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Endovascular Fellow TODAY

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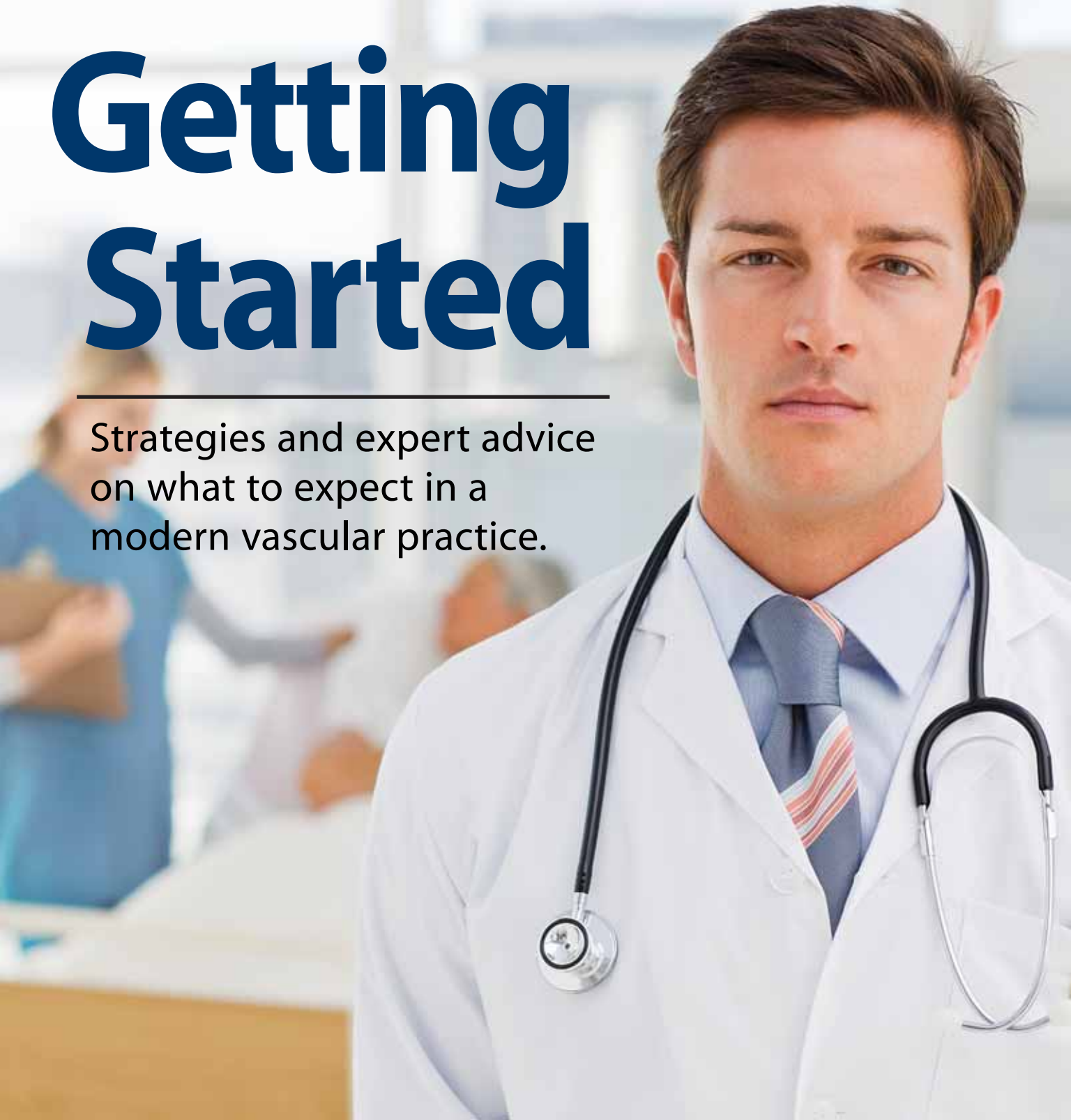
An *Endovascular Today* Special Edition

Getting Started

Strategies and expert advice on what to expect in a modern vascular practice.



As you enter into your endovascular practice, an entirely new set of challenges awaits—and not just on the operating table. In addition to striving to achieve excellent procedural outcomes and patient satisfaction, today's vascular interventionist must also successfully navigate the professional setting. This includes building a practice that suits your specific needs and desires, understanding employment agreements, proper procedural reimbursement, and also how to prepare for the possibility of malpractice litigation. *Endovascular Today* is pleased to provide you with this supplement, which focuses entirely on the fellow's transition into practice.

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Transitioning From Fellowship to Practice

What every vascular surgery resident or fellow needs to know.

BY ALIK FARBER, MD

Currently in the United States, a fellowship or integrated residency is required to become board eligible in the field of vascular surgery. During their training, physicians learn vascular anatomy, physiology, and pathophysiology. They are taught the differential diagnosis, work up, and medical management of vascular disease, and they learn about cross-sectional imaging and the noninvasive vascular laboratory. Finally, trainees acquire and hone open surgical and endovascular techniques that will enable them to treat patients with peripheral vascular disease.[1] Few would disagree that training to become a vascular surgeon is an intense, rich experience and that at the end of their apprenticeship trainees are able to independently manage patients with vascular disease.

However, there is more to being a vascular surgeon than performing a vascular anastomosis. Real world practice demands exposure to a variety of other skills that have traditionally not occupied a significant role in vascular training curricula. Learning how to craft a curriculum vitae (CV), how to look for a job, how to interact with a prospective employer, how to interview, how to assess an employment opportunity, and how to negotiate a contract are not routinely taught to vascular trainees. Furthermore, few trainees are formally educated about the different practice environments that vascular surgeons work in, different ways that they earn an income, and the range of that income potential. Finally, there is little emphasis placed on preparing the trainee for their first year in practice; details of vascular coding, interaction strategies with partners, referring physicians, and interventionist colleagues, and strategies of how to succeed in a given environment are all left to the trainee to figure out once they start their job. There has been reluctance to teach these skills in the medical profession. Conversely, skills that are imperative for success in the workplace are routinely taught in business school. Given the changes that are affecting our health care system, it is now more important than ever for vascular trainees to enter the workplace prepared to negotiate the complexities of current vascular surgery practice. To this end, the Association of Program Directors in Vascular Surgery and the Society for Vascular Surgery have started to organize focused workshops for vascular trainees at vascular surgery meetings.

This article cannot cover all topics of importance to graduating vascular residents and fellows. It does address the basic concepts of transitioning from vascular surgery training to practice. Specifically, it focuses on considerations surrounding the job search, navigation of the job pathway, interaction with a prospective employer, and assessment of a given job opportunity. The various ways that a vascular surgeon can generate income and that income range are also discussed.

BEGINNING THE JOB SEARCH

Due to high demands of their training programs, residents and fellows in vascular surgery seldom devote a significant amount of time thinking about what type of environment they want to ultimately practice in. This soul searching, however, is invaluable in organizing the successful job search process. Before starting the job search, the trainee should take time away from the stresses of clinical practice to reflect on what is important to him or her and to consider the following questions.

How do I want to spend my day?

The practice of vascular surgery can be broken down into a number of components: clinical practice, research, teaching, and administration. Clinical practice includes evaluation of patients in the office and hospital, open vascular surgery, and endovascular therapy. Research can be basic science, translational, or clinical. Teaching involves didactic and bedside education of students, residents, or fellows. Administration entails management of an office, a training program, a department, or a hospital. Each potential job, irrespective of practice type, includes some or all of these components in various ratios to one

another. There is no question that engagement in activities that are enjoyable to the surgeon will lead to a happy work experience. The opposite will contribute to work dissatisfaction. It is therefore essential for the trainee to consider which of these components of practice are both important and palatable. For instance, if the trainee does not like teaching then it may be unwise to accept a job in academics. Likewise, if the trainee enjoys the thrill of presenting at meetings, it would be optimal to search for a job where this activity is possible.

What sort of environment do I want to practice in?

In the past, private and academic practices were the main work settings available to the graduating vascular surgeon. Recently, the distinction between these environments has become blurred. Other practice options are available, and it is not altogether clear what the future of medicine will hold. In traditional private practice the surgeon ran a business whose product was clinical care of the vascular surgery patient. Activities that did not generate revenue, such as teaching and research, were not deemed important. Conversely, in academic practice, the surgeon held an appointment at a medical school, was part of a faculty practice plan, was expected to teach trainees, and participated in research. Decreasing reimbursements, increasing malpractice costs, increasing office expenses, and increasing regulatory bureaucracy affected both models of practice. These factors have made solo practice in vascular surgery difficult. In fact, there has been a significant decrease in the number of independent physicians practicing surgery in the United States.[2] Physicians have adapted by joining single or multispecialty groups, engaging in revenue generating activities other than clinical vascular surgery, and leaving private practice. Many vascular surgeons have sold their practices and opted to work as employees of a hospital, multispecialty group, or health maintenance organization. In academics, some groups were compelled to reevaluate the importance of research and teaching as nonrevenue-generating practices. The trainee looking for a job in 2010 should be aware of the dynamic changes to the practice environment of vascular surgery and avoid the temptation of looking at job opportunities through the prism of what private and academic practice was like 10 years ago.

