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BU$INESS MATTERS

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MAKE WAY FOR MORE PATIENTS

How to reimagine, renovate, and thrive.

BUILD A BIGGER—AND BETTER—PRACTICE

We have been dealing with the effects of an aging population in our clinics for years. Add in the FDA approval of therapies for geographic atrophy (GA), and we are scrambling to keep up with the growing demands of patient care.[1] Every retina practice should have a plan to handle the estimated 1 million US patients with GA who now have treatment options.[2] Even if you aren't ready to use the new therapies yet, patients are hearing radio and television ads and are coming to their appointments armed with questions—and we have to carve out precious chair time for additional patient education. So, what are we going to do?

If you aren't just referring GA patients to your buddy down the street, you are likely looking for ways to trim inefficiencies and save a few minutes here and there.

In 2021, long before GA therapy was muddying the waters of productivity, clinicians at Stanford realized that patients were spending nearly 1.5 hours in the clinic for each appointment. Lin et al set out to reduce the visit duration, starting with a root cause analysis, which revealed that imaging was a major bottleneck. They decided to train their technicians on multiple imaging modalities, relocate the equipment, and beef up the number of devices. The result? The average patient visit duration fell from 87 minutes to about 60 minutes—a 25% to 30% reduction.[3]

While this is impressive, that extra time can only take a practice so far. If you are already running as lean and mean as possible, the only way to add more patients is to expand. That's where this issue's featured article can help. Larry R. Brooks, AIA, an architect and practice flow advisor, provides key pearls for retina practices that need to add space without interrupting patient care. He covers everything from the initial needs assessment to the practical buildout to help you orchestrate a smooth expansion that will serve your growing patient population.

Once you've settled into your new space (or maybe when you can't focus on charting because of all the banging), check out the other articles in this issue, including a rundown of budgeting tips and tricks for that bigger practice, ways to protect your assets, and coding essentials for every retina specialist.

No practice is immune to the constant changes in the field of retina that force us to adjust our management approaches. With the information provided in this issue, you should be able to formulate some plans to improve patient care while maintaining a healthy practice. ■

ALAN RUBY, MD
SECTION EDITOR

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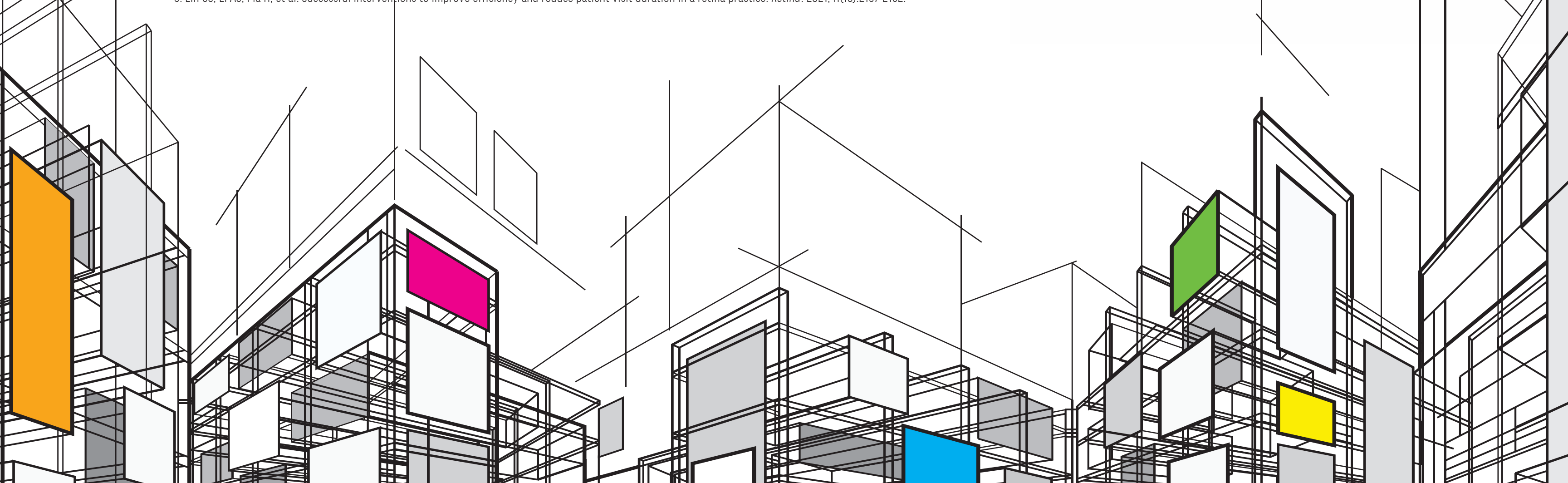

CODING ESSENTIALS TO MASTER SOONER RATHER THAN LATER

A little preparation upfront will save you from unnecessary claim denials and audit failures.

BY JOY WOODKE, COE, OCS, OCSR

When facing frequent claim denials, escalating accounts receivables, or consistent audit failures, the recurring theme echoed from retina specialists is, "I wish I had known this sooner." Often not a priority until a catastrophe emerges, achieving expert knowledge in retina coding and committing to ongoing education is a proactive measure that is essential to maintaining a viable retina practice. Here are four coding essentials you and your team should work on.

NO. 1. WHO IS THE PAYER?

