*

A. Provided that the appropriate state supervisory regulations (if any apply) are followed by the midlevel provider, then it is compliant to use E/M codes (99201-99215) for services rendered by a nurse practitioner or physician assistant. Medicare and some other payors reduce reimbursement by 15% for services rendered by the midlevel provider.

In order to get reimbursement at the full Medicare fee schedule, you may be tempted to bill all midlevel services with the supervising physician listed as the rendering provider.

For Medicare (and some other payors), however, it is important to understand the rules for incident-to billing. Incident-to is defined by Medicare and may not apply to a third-party payor, unless that payor requires the use of incident-to rules. If the midlevel's service meets the incident-to requirements, then the service may be reported using the supervising physician's national provider identification (NPI) number. Medicare will reimburse this service at full Medicare rates, as though the physician personally performed the service.

Under the incident-to rules, however, you may not bill with the physician as the rendering provider unless the visit meets specific criteria. To be considered incident-to, the physician must perform the initial visit for the patient's diagnosis/problem and document a treatment plan that the midlevel provider follows on subsequent visits. The physician must provide direct supervision of each service provided by the midlevel provider. "Direct supervision" does not mean that the physician must actually be present in the same room, but the physician must be present in the office and immediately available to provide assistance and direction to the midlevel provider. ■