What are my ultimate career goals?

Although career paths commonly change, it is important for trainees to strategize on what they are looking for in their vascular surgery job and where they want to find themselves 10 years later. For instance, if the trainee desires a job that does not involve significant on-call time, he or she may wish to join an established vein center. Alternatively, if the trainee wants to eventually become a department chief, he or she needs to accept the long hours, research, and administrative efforts that will need to be applied to achieve that goal.

How important is the geographical location of my job?

One cannot underestimate the importance of geography. Location of family, affordability of lifestyle, and quality of social life are important to many people. Geographical location may be less important to those who view their first job as a stepping stone to a different, better position.

NAVIGATING THE JOB PATHWAY

The job pathway can be defined as a series of steps that an applicant needs to take before deciding on a position. This series of events can be broken down into several components: identification of job opportunities, initial contact with a prospective employer, interview, evaluation of offer, and negotiation of terms.

To be successful in obtaining a desirable job, it is important for the trainee to be aware of the subtleties involved in this process. Unfortunately, the "devil is in the details," and those who are unaware of these details are apt to make critical mistakes that will either cause them to lose a desired position or to accept a job that will be ultimately be unsatisfying.

Identification of Job Opportunities

There are currently a number of ways that employment opportunities can be identified. These include the classified ads in the Journal of Vascular Surgery and a robust job listing on the Society for Vascular Surgery Web site (www.vascularweb.org). Division chiefs and program directors are frequently contacted by prospective employers and, therefore, can be an invaluable asset in this process. There a number of recruiting firms that specialize in placing vascular surgeons. Finally, because many desirable positions are not posted, local or regional vascular meetings may present a good opportunity to interact with prospective employers.

Initial Contact With a Prospective Employer

Typically, the trainee will contact the prospective employer by forwarding a short letter of interest and a CV. The CV should be written in easily legible font and organized in a logical, symmetrical fashion. It must be accurate, proofread, and spellchecked. Mistakes on a CV, no matter how small, will be interpreted as representative of the applicant's work product and will be looked at askance by the prospective employer. It is useful for the trainee to look at the CV of his or her mentor or chief and model it appropriately.

After receiving and reviewing the applicant's CV, the prospective employer will usually contact the trainee by telephone. This first contact is important because first impressions matter. The trainee needs to understand that the goal of the first conversation is to be invited for an interview. He or she should appear genuinely interested, spend more time listening than talking, not appear overly confident, and always have questions to ask about the position.

Interview

The interview process is an important component of the job pathway. It is an opportunity for the applicant to learn about the practice and the prospective employer to learn about the applicant. Poor performance during an interview will rarely lead to a job offer. During the interview, which will typically involve a visit to the practice, the applicant will meet with the prospective employer and colleagues, office staff, affiliated specialists, and representatives of hospital administration. The applicant will tour the facilities and have dinner with the surgeons. With regard to the first interview the applicant has two main objectives. The first objective is to gather information about the practice and the second objective is to be liked. It is imperative for the applicant to make a concerted effort during this visit to understand the positive and negative aspects of the practice. At the same time, he or she needs to behave in a way that would lead the prospective employer to extend an invitation for a second interview and eventually an offer.

The interview begins the minute that the applicant meets with the prospective employer. This may occur at the airport, a time and place that is sooner than the applicant may anticipate. Because first impressions are important, it behooves the applicant to be appropriately dressed and prepared for such an occasion. The applicant should always act interested, never be argumentative, confrontational, or condescending. He or she should be courteous to everyone; people that are perceived as not being important may have an unanticipated role in the interview process. Money or vacation time should not be brought up by the trainee applicant during the course of the first interview.

A successful first interview will often lead to an invitation for a second interview. The applicant will typically be invited back with his or her significant other. He or she will, once again, meet with everyone, have dinner with surgeons and their spouses, and have a real estate tour. The purpose of the second interview, from the perspective of the employer, is threefold: to take a second look at the applicant, to entice the applicant to accept a forthcoming offer, and to entice the applicant's significant other. In preparation, the applicant must be acutely aware of what he or she "brings to the table" and how this can contribute to the success of the practice. The applicant should try to meet with everyone of importance. For instance, an applicant who is interested in developing a dialysis access practice should meet with area nephrologists. The goal of the second interview, for the trainee, is to critically evaluate the opportunity, to critically evaluate the community, and to gather enough information to make the right decision should a job offer be extended.

Evaluating the Offer

The job offer is typically extended during or after the second interview. Before accepting a job, it is crucial to critically compare the offer with other pending job opportunities. To that end, the applicant needs to answer a number of important questions.

Why are they looking for someone? There are multiple reasons why a surgeon or group of surgeons may be interested in adding another associate. It behooves the applicant to understand those reasons. From the applicant's perspective, the following are positive reasons: expansion to another hospital with associated increase in case volume or market share and the need for specific expertise possessed by the applicant. Negative reasons include need for on-call coverage and operating room assistance. Applicants should avoid job opportunities where the reasons for a surgeon search are unclear. Such opportunities rarely lead to success and job satisfaction.

A common reason for a group to hire is to replace a surgeon who left the practice. Although there is always a rehearsed explanation for such a departure the applicant should make every effort to find out the real reason. Getting in touch with that individual may be the best way to not only get that question answered but also to learn invaluable information about the practice.

Can I work with this group? When evaluating an opportunity, attention needs to be focused on the interaction between surgeons within the group. Although, it is impossible to fully appreciate such intricacies from one or two visits, much can be learned even during limited exposure. A tension-filled environment where the surgeons do not appear happy or do not get along will rarely provide for a good professional opportunity.

Is a senior vascular surgeon available for advice and help with cases? Most physicians upon completion of their training are prepared to start clinical practice. However, a significant amount of learning has yet to occur for the trainee to mature into a capable vascular surgeon. This learning occurs best in an environment where experienced vascular surgeons are willing and able to assist in patient management in and out of the operating room. It behooves the freshly trained vascular surgeon to avoid a

TABLE 1. MEDICAL GROUP MANAGEMENT ASSOCIATION ANNUAL COMPENSATION STATISTICS FOR VASCULAR SURGEONS[3]

	Mean	Median	25th Percentile	75th Percentile	90th Percentile
Overall	$396,417	$379,589	$292,270	$454,074	$580,000
Group					
Single	$433,118	$379,589	$277,988	$467,142	$874,528
Multi	$389,056	$386,635	$297,352	$456,183	$558,656
Region					
East	$378,673	$387,109	$292,862	$448,216	$534,951
Midwest	$399,466	$382,268	$270,477	$477,404	$633,467
South	$465,167	$400,583	$337,206	$551,574	$859,915
West	$363,569	$359,552	$289,029	$423,636	$498,675

job environment where there is a lack of senior vascular surgery back up.

What is the status of endovascular access? Endovascular therapy has become an integral part of the modern vascular surgeon's armamentarium. Despite this fact, there are still institutions where turf wars among interventionists over endovascular privileges and access are in progress. The applicant needs to understand the details of endovascular credentialing and the environment of each job opportunity. The optimal environment is such where the appropriately trained applicant will have full privileges to freely schedule and perform endovascular procedures in a top of the line endovascular suite. The applicant needs to be wary of an environment where he or she will have limited endovascular privileges, have restricted access to an endovascular suite, or have access to a rudimentary endovascular setting such as a C-arm in the operating room in an institution that has well-equipped endovascular suites. Lastly, the applicant should beware of scenarios in which the hiring group has ingrained referral patterns of endovascular cases to other interventionists.

Will it be possible for me to succeed? Although every graduating vascular surgeon wants to succeed in his or her new job, such success is far from assured. It is imperative for the applicant to critically evaluate factors that will be important for such success. It is likewise important to understand how the employer will measure success. The are several potential metrics: charges, collections, relative value units, manuscripts published, grants submitted, and ability to fit in and get along with others. The applicant has to clearly understand which of these metrics will be used to evaluate him or her. Success can be rewarded by partnership, academic promotion, and money. It goes without saying that it is important to understand how the employer will reward success.

In many modern practices, endovascular therapy constitutes a significant and growing proportion of case volume. Therefore, it is imperative for the job opportunity to allow for full endovascular privileges, an appropriate endovascular environment to practice, and opportunity to have referrals for such procedures. It is hard to succeed if impediments to developing a busy endovascular practice exist.

The applicant needs to understand the agenda of the employer as it relates to him or her. The assumption that the hiring surgeon is interested in the applicant's personal success may not be accurate. Other factors may be operational. Success will be much more likely if the agenda of the applicant is parallel to the agenda of the employer.

A vascular surgeon in clinical practice typically competes with other surgeons and physicians. As part of this competition each party has advantages and disadvantages. The applicant needs to understand both the identity and strengths of these parties. The applicant must beware of scenarios where he or she will be directly competing with future partners or associates; such work environment rarely leads to success and job satisfaction.