Medicare usually publishes its guidelines, but other payers, including Medicare Advantage, commercial, and Medicaid, often have policies that vary. For example, in its National Coverage Determinations, Medicare only covers photodynamic therapy (PDT) reported as CPT code 67221 with a diagnosis of choroidal neovascular membrane secondary to AMD. There are also specific testing and documentation requirements outlined in the AAO's PDT documentation checklist.[1]

Alternatively, Aetna's policy for PDT covers this procedure for choroidal neovascular membrane due to AMD, pathologic myopia, presumed ocular histoplasmosis, or chronic central serous chorioretinopathy.[2]

Because of these nuanced coverage limitations, it is always best to answer the question, "Who is the payer?" before scheduling a procedure.

NO. 2. FIND AND CORRECT YOUR CODING MISTAKES BEFORE THE AUDITORS

Mistakes happen. But, if a Medicare auditor identifies your coding error, it will result in an audit failure, even if you were underpaid. For example, one of the top reasons for recent Supplemental Medicare Review Contractor audit failures was reporting the incorrect units for intravitreal injection medications.[3] Billing for 1 unit, instead of 2, 3, 5, or even 60 units, is not only a significant underpayment, but is also considered incorrect coding when auditing chart documentation. After the audit failure, the entire claim is recouped, and resubmission of a corrected claim may be denied due to issues with timely filing limitations.

To avoid an audit failure, and a declining cash flow, create internal reports to monitor all medication billing and identify errors at least monthly. This will allow you to resolve issues promptly with a voluntary refund and a subsequent corrected claim.[4] Along with using the correct units, ensure the appropriate medication was billed and indicated per FDA label or payer policies and the appropriate -JW or -JZ modifiers were employed.[5]

NO. 3. UNDERSTAND WHEN TO USE AN E/M OR EYE VISIT CODE

Appropriately maximizing reimbursement and avoiding denials depends on the correct coding of each office visit scenario, per payer. If you're exclusively reporting either E/M or eye visit codes, denials are inevitable, and reimbursements are unnecessarily low.

Armed with the current Medicare fee schedule and that of your top insurance payers, as well as a comprehensive knowledge of coding guidelines, you should review the chart documentation and select the appropriate level of E/M and eye visit code.[6]

Next, consider when you shouldn't report an eye visit code; for example, when the commercial payer has frequency limitations for the comprehensive eye visit codes, CPT codes 92004 or 92014.

Finally, choose the E/M or eye visit code based on the highest reimbursement. For example, if the E/M overall medical decision making is moderate for a new patient or CPT code 99204, this is the best selection over the eye visit comprehensive code, CPT code 92004. In 2024, choosing the E/M code for this scenario will be approximately $18 more for the Medicare Part B patient.

NO. 4. MASTER MODIFIERS

Understand the definition of each modifier and its appropriate use to minimize claim denials. For all procedures—including vitrectomies, intravitreal injections, and lasers—always report the appropriate anatomical modifier: -RT for the right eye, -LT for the left eye, or -50 for a bilateral procedure. This will help you avoid any claim denial due to a duplicate service or frequency limitations (eg, injections), which the Medicare Administrative Contractor for Kentucky and Ohio has reported as the top reason for claim denials in those regions.

Continue the mastery with a focus on office visit modifiers, or those to be reported only with an E/M or eye visit code.[7] These modifiers include:

- **Modifier -24:** An unrelated E/M service (or eye visit code) by the same physician during the postoperative period, or an office visit in the postoperative period not related to the original surgery (eg, new symptoms, significant changes in eye health requiring an evaluation of an unrelated problem or fellow eye)[8]
- **Modifier -25:** A significant, separately identifiable E/M service (or eye visit code) by the same physician on the same day of the procedure or other service, or an office visit on the same day as a minor surgery (0- or 10-day global period)
- **Modifier -57:** A decision for a major surgery, or an office visit on the same day or within 3 days of a major surgery (90-day global period)

Determining whether to use modifier -25 or -57 depends on the type of surgery (major or minor), which is defined by the global period. A decision for a vitrectomy (CPT code 67036) the next day, for example, would prompt the use of modifier -57 because this procedure has a 90-day global period.

Coding for retina laser procedures can be challenging, as the global periods vary between 10 and 90 days and the surgeries can be minor or major.[9] CPT code 67210, destruction of localized lesion of retina (eg, macular edema, tumors) with one or more sessions, has a 90-day global period, and modifier -57 would be applicable when a same-day examination is performed. Alternatively, CPT code 67228, treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), has a 10-day global period per Medicare and for most other payers. In this instance, when a same-day examination is performed and meets the definition of modifier -25, append it to the office visit code.

Next, understand when to append a surgical modifier to an additional procedure performed during a global period. The following should be considered for these scenarios:

- **Modifier -58:** A staged or related procedure or service by the same physician during the postoperative period
- **Modifier -78:** An unplanned return to the OR by the same physician for a related procedure during the postoperative period
- **Modifier -79:** An unrelated procedure or service by the same physician during the postoperative period

Modifier -58 has three definitions for use and is applicable for many retina procedures. First, when a lesser-to-greater procedure, or when a pneumatic retinopexy (CPT code 67110) is performed and then a repair of the retinal detachment is performed during the global period in the same eye (CPT code 67108), the subsequent procedure would be reported with modifier -58, as it is more extensive based on the definition and relative value unit.

Next, when preplanned and documented in the medical record that a subsequent procedure is planned in the global period, use modifier -58. For example, document that in the global period of pneumatic retinopexy, laser and/or cryotherapy is planned.

