Innovation in Occupational Health Marketing

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In a recent episode of the popular television show *Mad Men*, super ad man Don Draper opined to his up-and-coming colleagues that "marketing is all about innovation."

He's right.

But the best-laid plans often sink into the abyss of the "same old, same old." After all, if marketing is about distinguishing one's organization from its competitors, why not rely on the tried and true to punctuate the difference?

This reasoning is flawed, however; marketing should be all about going *against* the tide, not rolling with it.

Playing the stock market offers a compelling analogy. How often have you ignored the "buy low/sell high" axiom? Investors often buy a "hot" stock, only to find out that it was at or near its peak and will go down from there. But those who choose to assume some risk by investing in an emerging stock frequently ride it to the winner's circle.

The same mindset should apply to marketing. It is important to pay attention to trends and modify what's "in" at the moment in accordance with your clinic's situation, rather than replicate marketing tactics that seem to work for others. If your clinic emulates current best practices, you are unlikely to distinguish yourself from the urgent care services pack and may fall behind as competitors move forward with marketing innovations.

Old marketing habits die hard, especially in healthcare. Urgent care clinics are often steeped in yesterday's practices, resistant to change, and risk-averse. Many healthcare marketing professionals continue to mount the horse that brought them there, embracing what worked before rather than rolling the dice on what might work even better in the future.

I believe there is a continued over-reliance on 1980s marketing tactics such as print ads, radio and television spots, billboards, or, oversized wads of collateral material that throw benefits to the wind in the name of providing a comprehensive list of services. Relying on catch-up ball to get to a 2011 mindset, such marketers now are focused on high-touch tactics such as the use of social media, networking, email, and text messaging.

About 10 years ago, email blasts were the latest innovation. Now email blasts are common, even tired. Yet many in healthcare still view them as a breakthrough marketing technique. We have to stop thinking 2011 and start thinking 2016 and beyond.

1. *Look beyond healthcare.* Look beyond the innovation-resistant world of healthcare. Whether you are examining a product, service, or cause, ask yourself what is really getting through to you and if it is being marketed in a manner that you haven't seen before. When you find such examples, examine them and determine whether they might apply to your clinic's marketing needs.
2. *Follow politics.* Once you get beyond the sleaze and distortions that permeate modern political campaigns, there are considerable lessons to be learned. Watch how campaigns develop and reinforce their message (e.g., simple, repetitive, on message), pace their outreach, and mix their modalities.
3. *Diversify your tactic portfolio.* De-emphasize and then phase out current practices over time while incrementally adding new approaches. Rapidly adapt to social media and other networking mechanisms and use them proportionately compared with techniques such as printed materials and email blasts.
4. *Let others do the work for you.* Transmitting marketing information to a cohort of prospects with the intent of having them share the information with others is a great leveraging tool. A concerted effort should be made to encourage recipients of email blasts to forward them to others within or beyond their organization or to personal friends. If your distribution list is 1,500, and 10% of those recipients forward your message to 10 individuals, you have doubled your outreach and touched many people you otherwise would not have touched.

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CODING Q & A

Is there a new code now for 2010 for urgent care?
- Steven Fields, Laguna Niguel, CA

A. It is true that some payors have stopped paying the S9088 code. This was partly due to massive abuse by family practices, which used it for any walk-in patients. There are at least four reasons that a payor may be denying this S9088:

- The practice is not specifically contracted as an urgent care center.
- The practice does not meet the UCAOA criteria as an urgent care center.
- The payor will not pay unless reimbursement for the code is specified in your contract.
- The payor has made a blanket decision to no longer pay for the code.

There is no code out there that replaces the S9088 code. However, you may want to consider:

- *Opening negotiations* with the payor for additional reimbursement for the additional costs of operating an urgent care center.
- *Coding 99051:* This code can be used when you provide services "during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service."
- *Maximize coding capture:* We have found that many physicians significantly undercode E/M codes. Although this may be done from a good motivation to reduce patient costs or minimize audit risks, it is not compliant and can reduce clinic revenues by 10% to 20% or even more.

Q. Can you explain the logic behind using the -57 modifier just because the patient had a procedure with a 90-day global period during the same visit? Let's say we perform restorative treatment for a fracture; wouldn't we add modifier -57 to the E/M code even though the doctor did not necessarily make a decision for surgery?
- Stephanie Boling

A. Modifier -57 is used when the E/M involves a so-called "decision for surgery." This modifier is used to report an E&M service that resulted in a decision to perform a major surgical procedure on the day of or the day before the surgery.

It is easy to get confused by the word "surgery" in this situation. Payors, however, define any procedure with a 90-day global period as major surgery.

This surgery question is the same question that you may get from patients when they get their EOBs. Patients ask, "Why did you charge for 'surgery' when you only splinted my fracture?" Payors and CPT calls a fracture code a "surgery code," but this is not "surgery" in the sense that we normally think of the term. In this case, the "decision for surgery" was really the decision to perform restorative treatment on the fracture.

Q. When patients present for a B-12 injection, Depo-Provera injection, antibiotic-only injection, etc., how would you bill for those services?
- Abbi Olson, Bowling Green, KY

A. In a situation such as this, you should bill the HCPCS code for the medication and the CPT code for the injection. For example:

- J0696 x4: ceftriaxone (Rocephin) 1g
- 90772: Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

Note: If f you are not being reimbursed (i.e., are getting payment denials) for B-12 injections, you may need to look at the ICD-9 that you are using with the injection code. In order to get reimbursement, many payors (including Medicare) limit reimbursement to visits coded for specific conditions related to B-12 deficiency, such as pernicious anemia and dementias secondary to vitamin B-12 deficiency. ■

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OCCUPATIONAL MEDICINE

5. *Brainstorm—without judgment.* Innovations are often spawned by "silly" ideas. Sit down with a colleague and jointly list every conceivable marketing tactic, no matter how seemingly off-the-wall, and you will undoubtedly emerge with several great ideas.
6. *Swing for the fences.* Innovation is all about a willingness to fail some of the time as you search for a few real winners. Many of the greatest personal and institutional success stories in history involved people who failed many times, learned valuable lessons from their failures, and then got it exceptionally right. Resistance to innovation is a ticket to mediocrity for both your clinic and yourself. ■