Finally, an important fact to consider is whether the applicant will be able to share equally in the financial success of the practice. An assumption that this is true may be inaccurate. It is important to understand how the hiring group earns an income, what the sources of such income are, and whether certain individuals have exclusive rights to specific income streams.

Negotiation of Terms

Upon extension of an offer most employers will send the applicant a contract. Such contracts are crafted to leverage and optimize employer terms. It is best to have the contract reviewed by an attorney who specializes in medical contracts. Terms of negotiation can potentially include starting salary, potential future income and its sources, length of partnership track, vacation, benefits,

TABLE 2. MEDICAL SCHOOL FACULTY ANNUAL COMPENSATION STATISTICS FOR VASCULAR SURGEONS[4]				
	Assistant Professor	Associate Professor	Professor	Chief
25th Percentile	$220,000	$258,000	$275,000	$328,000
Median	$260,000	$311,000	$338,000	$369,000
75th Percentile	$314,000	$385,000	$411,000	$405,000
Mean	$280,000	$339,000	$359,000	$384,000

presence of restrictive covenants, malpractice insurance tail coverage, and termination. Before engaging in negotiation, the trainee needs to assess what value he or she brings to the practice. Unfortunately, many trainees may either not appreciate their value or, by the virtue of their inexperience, have limited value. This may curb the negotiating power that the trainee possesses for "big ticket" items such as length of partnership track or potential future income and its sources.

The starting salary is typically negotiable; vacation and benefits are usually not. Of utmost importance is to negotiate the malpractice tail coverage for claims-made policies. Such tail coverage should be partially or fully paid by the employer on the occasion of termination because its monetary value may be very high. The applicant should avoid signing a contract that allows for termination without cause. If the group resists removing this clause, it needs to be buttressed by a requirement for warnings and fees levied on the group in the case of involuntary termination.

EARNING AN INCOME

Few residents or fellows are aware of the various ways that vascular surgeons earn an income and what the range of income is in private and academic settings. It is important for the trainee to be familiar with this information as he or she enters the workforce so that appropriate expectations can be set.

Traditionally, open vascular and endovascular procedures, management of a vascular laboratory, and reading of noninvasive vascular studies comprised the "bread and butter" of vascular surgery income. Decreasing procedural reimbursements have forced many vascular surgeons to earn an income in less traditional ways. The following is a partial list of income stream components of many of today's vascular surgeons:

- Assisting spine surgeons with anterior exposure of the spine,
- Developing a cosmetic vein practice,
- Receiving salary from a hospital for services such as directing a wound center, operating rooms, vascular center, etc.,
- Engaging in industry-sponsored clinical trials,
- Maintaining ownership shares in a dialysis access center or surgery center,
- Consulting for industry,
- Legal expert review.

During potential job opportunity evaluation, the trainee needs to inquire about whether the hiring surgeons participate in these income-generating activities. It is important to clarify whether the applicant will be allowed to either engage in these activities or have an opportunity to share in this income stream.

Professional income is rarely formally discussed in vascular training programs. Yet, it is critically important for vascular trainees to know what mean incomes can be generated by a vascular surgeon. This knowledge is important for both contract negotiation and setting of appropriate expectations for life planning. Table 1 lists recently published vascular surgery annual compensation statistics based on type and region of practice.[3] These values were derived from a formalized survey that included physicians in both academic and private practice settings. Table 2 specifically summarizes statistics on vascular surgery annual salaries in an academic setting.[4]

For the vascular surgery trainee, transitioning from fellowship to practice represents the culmination of many years of learning, hard work, and sacrifice. Despite extensive training necessary to become a vascular surgeon, few trainees are prepared for the vagaries of the job search and the complexities of the first years of practice. In order to develop skills necessary for success, individual trainees need to actively pursue learning the particulars of real-world practice. Conversely, leadership of the vascular surgery community needs to ensure that this information is formally disseminated during fellowship training. ■

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Building and Maintaining a Successful Practice

A guide to the many ways community involvement and interaction may help your practice grow.

BY COLLEEN MOORE, MD

Before the ink dries on your contract, the work of building a practice should begin. By learning the local landscape, introducing yourself to and becoming part of the community, and maintaining a professional and welcoming appearance, you can start and build a highly successful practice.

LEARN THE LOCAL LANDSCAPE

Before your first day in the office, it is imperative to identify local physicians and determine their interactions with one another. This investigative process is important whether you have joined a group practice or are setting out on your own. Ignorance of the political landscape can lead to any number of faux pas that can take years to overcome.

This process begins with the medical staff offices of hospitals where you are seeking privileges. Deciphering inpatient consult patterns and the proper involvement of primary care physicians before admitting the first patient are paramount to your success. Understand that local practices may not be the custom where you trained, and early adaptability can lead to more outpatient referrals. In addition to identifying local customs, the medical staff office should be able to provide you with a list of physician contact information for the physicians practicing at that hospital.

Information from local and state medical societies will help you expand your list of potential referring physicians. Much of the information from local medical societies will overlap with the hospital medical staff office. When contacting a state medical society, it is helpful to provide a geographic radius or the zip codes of surrounding areas for a more focused search. If your practice will be in a larger city, it may be wise to chose a smaller radius than if you are moving to a primarily rural or tertiary care environment.

The Internet can also be a resource when compiling a list of potential referring physicians. The American Medical Association Web site can be searched to identify physicians within a geographic area.[1] It is wise to register with the American Medical Association and state and local medical societies because patients and physicians often look to these organizations for information. The final listing can be referenced with the local phone book to ensure that no physician is overlooked.

"Before your first day in the office, it is imperative to identify local physicians and determine their interactions with one another."

The final list can be culled and sorted according to specialty. It is impractical to think that you will contact every physician on the list, so identifying potential referral specialties is important. Primary care physicians, internists, family medical physicians, and nephrologists are logical choices. However, limiting the search to these primary care specialties excludes some potentially fruitful relationships. Neurologists are often the first physicians to evaluate and formulate a treatment plan for acute stroke patients. Early interactions with neurologists can result in multiple referrals for the evaluation and treatment of carotid disease. In addition, fibromuscular dysplasia and many of the more uncommon arteritides have cerebral manifestations. Early interactions with neurologists can ensure that you remain in the forefront of their consciousness when they encounter these patients. Rheumatologists can potentially refer patients for temporal artery biopsies and for complications of Takayasu's and giant-cell arteritis.

Podiatrists and nurse practitioners are often over-

looked as potential referral sources. Many are practicing independently in the hospital setting or within a large primary care group. Acknowledging their role in patient care and offering to evaluate their patients can go a long way to garner referrals. It also offers you an outlet to arrange diabetic foot care or set up patients with a new primary care provider.

Gynecologic contacts can be a source of very pleasant, healthy young patients, a demographic not often seen in vascular surgery practices. These women use their gynecologists as primary care providers and are often seeking information about treatment options for varicose veins that develop with pregnancies. Some women desire to preserve their uterus and so ask for uterine fibroid embolization procedures. Postpartum bleeding can be treated with embolization. Nonsurgical specialties that perform these last two procedures can not offer the understanding of post-procedure pain control or resuscitation that comes with the involvement of a surgeon interventionist. This results in better patient care, and the gynecologists are happy to refer to another surgeon.

Much of the focus when young physicians embark on the process of building a new practice is directed toward developing an arterial practice. Venous disease is overlooked and not felt to carry the prestige that an arterial practice brings. In addition to the gynecologists, dermatologists see a lot of venous disease that can be referred on. Women make the overwhelming majority of medical decisions for families, and each family has at least two parents that are aging and may likely require vascular care. A positive experience in the vein clinic can translate into many new arterial referrals.

INTRODUCTIONS TO THE COMMUNITY

Industry representatives are a valuable resource for gathering information about the community you are joining. Ask the local medical device representatives which physicians perform the majority of vascular surgery and the bulk of the endovascular interventions. It is important to gain an understanding of the role you are expected to play and the specific skill set that you were hired to provide. By identifying this early, you can establish a referral toehold.

As your role becomes more defined, it is time to make yourself known to local physicians. This is where your local medical society can provide additional assistance. These societies are designed to assist local physicians and can give you tips on local marketing practices that have been successful and those that do not work with your desired referral base or patient population.

Letters of introduction sent a few months prior to your anticipated arrival are nice. But, most practicing physicians do not take the time to read the letters and they often find the trash can before anyone reads them. If you decide to send out letters of introduction, keep it short and state your educational background and training. Briefly discuss procedures or new skills you bring the community. It is important to be humble in this initial communication. Speak in generalities and do not claim to perform procedures you hope to add to your armamentarium in the future.

"Industry representatives are a valuable resource for gathering information about the community you are joining."

Once your start date has been set, it is important that someone is always available to answer the phone. Your office staff will start interacting with referring offices before that first clinic. It is vitally important to educate your office staff on how you would like the phone answered and what information you would like from the referring physicians office. At this time, writing scripts for your office staff is helpful. This way no matter who answers the phone, the answers are always the same. It avoids conflicting information. Also ask for the minimum necessary information from the referring physician at that initial phone call. If they have to work too hard to get the patient seen, they are unlikely to call back. A pleasant interaction during the initial phone call goes a long way toward continued referrals. Office staffs have a large say in directing patient referrals. If the process to refer a patient is too cumbersome or the person on the other end of the phone is unpleasant, it is unlikely that more patients will find their way to your door.