Finally, when an injection is performed in the global period to treat the same problem as the original major surgery, for example, report with modifier -58. ■

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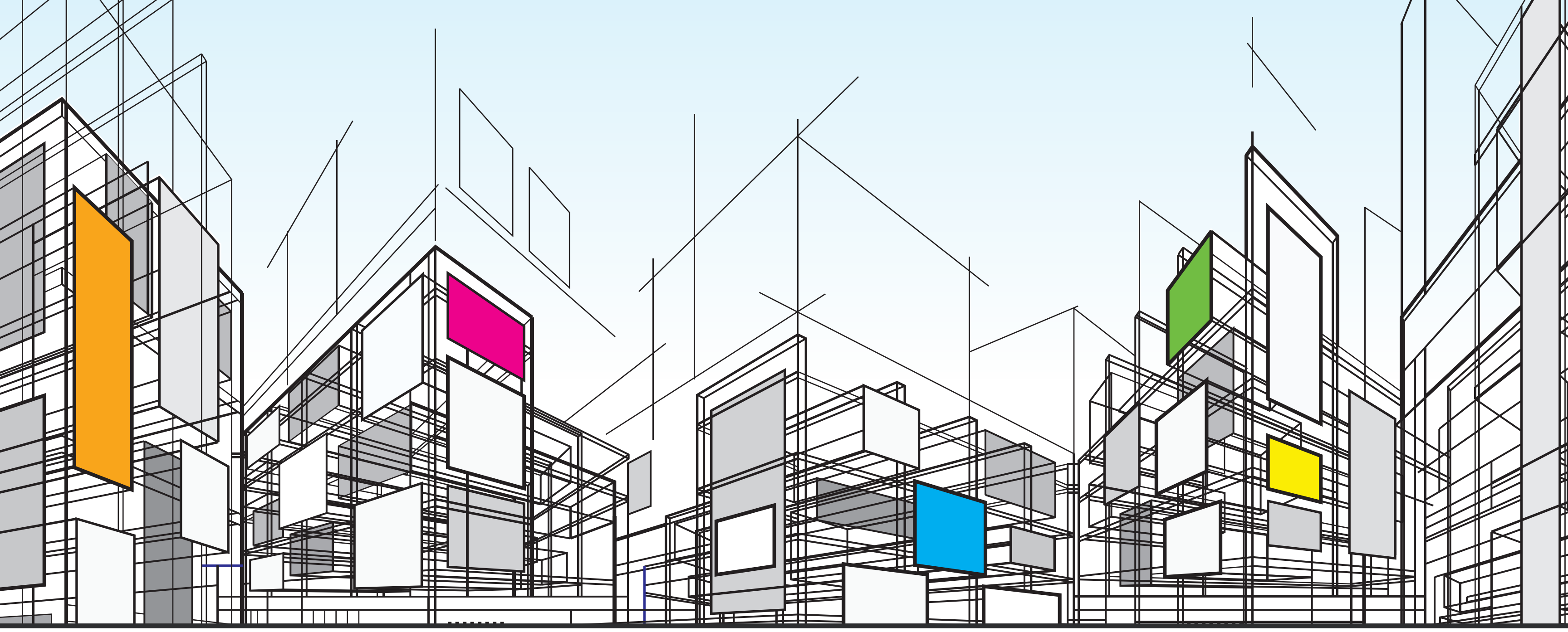

ADDRESSING SPACE CONCERNS IN THE RETINA PRACTICE

When patient volumes necessitate growth, here's what you can do to avoid disruption in the clinic.

BY LARRY R. BROOKS, AIA

As demand for retina care continues to grow and more office-based treatments are developed, retina practices are finding themselves handling higher patient volumes than ever before. This often means either finding ways to help current physicians be more productive or hiring more physicians. Both solutions create a physical space issue, and your team must find ways to add additional examination lanes, waiting space, and staff (and staff space).

In this article, I discuss how your practice can get more out of what you already have and how to get the most out of a necessary renovation/expansion with little disruption to your practice flow.

THE INITIAL ASSESSMENT

Whether working with the space you have or expanding, the first step toward addressing your needs is assessing the current practice flow, space usage, and productivity.

This practice flow assessment is an operationally focused evaluation of how you are using the current space and staff and how the physicians are using their time. The goals of this exercise are to: 1) identify how well the current office is supporting an efficient and productive practice flow, 2) pinpoint issues, and 3) brainstorm solutions. You and your team should concentrate on the following:

- how the physicians are using their time (eg, look at the physicians' weekly schedule to determine how many are in clinic at the same time);
- how long patients are waiting, whether in waiting

AT A GLANCE

- A practice flow assessment helps your team identify how well the current office is supporting an efficient flow, pinpoint issues, and brainstorm solutions.
- You can increase patient volume without adding space, potentially by adjusting the schedule to even out the number of physicians working at a time.
- When adding to your original footprint or converting non-patient care space into additional clinical space, look at the entire space to see how it should flow.

areas, imaging, or in the examination lanes;
- the rate of patient visits per day based on the appointment template; and
- the flow of patients based on visit types.

This information is important because all decisions pertaining to the practice's setup should be based on the best procedures that allow physicians to spend time practicing medicine, instead of lost to inefficient space, systems, or staffing models. These operational findings are then used to assess the current practice space to determine if it can be renovated or expanded to better support the practice. If not, a larger space may be required.

All too often, physicians believe the answer to eliminating wasted time in their day is to schedule more patients and have more examination lanes, but that is rarely the right approach.

Bottlenecks in practice flow are due to a disconnect in the input-throughput-output of the practice. Physicians are the output, and practice managers must know each physician's natural rate—how many patients they can see in an hour without any delays—to determine how everything upstream (ie, input and throughput, or the patient appointment template, tech workup, imaging, front desk tasks, etc.) should be set up. Using this model, patient scheduling should be determined as follows:

1. Each physician's natural rate determines how many patients per hour should be scheduled.
2. The natural rate plus the average amount of time staff requires to prepare the next patient determines how many lanes and technicians each physician needs.
3. The total rate of all doctors in the office at any given time determines how many parking spaces, waiting room seats, and receptionists are needed.

Once you have completed the time study for both physicians and staff (step 2 above), you can project the time needed for each patient; if this number does not match what the physicians feel is needed, assess the processes of the appointment template flow. For example, evaluate how patients move through the clinic and how many times they are handed off from technician to technician. Are injections done in an examination lane, or is the patient moved to an injection room? Are injections grouped into an injection clinic, or are they spread throughout the day? The answers to these questions can help you adjust the patient flow of the office and, hopefully, eliminate physician delays and increase productivity without adding examination lanes.

Don't forget to assess how long patients wait in examination lanes. Technicians only need to be one to two patients ahead of physicians, not three to four; preparing too far ahead occupies examination lanes unnecessarily and creates longer waits for patients in small, often uncomfortable rooms.

Figure 1. Practice A purchased space at the outset that was used as storage or subleased to the adjacent office until it was needed (A). When the practice was ready to grow, a careful renovation incorporated the new space beautifully (B).

IMPLEMENTING CHANGE

Once you have a full assessment of your practice's workflow and unmet needs, you can find ways to increase patient volume without renovating or adding space. For example, did you notice large disparities in the number of physicians in the clinic at once? If you have four physicians in the office on some days, but only two on others, adjusting the weekly schedule to even out the number of physicians working at a time (say, three) may be a better use of your space and limit examination lane bottlenecks. Changing a physician's weekly schedule is not an easy topic to broach, but all physicians should embrace the goal of efficiency and improving patient care with the lowest possible overhead.

A Bigger Footprint

If your assessment suggests that you don't have enough space, you may be able to address flow issues within your practice without moving offices entirely. Most practices do not have empty space just sitting around; therefore, this will require renovating to add additional space, or converting existing non-patient care space. Either way, you must find a way to transform your practice space while staying open with as little disruption to patient care as possible.

The best scenario is that you already thought of how additional space could be created when the time came. Let's discuss Practice A as an example (Figure 1). The practice owned space adjacent to the current office; it did not need the space initially, but the master plan included expansion when necessary. This additional space could be leased and subleased until needed, or the practice could

Figure 2. Practice B started with enough space to handle three physicians at a time. To squeeze in a fourth practitioner, it moved the business office functions across the hall (green).

Figure 3. Practice B used the entire floor of the building and then renovated both new and existing space to create an efficient workflow for a total of six physicians. In this solution, the general optometry patients go left, and the specialty/retina patients go right. To make the plan work, the practice took over the common hall that had initially split the practice. This flow also allowed a separation from the construction while the practice functioned normally. The practice moved into the new space and set up a temporary check in/out while the existing space was renovated.

have first right of refusal from the landlord.

If your practice did not plan for additional growth and your transformation needs to happen within your existing suite, the typical solution is to relocate non-patient care areas, such as administration and business office functions, to another location. During the COVID-19 pandemic, many practices moved business office functions to remote work, and that has remained a viable option for many even after the pandemic.

Although this provides more space for clinical activities, business space is rarely conveniently located to mesh into the current clinic. If you convert the back-office space into clinical space without blending it into your workflow, you risk exacerbating your flow issues.

When adding to your original footprint or converting non-patient care space into additional clinical space, look at the entire space—new and existing—to see how it should flow. The solution will probably require renovation beyond the new space, but doing so will create a much better solution.

The medical space planner and contractor will need to come up with a solution that allows the practice to stay open and minimize disruptions. The best approach is often renovating through phases. You can build out the new areas and then move portions of the practice into the new areas to free up other areas for renovation. During this process, some areas will be used differently for a short time, and temporary walls can help you separate construction zones from clinical space. Unfortunately, depending on the magnitude of the renovation, the practice may need to shut down for a day here and there. This is often done over a long weekend to minimize the disruption to patient care.

Let's discuss Practice B as an example. Initially, the practice had space to accommodate three physicians at once but often squeezed four into the schedule (Figure 2). The practice had already moved the business office functions across the hall but had reached a point that it needed to expand again to accommodate six physicians. Thus, the practice repurposed existing space and renovated new space to create a larger overall suite that addressed both flow issues and space needs (Figure 3).

GROW WITH CARE

Many retina practices are straining with the onslaught of patients in need of specialty care. For those who are ready to make a change, a careful renovation can make a huge difference in practice efficiency and help you better care for your patients. ■