An effective way to introduce yourself to both physicians and the community alike is through the local newspapers. A small advertisement with a photo, a statement of your clinical interests, the office location, and phone number can be lucrative. Newspaper advertising can be slightly more expensive, but the return on your investment is excellent. This is especially so for more competitive markets such as the cosmetic vein market.

The days of driving to each referring physician's office, introducing yourself, and having a cup of coffee are gone. Although it may be reasonable to visit a few physicians who are likely to refer a large volume of patients, it may be easier to have them come to you. A cocktail party or open house at your home or office provides an

excellent opportunity to shake hands and let physicians interact with you socially. This event shouldn't require professional party planners or rival a Hollywood red carpet event. A simple, informal affair is sufficient to allow you and your future partners to discuss the role within the community that you expect to fill and how you can evaluate and treat their patients.

Another professional venue to meet a variety of physicians is in the physicians lounge at the hospital. Although the fare may leave a lot to be desired, the opportunity to socialize can be unparalleled. Attending hospital staff meetings, department meetings or even faculty meetings, for those entering and academic practice, can prove fruitful.

KEEPING UP APPEARANCES

Because appointments are easy to schedule when your office is just opening, and local physicians are apt to try and help you out, referrals will come in at the beginning. To keep new patients coming through the door, however, it is important to stay in the forefront of the local consciousness.

Local medical societies meet regularly and are frequently looking for speakers. Take the initiative and approach some of these groups and ask to speak. These forums provide you with a venue in which to explain your approach to common problems. When selecting a topic, it is important to speak about diseases you are comfortable and able to treat in the community where you now practice. It is important to establish a reputation as a competent surgeon and interventionist before pushing the envelope on the local landscape.

It is also important to acknowledge the local competition. If someone else provides similar services, do not expect to come in and dominate the market. Rather, explain what additional services you may offer or how your approach may differ. In addition, be humble. Presenting an arrogant façade does not endear you to physicians that have been practicing in that community for years. Their methods may be antiquated, but by presenting a distinctive approach in a collegial manner, it is possible that you may be able to alter the local landscape and get people to come around to your way of thinking.

An additional speaking venue is hospital departmental meetings. Approaching various departmental chairs and asking for 5 minutes to introduce yourself to these small groups provides access to small groups of physicians. These opportunities show your commitment to establishing a successful practice and your desire to form a cordial working relationship with them. It also allows for frank and open discussion about the referral process and what you can do for them.

Establishing a relationship with local health reporters either in the print media or television is a great way to expose your practice to a large variety of people. Coordinating a patient education series during Heart Health Month ties in nicely with your practice. In addition, if you decide to provide free venous screenings, a short press release or piece on the local news establishes you as an expert in the field. The American Venous Forum provides a toolkit that allows you to provide free community screenings to assess deep vein thrombosis risk as well as to assess for the signs and symptoms of chronic venous insufficiency and venous obstruction.[2]

Another speaking opportunity that can result in a variety of referrals and establishes you as a local expert is the infamous "rubber chicken" dinner. These are often sponsored by local philanthropic organizations. Although the venue may not be glamorous, the attendees are interested and grateful for the time you have spent with them. Make sure your presentation is appropriate for the layman. At the conclusion of your talk, leave plenty of time for questions. Attempt to answer all of the questions that are asked no matter how bizarre or seemingly unrelated. If you establish that you are genuinely concerned, they are likely to self-refer or send a friend or family member.

COMMUNITY INVOLVEMENT

Community involvement is mandatory for any physician starting a new practice. Becoming involved with various community organizations gives an impression that you are there to improve the community and not just to make money. By giving back to the community, you will get more in return that you ever imagined. This does not need to be a daunting task. By simply reading the paper or watching the local news, you can identify organizations that will benefit from your expertise. Social clubs and country clubs are often viewed as elitist; however, these organizations provide an opportunity to interact with a wide variety of people outside the community and can provide access to a variety of organizations with varied political and social agendas.

Often the easiest way to become involved is through children's activities such as sports, dancing, and music. These provide excellent networking opportunities. Becoming a head coach may not be feasible due to the unpredictability of your work schedule, but you can volunteer to assist. Attend games and practices. Learning names of players and cheering from the stands is a great way to be involved and recognized.

Through active community involvement, potential patients see you as more human and much more like

(Continued on page 13)

Understanding Medical Malpractice Litigation

Knowing the fundamentals of medical malpractice lawsuit can help physicians avoid unwanted legal disputes.

BY O. WILLIAM BROWN, MD, JD

It has been said that the only things that are certain in life are death and taxes. O. William Brown, MD, JD, a vascular surgeon and a professor of law, would add a third certainty: If a physician practices medicine long enough in the United States, he will be named in a medical malpractice suit. If a physician hopes to successfully navigate the shark-infested waters of medical malpractice litigation, he must fully understand the legal process governing the filing and course of a medical malpractice lawsuit.

WHAT ARE THE BASIC ELEMENTS TO A MALPRACTICE LAWSUIT?

There are four prongs to any medical malpractice suit: duty, breach of duty, proximate cause, and damages. All four of these must be present if a medical malpractice suit is to be successfully filed. Duty is most often established by proving that a physician-patient relationship existed. Breach of duty refers to a violation of the standard of care. Proximate cause means that the negligence on the part of the physician was the cause of the patient's damages. Finally, the patient must show that he did, in fact, sustain damages.

HOW IS A PHYSICIAN-PATIENT RELATIONSHIP ESTABLISHED?

A physician-patient relationship may be established in one of several ways. If the patient is seen by the physician in his office or is seen in the hospital in response to a consultation, a relationship has been established. Similarly, if a physician is called by his resident or by a nurse regarding a patient in the emergency room, a relationship will most likely be deemed to have been established. A relationship may sometimes be assumed to exist by a simple comment made by a physician in a social setting. For example, if a vascular surgeon, after being questioned by a fellow party guest concerning leg swelling, tells the guest that the swelling is probably not significant, a physician-patient relationship may be presumed to have been established. Accordingly, if the guest in question subsequently develops a pulmonary embolism and dies, the physician may be held liable. It should be stressed that whether or not the physician has charged or been paid for his services is unimportant in determining if a physician-patient relationship exists. However, a routine hospital consultation must be distinguished from the unique entity of a "sidewalk consultation." A sidewalk consult occurs when one physician informally discusses the medical findings of a patient with another physician and asks the second physician for advice on how to care for the patient. The legal system has determined that this type of request for assistance does not establish a physician-patient relationship.

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A physician-patient relationship may be terminated in one of three ways. First, the patient can dismiss the physician. Second, the physician may withdraw from giving care, but only after providing the patient with sufficient notice. Finally, if the patient's medical problem has been resolved, the physician-patient relationship no longer exists.

WHAT DEFINES STANDARD OF CARE?

The standard of care may be established in one of five ways. Most often, it is determined by expert witnesses. The definition of a medical expert varies from state to state. In some states, any physician may give expert testi-

mony in any type of medical malpractice case. In other states, the qualification of the expert is more narrowly tapered. In Michigan, if the defendant is board certified, the experts must be board certified in the same specialty. The standard of care may also be established by the defendant if the defendant admits that he has violated the standard of care. The third method is known by the Latin phrase *res ipsa loquitur*, or it speaks for itself. An example would be leaving a sponge in the abdomen of a patient after a laparotomy. A fourth method of determining the standard of care is by the plaintiff, if he is a medical expert. The final method is by citing the common knowledge doctrine. An example of this would be performing extensive x-ray evaluations on a woman who is in the first few weeks of her pregnancy. Even a layperson knows that x-ray use early in pregnancy can produce birth defects.

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The standard of care applied to physicians is a national standard. That is, a physician from the small city of Munising, Michigan, is held to the same standard of care as a physician in Boston, Massachusetts. Location becomes a consideration only when hospital equipment is an issue. A physician cannot be held liable for failing to obtain a 128-slice computed tomography scan on a patient if the hospital does not have such a scanner.

Finally, the standard of care is not static. It may be altered by clinical data or changes in technology. Today, the standard of care for the treatment of an isolated, 2-cm noncalcified common iliac stenosis is not the same as it was 20 years ago.

HOW DOES A PHYSICIAN OBTAIN INFORMED CONSENT?

The statement "risks and benefits discussed with the patient" does not constitute informed consent. Any note attempting to establish informed consent must contain at least five basic components: diagnosis, treatment plan, risks and benefits, treatment alternatives, and prognosis with and without treatment. In addition, the physician must tell the patient anything that could affect his decision as to whether or not to proceed with the treatment.

Moreover, obtaining informed consent is a nondelegable duty, meaning that the informed consent for a procedure must be obtained by the physician performing the procedure and not the resident or physician assistant who is helping the physician with the procedure. Lastly, a signed operative consent form does not constitute informed consent. In truth, the only purpose of the operative consent form is to protect the physician from liability for civil or criminal battery. This is particularly important when one considers that malpractice insurance will not cover monetary verdicts resulting from a civil battery suit.