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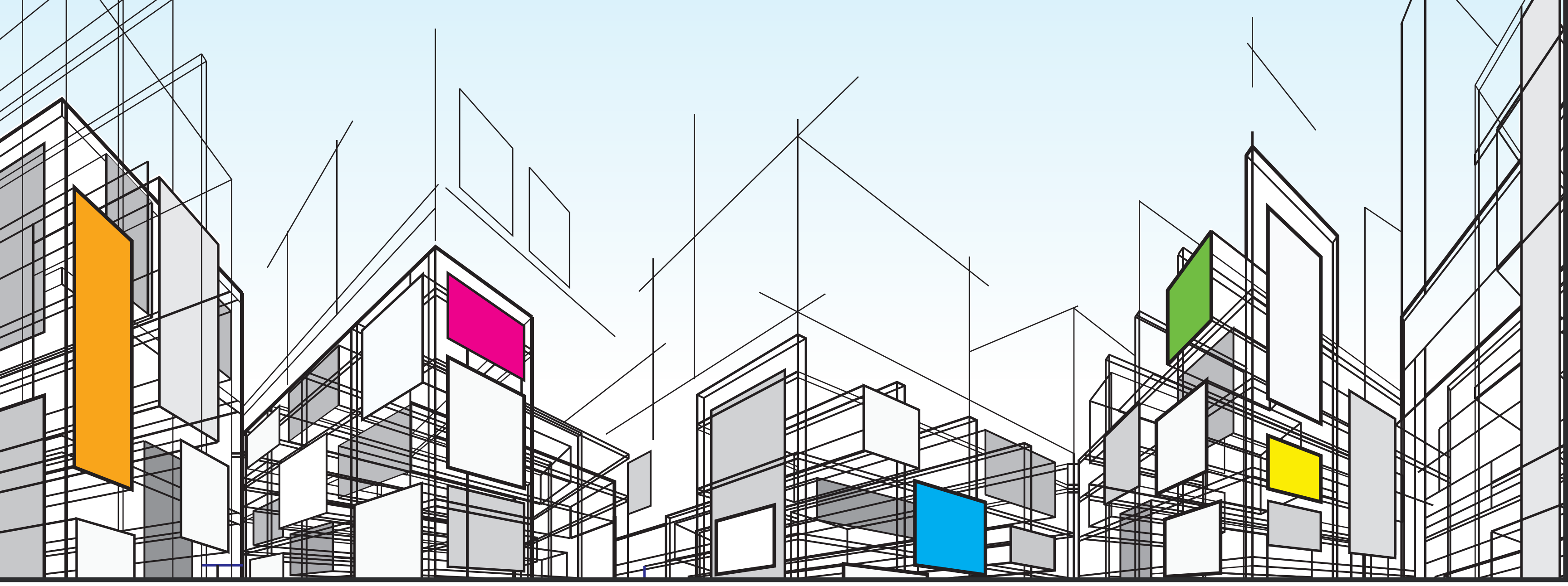

DEI IN CLINICAL PRACTICE

A summary of recent efforts in the clinic and beyond.

BY ALEX BRODIN, MA, ASSOCIATE EDITOR

Diversity, equity, and inclusion (DEI) in clinical practice is a two-pronged issue. It affects patients, many of whom are underserved and lack equitable access to care, and providers, particularly those who are underrepresented in medicine (URiM) and may not have equitable access to education and professional opportunities.

Patient-practitioner concordance (ie, shared identity between patient and provider based on a demographic attribute such as race, sex, or age) is important, and research shows a lack of concordance means patients are less likely to have visited an eye care practitioner.[1] This is unsurprising when you consider the persistent lack of diversity among eye care providers. One study showed a decrease in the percentage of American Board of Ophthalmology diplomates who self-identified as URiM ($P < .001$) between 1992 and 2020.[2] In addition, investigators found a 2.5% decrease in the percentage of female ophthalmology residents from 2011 to 2019 ($P = .02$).[3] Clearly, there is more work to be done.

This article highlights two programs—one patient-centered, one provider-centered—that aim to promote inclusivity within ophthalmic clinics.

CONNECTING WITH SOCIAL SERVICES

The Bascom Palmer Eye Institute (BPEI) created an ophthalmology-specific social services department to better serve its complex patients. The program offers a wide range of social services that are free of charge to patients (although associated interventions may be billed for), including psychosocial assessments, assistance with health insurance and housing issues, transportation, pre- and postoperative care, vision enhancement services, medication access, and more.

The efforts to create the program began in the 80s, when Myriam Lohr, an employee who worked in patient access at BPEI, noticed a significant population of patients who could not afford to adhere to their doctors' recommendations. Ms. Lohr worked with these patients and pharmaceutical companies to identify ways to help them access care through patient assistance programs. "The more interest she took in it, the more services she discovered that patients needed," said Basil K. Williams Jr, MD, in an interview with *Retina Today*.

The department was formalized when it hired its first licensed social worker, Maria Henao, LCSW, in 2017; today, the department consists of two licensed social workers and three additional staff.

AT A GLANCE

- A lack of patient-practitioner concordance means patients are less likely to have visited an eye care practitioner.
- The Bascom Palmer Eye Institute's ophthalmology-specific social services department offers social services that are free of charge to patients.
- Harvard University's Eye Can program uses a multitiered approach to support students and faculty at each level of education and development.

ONGOING EFFORTS

ADA & Genentech Awareness Campaign
Genentech and the American Diabetes Association have partnered to encourage patients with diabetes to pledge to have annual eye examinations.

University of Michigan Program
The University of Michigan Kellogg Eye Center's Ophthalmology Pathway program aims to increase the diversity of the ophthalmology residency applicant pool by offering mentoring, networking, and professional development opportunities.

Helping patients access medications is one of the largest functions of the department. "This is especially important for intravitreal injections for patients with diabetic retinopathy (DR), macular degeneration, and other conditions," Dr. Williams explained. "And for glaucoma, there is an assistance program for patients to obtain their eye drops." Research shows that certain vision-threatening pathologies, such as DR, requiring regular care and monitoring tend to affect underserved patients disproportionately. One study found that Black and Hispanic patients initiating anti-VEGF therapy presented with worse baseline DR compared with White and non-Hispanic patients ($P < .01$).[4] Thus, the department strives to ensure that underserved populations receive care as early as possible to prevent vision loss.