WHAT ARE THE DEFENSES TO A MALPRACTICE LAWSUIT?

There are several medical malpractice defenses. The first is that the physician acted in a manner consistent with a reasonably prudent physician. A second defense is that the damages were a result of an error in judgment and not negligence. A third defense is "assumption of the risk." An example of this would be a patient, who was told not to run after having a hip replacement, deciding to participate in a marathon, whereby the hip becomes dislocated. Contributory negligence is a fourth defense. An example of this would be if a patient was told to stop smoking after a femoropopliteal bypass but continued to smoke three packages of cigarettes per day. Let us assume the graft occludes. Even if the vascular surgeon placing the graft was found to be negligent, many states would reduce the award by the percentage that the patient contributed to the graft's occlusion by continuing to smoke cigarettes.

WHAT ARE GOOD SAMARITAN STATUTES, AND HOW DO THEY WORK?

In most states, a Good Samaritan statute exists. This statute covers physicians who provide medical care in an emergency situation to patients whom they have no duty to treat. The classic example of a Good Samaritan is a physician who stops at the side of the road to help an accident victim. However, in many states, the Good Samaritan statute has been extended to cover acts that occur within the hospital. For example, if a vascular surgeon is called emergently by an orthopedic surgeon to assist in the repair of a popliteal artery injured during a total knee replacement, the vascular surgeon, if he is not on call, can refuse to see the patient. If the vascular surgeon does choose to help the orthopedic surgeon, under the Good Samaritan statute, the vascular surgeon cannot be held liable for ordinary negligence; the vascular surgeon can only be held liable for willful or wanton acts (those that are intentionally negligent). It is therefore important for all vascular physicians to be familiar with the Good Samaritan statute in the state in which they practice.

STATUTES OF LIMITATIONS

Although statutes of limitation vary from state to state, it is important to remember that there is no statute of limitation for fraudulent concealment. Therefore, it is imperative that the patient and the patient's family be informed of any significant occurrence in the operating room.

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WHAT ARE THE DIFFERENT TYPES OF MEDICAL MALPRACTICE INSURANCE, AND HOW DOES THEIR COVERAGE DIFFER?

There are basically two types of medical malpractice insurance: occurrence and claims made. Occurrence insurance covers any lawsuits that arise when the physician was covered by the occurrence policy. For example, assume that a physician purchases an occurrence policy for the year 2008 and then discontinues the policy. Even if the lawsuit is filed in 2010, if the event in question occurred in 2008, the policy is still deemed to be in force. However, if the same physician purchased a claims-made policy for 2008, and the lawsuit is filed in 2010, he is not covered by that policy. He would be covered only for claims filed in 2008, no matter when the event in question occurred.

Although claims-made insurance is less expensive for the first few years, after several years, the price for claims-made insurance approaches that for occurrence insurance. Finally, if a physician selects claims-made insurance and then leaves town or stops practicing, he will need to purchase what is referred to as tail coverage, which will cover him for all future years, even though he no longer has active malpractice insurance.

If vascular surgeons wish to prevail in the legal system, they must know and understand the rules of the game. ■

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them. Referring physicians recognize that you are there to stay and to improve the local environment. The perception becomes that you are there to stay and not just passing through on your way to bigger and better things. It is important to remember that signing up is not sufficient—it is imperative that you project a sense of commitment and dependability. Keep the commitments you have made. Be more than a name on the roster.

CONTINUED UPGRADES

Just as you continue to upgrade your computer, you must continue to upgrade your practice. Things such as keeping up with dictations and maintaining a relatively flexible schedule early on put referring physicians at ease. They can be assured you have seen their patients and developed a plan of care. In addition, a flexible schedule means they can get patients seen in a timely manner. If you identify patient- or physician-access problems to your practice, acknowledge these with a personal phone call and provide a solution to the problem.

Once your practice has been up and running for a few months, ask someone to be a "secret shopper." This can be any random person that you trust to give you an honest assessment of your practice. Have them call to schedule an appointment and come in as a new patient. This can provide you with invaluable feedback as to what works well and what needs to be fixed within your practice. Continuous upgrades of your office processes will only make you more efficient and keep your patients very happy.

CONCLUSION

It is easy to sign a contract, but it is much more difficult to establish a practice that encourages patient referrals. By taking the initiative to step to the front of the local medical community and the community at large, you will encourage patient referrals. Once the patient flow begins, it is important to provide patients and referring physicians with the service and care you would expect for your family. Keeping the waiting room full requires constant care and maintenance. ■

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Components of Physician Reimbursement

2009 endovascular aortic aneurysm repair coding, coverage, and payment.

BY JENNIFER WILLIAMS

The rigors and trials of medical school and residence programs often do not prepare physicians for the potentially confusing and frustrating world of reimbursement. In order to understand physician reimbursement, you need to understand the three key components of reimbursement from the payers' perspective:

Coding: Based on International Classification of Diseases (ICD-9) diagnosis codes and Current Procedural Terminology (CPT) codes for procedures.

Coverage: Based on payer-specific coverage decisions that may limit the coverage of certain procedures based on the appropriate diagnoses.

Payment: Based on the payer arrangements with the providers. Medicare physician payments are based on a physician fee schedule that is specific to geographic localities.

The foundation of these components of reimbursement is built on the complete and concise documentation of the reason for the procedures and description of the procedures performed. This article discusses the nature of that documentation.

COMPLETE AND CONCISE DOCUMENTATION

Accurate and appropriate coding and billing is important not only for efficient submissions of Medicare claims, but also to ensure that your claims stand up to the scrutiny of Medicare audits. Payers such as Medicare make their payment decisions based on precise diagnosis and procedural coding. To code accurately, you must document clearly and completely (Table 1):

- **Why** was the procedure performed?
- **Who** performed the procedure?
- **What** was done?
- **How** was it performed?

COORDINATING PROCEDURES WITH PHYSICIAN COLLEAGUES

Before performing any procedure, especially endovascular aortic aneurysm repair (EVAR/TEVAR), you must decide with your physician colleagues how the procedure will be performed and coded. Reaching a previous agreement among the physicians will avoid misunderstandings regarding documentation, coding, and ensure equitable payment for specific aspects of the procedure.

For example, if a vascular surgeon and an interventional radiologist are performing the procedure together as co-surgeons (-62 modifier) or with one serving as an assistant surgeon (-80 modifier), both physicians should document their aspect of the procedure and clearly state the components of the procedures performed as co-surgeons or assistant surgeons. Depending on the scenario, Medicare payments can differ greatly based on the documentation and coding of the procedures. It is

TABLE 1. QUESTIONS TO ADDRESS WHEN CODING

Who?	Identify the primary surgeon and other physicians involved in the procedure (eg, co-surgeon, assistant surgeon)
Why?	Identify the applicable principal diagnosis as well as complications and comorbidities (especially important for proper hospital Medicare inpatient payment)
What?	Procedural summary included in your operative note, describing primary procedures performed using key "CPT terminology" to define steps
How?	Detailed description of the order and technique used to perform procedures and the interpretation of the imaging

also helpful to describe why more than one physician is required. Tables 2 through 7 demonstrate coding and payment for a variety of abdominal aortic aneurysm (AAA) and thoracic aortic aneurysm (TAA) endovascular repairs using different combinations of a single surgeon, co-surgeons, and primary and assistant surgeons.

CO-SURGEONS OR ASSISTANT SURGEONS?

When coding for co-surgeons (-62 modifier) or a primary and assistant surgeon (-80 modifier), it is important to understand how these modifiers are defined for coding purposes. Both of these modifiers are used when two surgeons are involved in a single procedure (a single CPT code, which is shared). These modifiers do not apply when describing when each surgeon performs a different procedure represented by different CPT codes (eg, one surgeons performs the cutdown and the other deploys the endoprosthesis).

-62 Modifier: Co-Surgeons. Modifier -62 is used when two primary surgeons are required to perform the same procedure (represented by a single CPT code). Both surgeons must bill with the -62 modifier after the applicable CPT code(s), and Medicare will then pay 62.5% of the fee schedule rate for the procedure (please note that only selected procedure codes are eligible for this modifier, and additional discounts for multiple procedures may still apply when calculating payment).

It is possible for two surgeons of the same specialty to bill as co-surgeons; however, this policy may vary among payers (Medicare and commercial payers). It is best if each co-surgeon dictates an operative report describing his or her specific role in the procedure (Tables 3 and 6).

-80 Modifier: Assistant Surgeon. Modifier -80 is used when two primary surgeons are present, but one surgeon is considered primary while the second assists the primary surgeon in performing the procedure. The primary surgeon will submit the procedure code(s) without a modifier, and the assistant surgeon will submit the same procedure code(s) with an -80 modifier.

It is important to note that simply indicating "Assistant Surgeon" on the operative notes will not be adequate documentation to support the use of modifier -80 on claims; rather, the operative note should clearly state on which procedure(s) the assistant surgeon was involved.

Medicare will then pay 16% of the fee schedule rate for the procedure (please note that only selected procedure codes are eligible for this modifier, and additional discounts for multiple procedures may still apply when calculating payment).

Tables 4 and 7 demonstrate coding and payment for AAA and TAA endovascular repairs using a primary and an assistant surgeon.

TABLE 2. ENDOVASCULAR AAA REPAIR CODING EXAMPLE: SINGLE SURGEON

Single physician operator deploying modular bifurcated stent graft with one docking limb, right and left iliac extension cuff. Medicare Locality: National

CPT	Modifier	Modifier Adj	Multiple Procedure Modifier Adj Pymt = Adjusted Payment (-51)	2009 Adjusted Payment	
34812	50, 51	150%	50%	$265.90	Femoral artery exposure bilateral
36200	50, 51	150%	50%	$116.86	Catheter placement bilateral
34802		100%	100%	$1,260.89	Deploy AAA stent graft
34825	51	100%	50%	$353.09	Deploy extension for AAA right iliac
34826		100%	100%	$209.55	Extension add-on aortic cuff proximal to stent graft
75952	26	100%	100%	$228.66	Endovascular AAA repair radiological supervision and interpretation
75953	26	100%	100%	$69.25	Endovascular AAA repair extension radiological supervision and interpretation
75953	26	100%	100%	$69.25	Endovascular AAA repair extension radiological supervision and interpretation
Physician No. 1				$2,573.45	Total: $2,573.45

TABLE 3. ENDOVASCULAR AAA REPAIR CODING EXAMPLE: TWO SURGEONS (CO-SURGEONS)

Two surgeons deploying a modular bifurcated stent graft with one docking limb, right and left iliac extension cuff.
Medicare Locality: National

CPT	Modifier	Modifier Adj	Multiple Procedure Modifier Adj Pymt = Adjusted Payment (-51)	2009 Adjusted Payment	
34812	50, 51	150%	50%	$265.90	Femoral artery exposure bilateral
36200	50, 51	150%	50%	$116.86	Catheter placement bilateral
34802	62	62.5%	100%	$788.06	Co-deploy AAA stent graft
34825	62, 51	62.5%	50%	$220.68	Co-deploy extension for AAA right iliac
34826	62	62.5%	100%	$130.97	Co-deploy extension for AAA left iliac
Physician No. 1				$1,522.46	
34802	62	62.5%	100%	$788.06	Co-deploy AAA stent graft
34825	62, 51	62.5%	50%	$220.68	Co-deploy extension for AAA right iliac
34826	62	62.5%	100%	$130.97	Co-deploy extension for AAA left iliac
75952	26	100%	100%	$228.66	Endovascular AAA repair radiological supervision and interpretation
75953	26	100%	100%	$69.25	Endovascular AAA repair extension radiological supervision and interpretation
75953	26, 59	100%	100%	$69.25	Endovascular AAA repair extension radiological supervision and interpretation
Physician No. 2				$1,506.87	Total: $3,029.33

TABLE 4. ENDOVASCULAR AAA REPAIR CODING EXAMPLE: TWO SURGEONS (PRIMARY AND ASSISTANT SURGEONS)

Primary and assistant surgeon deploying modular bifurcated stent graft with one docking limb, right and left iliac extension cuff.
Medicare Locality: National

CPT	Modifier	Modifier Adj	Multiple Procedure Modifier Adj Pymt = Adjusted Payment (-51)	2009 Adjusted Payment	
34812	50, 51	150%	50%	$265.90	Femoral artery exposure bilateral
36200	50, 51	150%	50%	$116.86	Catheter placement bilateral
34802	80	16%	100%	$201.74	Deploy AAA stent graft, assistant
34825	80, 51	16%	50%	$56.49	Deploy extension for AAA right iliac, assistant
34826	80	16%	100%	$33.53	Deploy extension for AAA right iliac, assistant
Physician No. 1				$674.52	
34802		100%	100%	$1,260.89	Deploy AAA stent graft
34825	51	100%	50%	$353.09	Deploy extension for AAA right iliac
34826		100%	100%	$209.55	Deploy extension for AAA left iliac
75952	26	100%	100%	$228.66	Endovascular AAA repair radiological supervision and interpretation
75953	26	100%	100%	$69.25	Endovascular AAA repair extension radiological supervision and interpretation
75953	26, 59	100%	100%	$69.25	Endovascular AAA repair extension radiological supervision and interpretation
Physician No. 2				$2,190.69	Total: $2,865.21

TABLE 5. ENDOVASCULAR TAA REPAIR CODING EXAMPLE: SINGLE SURGEON

Single physician operator deploying modular stent graft with no subclavian coverage, open femoral exposure on right side and percutaneous access on left side. Medicare Locality: National

CPT	Modifier	Modifier Adj	Multiple Procedure Modifier Adj Pymt = Adjusted Payment (-51)	2009 Adjusted Payment	
34812	51	100%	50%	$177.27	Femoral artery exposure
36200	50, 51	150%	50%	$116.86	Catheter placement bilateral
33881		100%	100%	$1,533.91	Deploy TAA stent graft – main body and distal extensions
75957	26	100%	100%	$306.93	Endovascular TAA repair radiological supervision and interpretation
Physician No. 1				**$2,900.47**	**Total: $2,900.47**

TABLE 6. ENDOVASCULAR TAA REPAIR CODING EXAMPLE: TWO SURGEONS (CO-SURGEONS)

Two surgeons deploying modular stent graft with no subclavian coverage. Surgeon 1 performs open femoral exposure and catheter placement on right side. Surgeon 2 performs percutaneous access, catheter placement on left side and radiological supervision and interpretation. Medicare Locality: National

CPT	Modifier	Modifier Adj	Multiple Procedure Modifier Adj Pymt = Adjusted Payment (-51)	2009 Adjusted Payment	
34812	51	100%	50%	$177.27	Femoral artery exposure
36200	51	100%	50%	$77.91	Catheter placement
33881	62	62.5%	100%	$958.69	Co-deploy TAA stent graft – main body and distal extensions
Physician No. 1				**$1,213.86**	
36200	51	100%	50%	$77.91	Catheter placement
33881	62	62.5%	100%	$958.69	Co-deploy TAA stent graft – main body and distal extensions
75957	26	100%	100%	$306.93	Endovascular TAA repair radiological supervision and interpretation
Physician No. 2				**$1,343.53**	**Total: $2,557.39**

TABLE 7. ENDOVASCULAR TAA REPAIR CODING EXAMPLE: TWO SURGEONS (PRIMARY AND ASSISTANT SURGEONS)

Two surgeons deploying modular stent graft with no subclavian coverage. Surgeon 1 performs open femoral exposure and assists on stent graft deployment. Surgeon 2 performs percutaneous access, bilateral catheter placement, deploys stent graft and performs radiological supervision and interpretation. Medicare Locality: National

CPT	Modifier	Modifier Adj	Multiple Procedure Modifier Adj Pymt = Adjusted Payment (-51)	2009 Adjusted Payment	
34812	51	100%	50%	$177.27	Femoral artery exposure
33881	80	16%	100%	$245.43	Deploy TAA stent graft – main body and distal extensions – assistant
Physician No. 1				**$422.69**	
36200	50, 51	150%	50%	$116.86	Catheter placement bilateral
33881	62	100%	100%	$1,533.91	Deploy TAA stent graft – main body and distal extensions
75957	26	100%	100%	$306.93	Endovascular TAA repair radiological supervision and interpretation
Physician No. 2				**$1,957.90**	**Total: $2,380.39**

DOCUMENT ALL APPLICABLE DIAGNOSES

Complete identification and documentation of the primary and all other diagnoses impacts Medicare coverage decisions as well as Medicare hospital inpatient payment assignments. Incorrect or nonspecific diagnoses may lead to coverage denials or incorrect Medicare hospital inpatient diagnosis-related group (MS-DRG) assignments. For AAA repair, the absence of documentation and coding of a complication and/or comorbidity can cause a hospital discharge to track to MS-DRG 238 instead of MS-DRG 237, an average difference of more than $11,000 per discharge.

ICD-9 Diagnosis Codes: Aortic Aneurysms

441.4—Abdominal aortic aneurysm (AAA) without mention of rupture; other diagnoses (complications and comorbidities)

441.2—Thoracic aortic aneurysm (TAA) without mention of rupture; other diagnoses (complications and comorbidities)

SUMMARIZE PROCEDURES USING CPT TERMINOLOGY

AAA Endovascular Repair Coding

Incorporating a summary in your documentation of procedures performed will simplify and eliminate coding confusion. By using key CPT code descriptions in the summary, your coder will be able to identify the correct code to bill. Specifically identifying the endovascular AAA stent graft type will help identify the correct CPT code to bill for the procedure.

The stent graft design impacts the coding for the procedure.

CPT 2009 Code Descriptions: Prosthesis Codes

- **34800**—Aorto-aortic tube prosthesis
- **34802**—Modular bifurcated prosthesis with one docking limb
- **34803**—Modular bifurcated prosthesis with two docking limbs
- **34804**—Unibody bifurcated prosthesis
- **34805**—Aorto-uniiliac or aorto-unifemoral prosthesis

Note: With devices utilizing a docking limb, the placement of the contralateral limb is included in the main procedure code.