The department also helps uninsured patients acquire health insurance, as lack of insurance and challenges with health literacy are significant barriers to eye care.

Not every ophthalmology department or clinic has the resources to open a fully staffed social services department, but they can identify an employee or two who can work part-time on patient access and assistance programs.

"The goal of medicine in general is to take care of patients to the best of our ability and provide quality care for everyone," said Dr. Williams. "The psychosocial and emotional aspects of what our social services department offer are powerful and meaningful for a significant proportion of our patients. It's an opportunity to connect with the community and eliminate or, at the very least, reduce health disparities."

EYE CAN MENTORSHIP PROGRAM

Harvard University's Eye Can program is a multitiered approach to offer support for students and faculty at each level of education and professional development.

"The foundation of an inclusive community is an open, welcoming, and affirming environment in which everyone feels they truly belong," explained Joan W. Miller, MD, during her 2023 AAO Annual Meeting lecture, "Inclusion, Diversity, and Equity: Strategies for Building an Inclusive Community in Your Department, Institution, or Professional Group."[5]

The program includes several branches geared toward different student populations. The Harvard Retinal Imaging Lab Underrepresented in Medicine Mentorship Program was launched in 2021 to provide clinical exposure, research opportunities, and mentorship to URiM college students at Harvard. The program currently boasts 109 members, including students and mentors.

The Harvard Ophthalmology Research Scholars Program provides URiM medical students with a mentored experience in ophthalmology, including a summer research project with clinical shadowing, weekly mentoring sessions, and authorship on a case report with a resident and faculty member. The program provides ongoing mentorship throughout medical school and support for the scholars to return to the university's annual alumni meeting.

The Harvard Ophthalmology Faculty Mentoring Program was established in 2014 to support faculty in understanding the complicated promotion process, as well as professional development through societies. The program pairs a junior faculty member with two senior faculty mentors and specifically tracks the URiM faculty to ensure equitable career growth. Currently, 88 mentors are working with 158 junior faculty mentees in the program.

"Whether your organization is an academic institution or a private practice, it's important to sponsor your junior ophthalmologists in leadership opportunities," Dr. Miller emphasized in her lecture. Mentorship need not exist in universities alone but can be put into practice wherever more senior ophthalmologists are willing and able to lend support to those who are younger or URiM. Beyond an official mentorship initiative, creating an affirming environment should be a top priority for any practice.

ROLL UP YOUR SLEEVES

The programs highlighted here are doing important work to eliminate disparities among patients and providers, and the key components—mentorship, community engagement, and empathy—are transferable, no matter the size of your department or clinic. Be creative, and use what you have, to make a difference in your community. ■

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PRACTICE MANAGEMENT

BUDGETING FOR THE RETINA PRACTICE

A financial roadmap can help you navigate today's challenging environment.

BY ANDREW MALLER, MBA, COE

Since the COVID-19 pandemic, retina practices have faced many challenges that have affected the financial health of their organizations. Some of these challenges are based on macroeconomic factors, such as inflation, rising interest rates, and the threat of recession. Factors specifically affecting medical practices at the microeconomic level include lower reimbursement rates, staff wage inflation, and the increase in cost to run a successful business. These factors have negatively affected profit margins, threatening retina practices' ability to remain financially viable.

To thrive in this environment, retina practices must take a disciplined approach to managing all facets of their organization. One of the most common tools to achieve this is a practice budget, which serves as the financial roadmap to navigate challenges that may arise.

While most practice leaders would agree that financial planning and forecasting is an important piece of financial management, the reality is that most practices do not go through a formal budgeting process each year. Reasons may include the amount of time the process takes, inability to make accurate projections, and lack of buy-in from physician ownership and administration. While these reasons may be valid barriers, the economic challenges practices face today leave them no choice but to be proactive and make budgeting a priority.

WHY CREATE A BUDGET?

Before breaking down the steps to create a meaningful budget, it's important to consider the benefits of undertaking this process. When done properly, the benefits easily outweigh the hindrances, and may include:

- Predicting future results by measuring historic and current practice performance, such as the profit and loss statement (P&L), productivity reports, payroll and staffing trends, etc.;
- making plans toward the practice's short- and long-term financial goals;
- providing a sense of financial control by removing the guesswork; and
- addressing threats and analyzing business opportunities, such as assessing staffing needs and growth prospects, purchasing new equipment, etc.

THE BUDGETING PROCESS

The budgeting process can be boiled down into four essential steps:

1. **Reviewing** historical data,
2. **assessing** changes likely to affect the practice in the budget year,
3. **forecasting** future productivity levels and operating expenses, and
4. **integrating** the budget into monthly management reports and strategic conversations.

Step No. 1: Review Historical Data

Although there is never a wrong time to start budgeting, ideally the process should begin 2 to 3 months before the forecast year; thus, preparation should start in October or November to budget for the upcoming calendar year.

The entirety of the process should not fall on the shoulders of the practice administrator; rather, it is critical to form a budget workgroup consisting of administration, department heads, and physician owners. This ensures all viewpoints are considered, which is particularly important in larger practices.