CPT 2009 Code Descriptions: Procedural Codes

- **34812**—Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral. *(Note: Closure is considered part of the procedure and is not coded or reimbursed separately.)*
- **36200**—Introduction of catheter, aorta
- **34802**—Endovascular repair of infrarenal AAA or dissection using modular bifurcated prosthesis (one docking limb)
- **75952-26**—Endovascular repair of infrarenal AAA or dissection, radiologic supervision and interpretation; professional component
- **34825**—Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal AAA or iliac aneurysm, false aneurysm, or dissection; initial vessel. *(Note: AAA extensions are coded per vessel in which they are deployed, not per extension piece)*
- **34826**—Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal AAA or iliac aneurysm, false aneurysm, or dissection; each additional vessel (list separately in addition to code for primary procedure). *(Note: AAA extensions are coded per vessel in which they are deployed, not per extension piece)*
- **75953-26**—Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiologic supervision and interpretation; professional component

TAA Endovascular Repair Coding

Proper coding and billing of an endovascular repair of a descending thoracic aortic aneurysm also will require clear summaries of what procedures were performed. The main procedure code is dependent upon whether the left subclavian artery is covered or not while deploying the main body of the endoprosthesis, and only extension pieces proximal to the heart, when coverage of the left subclavian is not involved, are eligible for billing during the initial operative session. All distal extensions are paid as part of the placement and deployment of the main body.

CPT 2009 Code Descriptions: Prosthesis Codes

- **33880**—Initial prosthesis plus descending thoracic aortic extension(s), involving coverage of left subclavian artery origin
- **33881**—Initial prosthesis plus descending thoracic aortic extension(s), not involving coverage of left subclavian artery origin

CPT 2009 Code Descriptions: Procedural Codes

- **34812**—Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral. *(Note: Closure is considered part of the procedure and is not coded or reimbursed separately.)*
- **36200**—Introduction of catheter, aorta
- **33880**—Initial prosthesis plus descending thoracic

TABLE 8. MODIFIERS THAT IMPACT MEDICARE ALLOWABLE PAYMENTS

Modifier	Description	Payment Impact
26	Professional component	Professional component of Medicare fee schedule
50	Bilateral procedure	150% of Medicare fee schedule
51	Multiple procedure reduction	50% reduction of Medicare fee schedule applied to select surgical procedures
59	Distinct procedure or service	Overrides coding edits for duplicate procedures
62	Two surgeons work together as primary surgeon	62.5% of Medicare fee schedule
80	Assistant surgeon	16% of Medicare fee schedule
82	Assistant surgeon (resident surgeon unavailable)	16% of Medicare fee schedule
AS	Assistant-at-Surgery (nonphysician practitioner)	85% of 16% of Medicare fee schedule

aortic extension(s), involving coverage of left subclavian artery origin

- **75956-26**—Endovascular repair of descending thoracic aorta, involving coverage of left subclavian, radiologic supervision and interpretation; professional component
- **33881**—Initial prosthesis plus descending thoracic aortic extension(s), not involving coverage of left subclavian artery origin
- **75957-26**—Endovascular repair of descending thoracic aorta, not involving coverage of left subclavian, radiologic supervision and interpretation; professional component
- **33883**—Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta, initial extension *(Note: Do not code if covering left subclavian–that is included in CPT 33880.)*
- **33884**—Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta, each additional extension
- **75958-26**—Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta, radiological supervision and interpretation; professional component
- **33886**—Placement of distal extension prosthesis delayed after endovascular repair of descending thoracic aorta
- **75959-26**—Placement of distal extension prosthesis delayed after endovascular repair of descending thoracic aorta, radiological supervision and interpretation; professional component

DOCUMENT IN DETAIL THE TECHNIQUE AND FINDINGS

The body of the documentation should clearly describe the technique used to perform the intervention listed in the operative note summary. You or your certified coder will use this component of your documentation to determine the appropriate CPT codes and necessary modifiers. Modifiers are used to describe the specific situation or circumstance in which the procedure was performed, as well as to affect how much the procedure will be reimbursed (Table 8).

CONCLUSION

Complete and concise documentation simplifies coding, eliminates coverage denials, expedites and ensures accurate payment, and will help ensure your claims withstand the scrutiny of future audits. The mystery of physician reimbursement becomes clearer as you understand and use CPT descriptions in your documentation and make use of professional coding resources from the Society of Vascular Surgery and the Society of Interventional Radiology. ■

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21st Century Physician Employment Agreements

Critical elements you should consider to help ensure that your agreement suits your specific needs.

BY TERRELL J. ISSELHARD, JD

One of the more perplexing issues physicians confront as they transition from fellowship to practice is their employment agreement. These agreements can vary from an informal offer and acceptance conveyed over a phone call to a complex written contract the size of a small novel. This article addresses the question of when a written employment agreement is appropriate, the advantages and disadvantages of entering into a comprehensive employment agreement, and several provisions critical to providing physicians with the legal protection necessary in their employment relationship.

LIMITATIONS OF ANALYSIS

This article is intended to familiarize the reader with several of the pertinent issues they may choose to address in their employment agreements. It is not a review of all legal issues that will impact your respective agreement. In the United States, employment agreements are governed by the law of the state with the most significant contacts with the contracting parties. In this context, contacts refers to the state in which the contracted employment is to take place, but (as with most legal rules) there are exceptions. A physician may agree to work for a practice with offices in two neighboring states that have conflicting laws regarding the relevant provisions of the employment agreement. Because it is not possible to provide a dissertation on the employment laws of all 50 states within the context of this article, I strongly recommend that any physician preparing to enter into an employment agreement meet with an attorney familiar with the employment laws in the state governing your contract.

WHEN IS AN EMPLOYMENT AGREEMENT APPROPRIATE?

Under the law in many states, an employee hired without an agreement is considered to be an "employee at will," meaning that the employer can fire the employee without cause, notice, or compensation (aside from compensation already earned) at any time. Although various federal and state statutes protect employees from age, sex, racial, and disability discrimination in the workplace, unless there is a verbal or written agreement to the contrary, an employee working for a business organization has no additional legal rights concerning dismissal.

Therefore, the first issue to address is whether it is in an employee's best interest to have a written agreement. The most obvious benefit of a written employment agreement is evidence of the terms of employment. Although a verbal employment agreement is valid and enforceable, the parties may subsequently dispute the exact nature of those terms, and the only evidence of the details will be the parties' own conflicting testimony. A written agreement can address a wide range of terms and provide the employee with certainty regarding his or her position at the practice. On the other hand, the ambiguity of a verbal agreement has advantages: some terms contained in a written agreement (such as a noncompete agreement) may be against the best interest of the employee. An employee who is planning on a short stay at a particular medical facility before moving to another job in the same geographic area may prefer a verbal agreement, trading a degree of uncertainty regarding the specific terms of employment for the freedom to change jobs.

NONCOMPETE AGREEMENTS

A medical practice that has an existing patient base may wish to restrict a new hire from competing with the practice when the employee terminates employment. It is not a question of if, but when the employee will terminate. In every employee/employer relationship, the employee will ultimately terminate employment, whether due to death, disability, termination (voluntary or involuntarily), retirement, or finding another job.

Enforceability

The enforceability of restrictive covenants presents an excellent example regarding the disparity of the states'

treatment of employment agreements. In some states, restrictive covenants are enforceable; in other states, the courts deem these covenants contrary to public policy and unenforceable. A third group of states will enforce such covenants subject to certain limits. In these states, the restriction must be limited as to time (often 1 to 2 years) and to a geographical area that bears a significant relationship to the actual business interests of the medical group. For example, a cardiologist in central Illinois whose practice serves a 50-mile radius of his office may be able to enforce a restrictive covenant that covers that 50-mile radius for a 2- or 3-year period. On the other hand, a cardiologist working within the Chicago city limits may only be able to enforce such a covenant within a 3- to 5-mile radius, and a cardiologist leaving that practice may only lose hospital staff privileges at one or two hospitals.

In addition to the limitations on enforceability, these agreements often face other stumbling blocks. Most states provide that any ambiguity in an agreement should be construed against the party who drafted the agreement (usually the employer). In addition, a restrictive covenant may not be enforced if the employer has materially breached the employment agreement (ie, not paid compensation or kept other promises, such as setting up a promised 401[k] plan). If an employer has failed to meet its contractual obligations, the employee can argue that the restriction would be unfair to enforce. Therefore, it is critical therefore that an employer strictly honor its promises if it wants to enforce a restrictive covenant. Finally, if an employee wants to break a restrictive covenant, the employee should seek legal counsel first to determine whether the state honors such agreements and whether the employer has met all of its contractual obligations.