During initial planning meetings, it is important to gather the relevant historical information. Although this will vary by practice, some of the most important pieces of information will include the following:

- Financial statements for the current year-to-date (YTD) and previous 2 fiscal years;
- the typical payment cycle to drug vendors for injections (be aware of whether your practice takes advantage of longer payment terms, which can distort true financial results);
- production reports for each provider showing total charges, payments, and volume for the same time period (although production should be measured

TABLE 1. POTENTIAL FACTORS AFFECTING PRACTICE FINANCES	
External Factors	**Internal Factors**
Medicare fee schedule changes	Provider schedules, especially for newer physicians and others who may be slowing down
Commercial fee schedule changes for top 10 payers	Staffing levels and increased wages
Merit-Based Incentive Payment System	Facility changes
Interest rates and overall economic effect	New equipment or service lines

TABLE 2. SAMPLE PHYSICIAN REVENUE FORCAST			
Current Year (through October)	**MD 1**	**MD 2**	**Total**
Professional fee collected revenue	$900,000	$1,200,000	$2,100,000
Patient encounters	4,500	4,000	8,500
Clinic sessions	250	200	450
Revenue rate per patient encounter	$200	$300	$247
Patient encounters per clinic session	18.0	20.0	18.9
Budget Year	**MD 1**	**MD 2**	**Total**
Estimated clinic sessions	300	250	550
Estimated patient encounters (based on current year)	5,400	5,000	10,400
Estimated revenue by provider (based on current year revenue rate per patient encounter)	$1,080,000	$1,500,000	$2,580,000

based on professional payments only, production by J-code should also be considered when looking at the drug expenses on the P&L statement);

- clinic sessions or days worked by each provider using metrics, such as patient visit volume per clinic session;
- employee data, including staff roster, payroll report showing total gross wages and hours worked per employee, and benefit costs per employee;
- building and equipment lease information; and
- capital expenditures.

Once these historical data have been gathered and reviewed, practices can move on to the next step of the budgeting process.

Step No. 2: Assess Changes in the Budget Year

This step usually involves more of a strategic discussion, during which the budgeting team considers various external and internal factors that may affect financial results. This important step is often overlooked, but developing an accurate forecast is difficult without this discussion (Table 1).

Step No. 3: Forecast Revenue and Expenses

It is now time to start building the first draft of the budget. The setup should look like the P&L statement for the practice, which can be produced by matching the various revenue and expense categories in a spreadsheet or using a template from the practice accounting system. Start by taking the YTD results from the current year and dividing them by the number of months to create monthly averages, which will be useful for creating the various revenue and expense forecasts.

A practice will likely use a combination of objective and subjective data points to estimate its revenue forcast. The practice must gather a few key YTD data points from the current year, including professional revenue, patient visit volume, and the number of clinic sessions worked (Table 2). This will allow for the creation of specific metrics

TABLE 3. SAMPLE EMPLOYEE WAGE SUMMARY						
Employee Name	**Current Salary**	**Payroll Taxes**	**Wage Increase (%)**	**Budget Salary**	**Payroll Taxes**	**Benefits**
Tech 1	$60,000	$4,500	10%	$66,000	$5,000	$5,000
Tech 2	$50,000	$3,800	3%	$51,500	$3,900	$5,000
Front Desk	$45,000	$3,700	2%	$45,900	$3,750	$5,000
Biller	$60,000	$4,500	3%	$61,800	$4,700	$5,000
New Hire	$0	$0	0%	$55,000	$4,300	$5,000
Total	**$215,000**	**$16,500**		**$280,200**	**$21,650**	**$25,000**

that can be used to create the forecast in the budget year.

It is important to factor in potential changes between the current and upcoming budget year, such as anticipated schedule changes or newer providers who have been ramping up. Be sure to look at each provider individually to anticipate such changes and the corresponding effect on the budget.

Projecting operating expenses can (and should) be a granular process for many of the larger expense categories, but other, smaller categories be can forecasted through a simple projection (eg, with a percentage increase or decrease).

Staff-related costs for nonprovider employees tend to be the largest fixed expense for a practice, often representing more than 30% of revenue or more. Practices should take a detailed look at each department and employee to forecast current wages and perform a needs assessment for anticipated hires in the budget year (Table 3). Be sure not to project only gross wages, but also payroll taxes and benefits. Other expense categories may include:

- **Occupancy:** Use your historical data to predict changes in base or additional rental costs.
- **Capital:** Although sometimes separate from the P&L statement, many practices also create a capital budget to estimate the effect of new equipment needs, furnishings, leasehold improvements, etc. It is important to identify the timing, anticipated cost, financing terms, and depreciable life of the asset. Depending on the purchase method, the practice will likely incur depreciation and interest expenses, which should be factored into the budget.
- **IT:** The budgeting period is a perfect time to assess new IT equipment needs, such as computer equipment and software licenses.
- **Drugs:** As mentioned earlier, the timing of drug expense payments can muddy the financial results of the practice. Practices should match the estimated projected expense with the expected revenue. For example, if the estimated revenue or volume from a certain drug can be projected, simply use the cost per unit as the estimated cost.

This list is not exhaustive, and smaller expense categories should also be projected to build an accurate budget. Consider examining each expense type and forecasting whether the expense will increase, stay the same, or decrease in the budget year. Then assign a percentage change from the current year expense.

Step No. 4: Integrate the Budget

At this stage, the first draft of the budget is now complete. Unfortunately, some practices consider this the end of the process, which may result in failure to actively use the budget as a true management tool. Rather, consider the budget to be a living document that gets fully integrated into the financial performance review and regular strategic conversations.

For practices that put together monthly financial and performance summaries, consider adding a section to compare actual results versus the budget forecast versus the previous year's performance during the same period.

STAY ON TOP OF IT

A proactive, comprehensive budget enables practices to properly track results, identify areas of concern, and quickly intervene when issues arise. Most importantly, a living budget allows practices to navigate the numerous challenges of today's marketplace. ■

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ASSET PROTECTION: AN ONGOING PRIORITY

The sooner you protect yourself, your practice, and your family, the better.