Damages for Breach of Restrictive Covenant Not to Compete

Depending on how the restrictive covenant is drafted, the consequences of such a breach may be monetary damages, an injunction, or both. Monetary damages are generally a dollar award determined by the court or mediator to compensate the employer for lost revenue caused by the breach of agreement. An injunction would prohibit the terminated party from establishing a competing medical practice. Some parties agree in the employment contract to "liquidated damages," which represent the sum that the parties estimate that the employer would likely suffer if the employee were to breach the restrictive covenant. These liquidated damages are generally upheld (in those states that enforce restrictive covenants) so long as it is not perceived as a punitive amount. I recommend liquidated damages to my clients because these provisions reduce the likelihood of future court proceedings regarding the actual business loss incurred by the employer.

To Sign or Not to Sign?

When I represent employers, I encourage them to have a restrictive covenant to protect their patient base. It is unfair for a junior physician to move into a community, be introduced to the patient base and financially supported by the established medical practice, and then leave the medical practice and significantly damage it by taking a large number of patients. When I represent an employee joining a medical practice, I advise them to not enter into an employment agreement with a restrictive covenant unless they clearly intend to honor it or unless the restrictive covenant has a prearranged liquidated damages provision that will allow them to "buy out" of the restriction. The costs to both parties in any litigation to enforce or breach the restrictive covenant are time consuming, costly, and uncertain because courts are reluctant to enforce such restriction.

Extending the Period of Restriction of Practice

If a terminated physician goes to court to have the covenant not to compete declared unenforceable, a problem can occur because the court may not decide the issue for 2 or 3 years. If the terminated physician is successful in being allowed to practice during the litigation, the restricted period may thus be ineffective because the employee may be allowed to continue to practice during the litigation and patients will go to the employee. To alleviate this problem, a provision may be included in the employment agreement.

If the employee terminates employment, the period that the employee cannot practice within the restricted area can be automatically extended by the length of any period during which the employee is in breach of the noncompetition agreement and for any period that the medical practice institutes litigation to enforce the restrictive covenants. Therefore, the covenant will continue in full force and effect throughout the duration of such an extended period. For example, if the restricted period is for 2 years after employment and the litigation extends for 3 years after employment, and if the court rules in favor of the medical practice, the employee would be restricted from providing medical services within the restricted area for the 4th and 5th year after termination of employment.

Termination of Medical Staff Privileges

Upon termination of employment, the employee can also be required to terminate privileges at the hospitals

that are in the restricted area and not reapply for privileges at such hospitals for the restricted period after the date of termination of employment. The employee can irrevocably appoint the president of the medical group, or his designee, as the employee's attorney-in-fact to submit such resignations on the employee's behalf if the employee fails to do so after the effective date of the termination of employment. In connection with the relinquishment of such privileges, the employee waives any and all rights that the employee may have by virtue of such medical staff membership, including but not limited to, any rights to a fair procedure or due process under any medical staff bylaws, or rules and regulations thereof, or any part of or supplement thereto governing hearing and appeals.

MALPRACTICE INSURANCE

Deciding who pays the cost of professional liability insurance for the employee upon the employee's termination is probably the most critical and controversial provision in current employment agreements. The rising cost of malpractice insurance and the grim possibility of exposing your personal assets to a judgment makes this both a costly and essential area of negotiation.

Before analyzing the contractual issues, it is essential to understand a few basic concepts regarding medical malpractice insurance policies. Coverage of a physician under a malpractice insurance policy is triggered by events described in your insurance policy. There are two types of policies that have two very different triggers.

Occurrence Policies

These policies cover acts of malpractice that occurred during the policy year, regardless of when the patient or physician is first notified of the alleged malpractice.

Claims-Made Policies

These policies cover acts of malpractice when the claim is reported during that policy year, even if the malpractice occurred years before. This is an important distinction. If the physician is covered by an occurrence policy, he or she is covered for malpractice that occurred during the policy year, even if the malpractice does not manifest itself for years after the policy expires. Under the more prevalent claims-made policy, if the malpractice occurs in 2006 but no claim is made until 2008, the policy that was in effect in 2006 would not provide coverage. A physician under a claims-made policy who terminated employment at the end of 2006 would need to carry insurance to cover those claims that may arise from malpractice that occurred during 2006 but does not result in a claim until years later.

Tail Policy Coverage

The most common situation I encounter in negotiating employment agreements is whether the employer or the employee is responsible for purchasing the tail coverage for the professional liability coverage after termination of employment. A tail policy covers any lawsuit filed after termination of employment that relates to activities performed by the physician while an employee of the medical practice. Many years ago, most professional liability policies were occurrence policies. As a result, there was no need to buy tail coverage because the typical policy provided insurance protection for any claim made for acts that occurred while the physician was an employee, even if the claim did not arise until after termination of employment. Thus, if you are fortunate enough to be covered by an occurrence policy, the cost of professional liability insurance after employment is a nonissue. Unfortunately, most insurance policies today are claims-made policies, and it is that type of policy that most of my clients must deal with on a day-to-day basis.

The general rule has been that medical groups will pay for the professional liability coverage during the period the physician is employed. Once the physician terminates employment, however, most medical groups place the burden of purchasing the tail coverage policy on the terminating employee. One exception to this rule may occur if the particular medical specialty has a reasonable professional tail coverage cost.

When I represent medical groups, I always recommend that the medical group not pay for the tail coverage. When I represent the individual physician, I attempt to carve out situations in which the medical group would pay (ie, the employment agreement is terminated because the medical group has materially breached the agreement or the medical group terminates the employment of the physician without cause). Medical groups are hesitant to pay for tail coverage if they terminate the agreement for cause because it creates a litigious environment, which questions the meaning of "for cause" and "material breach."

An occasional compromise is that the medical group and the physician may agree that they will split the cost of tail coverage if the physician leaves for whatever reason in the short term. For example, if the physician's employment is terminated within 1 to 2 years of employment, the medical group may pay a portion of the cost (say 50%) and the physician pays the remaining 50%, so long as the physician leaves the area and does not compete with the medical group.

Many factors will determine which posture can be used in negotiating an employment agreement. If the physician is highly trained in a subspecialty, an existing

medical group may be willing to make an exception and provide tail coverage as an enticement to the physician to join the group. On the other hand, if the medical group has had disappointing experiences with physicians voluntarily leaving the group, and not as a result of the group not fulfilling its obligations, then it is more likely they will not make this accommodation.

Employment With Hospital Systems

Because of the economic climate, a number of physicians and physician groups have or are considering becoming employees of hospital systems. The major advantage of joining a hospital system is that the physician will be insured under the hospital system's professional liability policy as an employee. Thus, if there is a liability claim, the hospital will defend and pay for any claim because the physician is an employee, not an independent contractor. If you are entering into an arrangement with a hospital system, it is important to clearly identify the following factors: (1) whether you are an employee or independent contractor; (2) whether the hospital system's coverage is self-insured, or insured through a third party carrier; and (3) the terms and conditions of the hospital system's insurance policy. If it is an occurrence policy, there is no need for the physician to have to buy a tail policy when he or she terminates employment. On the other hand, if the hospital policy is a claims-made policy, it is extremely important that the physician's employment agreement with the hospital specify whether the hospital or the physician is responsible for paying for the tail coverage, if any.

Changes to Coverage

You should also be aware that when physicians join a hospital system or any other health care provider, the type of insurance coverage can change. Even if they have an occurrence policy on the date of employment, that may not be the situation at the time of termination of employment. Medical groups and hospitals change insurance coverage and policies from time to time, depending on the cost and other circumstances. Therefore, to fully protect yourself, you should clearly spell out in the employment agreement that upon termination of employment, the hospital system will pay all costs and expenses relating to professional liability coverage for the period of employment, including any required tail coverage, regardless of whether the hospital system has a claims-made or occurrence policy at the date of employment termination.

Self-Insurance Programs

Because of the dramatic increase in the cost of professional liability insurance policies from traditional insurance carriers, some medical groups have established their own self-insured insurance programs. When I negotiate an employment agreement for a physician who joins a medical group that has a self-insurance program, I first advise the physician of the major issues unique to such a program. The establishment of a self-insured program should only be considered if conventional insurance policies cannot be obtained, or the cost of conventional policies is economically prohibitive for the group. Extreme caution and care should be taken when establishing such a self-insured program.

A major detriment is the maintenance of sufficient reserves to cover several significant claims that may occur within a short period of time. Although self-insured programs generally have a supplemental insurance policy to cover a portion of the excess claims, any group seriously considering such a program should do an in-depth analysis of the self-insured program. The group should also analyze how to position the entity's assets and the physicians' individual assets in an asset protection program, in the event that the self-insured program does not have sufficient funds to pay significant claims.

CONCLUSION

Your ability to negotiate your employment agreement will be determined in large part by your economic reality and your own needs. If you do not plan to stay at a position long, you may prefer a verbal agreement and a handshake, with the parties filling in the details as you go along, leaving you free to join a competing practice at your leisure. On the other hand, a physician seeking employment at a sought-after practice with an ample supply of resumes may also find that there is no room to negotiate, even the most basic provisions. Regardless of your position, it remains important for all fellows to be aware of the terms of their employment agreement and to seek a legal opinion regarding any provision with which you are uncomfortable before you sign. ■

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