BY DAVID B. MANDELL, JD, MBA

Physicians of all specialties typically prioritize asset protection in their wealth planning goals—along with tax reduction, retirement modeling, and investment growth—and ophthalmologists and retina specialists are no different. This is particularly important given the potential liability from employee claims, HIPAA violations, and other risks related to the practice of medicine.

When considering liability risks, medical malpractice liability is typically top-of-mind. This awareness has been even more prominent in the last year due to an enormous medical malpractice judgment that made waves within and beyond the medical profession.

You may have read about this headline-grabbing 2023 malpractice case, in which Chris Maragos, a former captain of the NFL Philadelphia Eagles, sued his orthopedic surgeon and the medical practice itself.[1] After the trial, in which many high-profile athletes testified on behalf of Maragos and several surgeons testified on behalf of the defendants, the jury handed down a verdict that awarded $43.5 million in damages. Notably, the liability was split—the surgeon owed $29.2 million and the practiced owed $14.3 million. Thus, the medical practice and its partners (at least through their value in the practice) are now faced with a significant debt, even if they were completely uninvolved with the care of this patient.

Since this verdict was announced, I have seen a sharp uptick in questions from physicians of all specialties about protecting personal and practice assets. In this article, I define *asset protection* and highlight the importance of this type of planning for physicians.

ASSET PROTECTION DEFINED

The goal of asset protection planning is to position a physician's assets in such a way that it makes it difficult, and in certain cases nearly impossible, for a future lawsuit plaintiff to gain access to them. A well-executed asset protection plan will surely help physicians feel more secure knowing that they will not lose what they have worked so hard to build.

A fundamental concept retina specialists should understand about asset protection planning is that it is a discipline of degrees, not a black and white or vulnerable versus protected analysis. We use an asset protection rating system to rank a physician's assets from -5 (completely vulnerable) to +5 (superior protection). The goal is to move as much wealth as possible from the negative vulnerable positions to the higher, positive protected positions—ideally with as little cost and interruption as possible.

PERSONAL ASSET PROTECTION PLANNING

Personal asset protection encompasses shielding a physician's home, retirement accounts, other investment accounts, second home or rental real estate, and valuable personal property.

State Exempt Assets

We typically recommend that physicians leverage their state's exempt assets as a priority, because these assets enjoy the highest (+5) level of protection, and these assets involve no legal fees, state fees, accounting fees, or gifting programs. In other words, you can own the exempt asset outright in your name, have access to its value, and still have it 100% protected from lawsuits against you.

Each state law has assets that are absolutely exempt from creditor claims, thereby achieving a +5 protection status. For example, many states provide exemptions for qualified retirement plans and IRAs, cash in life insurance policies, annuities, and primary homes. Make sure you seek an asset protection expert to determine the exemptions that apply to your situation.

In some states, tenancy by the entirety (TBE) can be a valuable ownership form for married physicians, as certain assets in such states are protected completely from a claim against only one spouse. Approximately 20 states have TBE protections for some types of assets. As is the case with all exemptions, the rules vary widely among the states, and expertise is needed here.

A WELL-EXECUTED ASSET PROTECTION PLAN WILL SURELY HELP PHYSICIANS FEEL MORE SECURE KNOWING THAT THEY WILL NOT LOSE WHAT THEY HAVE WORKED SO HARD TO BUILD.

Other Asset Protection Tools

Beyond exempt assets and TBE, basic asset protection tools, such as family limited partnerships (FLPs), limited liability companies (LLCs), and certain types of trusts should be considered. FLPs and LLCs provide good asset protection against future lawsuits, as well as potential income and estate tax benefits, and they allow the LLC/FLP manager or general partner (typically the physician and/or their spouse) to maintain control. Specifically, these tools will usually keep a creditor outside the structure through "charging order" protections, which often create enough of a hurdle against creditors to allow the physician to negotiate a favorable settlement. For these reasons, we often call FLPs and LLCs the "building blocks" of a basic asset protection plan.

There are many types of trusts that also provide significant protection for physicians. These can range from life insurance trusts and charitable remainder trusts to grantor retained annuity trusts and domestic asset protection trusts. Each type of trust has its own set of pros and cons, costs, and benefits. For now, it is important to understand that only irrevocable trusts provide asset protection benefits. Although revocable trusts are valuable for estate planning and incapacitation planning (and many physicians have implemented such trusts for these reasons), they do not provide any asset protection benefits, at least while you are alive.

For all FLPs, LLCs, and trusts, the asset protection benefits rely on proper drafting of the documentation, proper maintenance and respect for formalities, and proper ownership arrangements. If all these are in place, a physician can typically enjoy solid asset protection for a relatively low cost.

THE IMPORTANCE OF TIMING

The timing of asset protection plays a fundamental role in its effectiveness. This is because federal law and the laws of every state have what are called *fraudulent transfer laws*, *fraudulent conveyance laws*, or, most recently, *voidable transaction laws*. These laws can be used by a judgment creditor to undo any transfers made after liability is "reasonably foreseeable." Thus, the longer the time between the implementation of asset protection planning and the occurrence of a liability situation, the better.

PROTECT YOURSELF AND OTHERS

Practicing as a retina specialist comes with inherent risks, primarily from medical malpractice, as a recent legal case demonstrates. Asset protection planning can help all physicians protect their assets in the event liability does occur. ■

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Reference: 1. Data on file. Regeneron Pharmaceuticals, Inc.

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