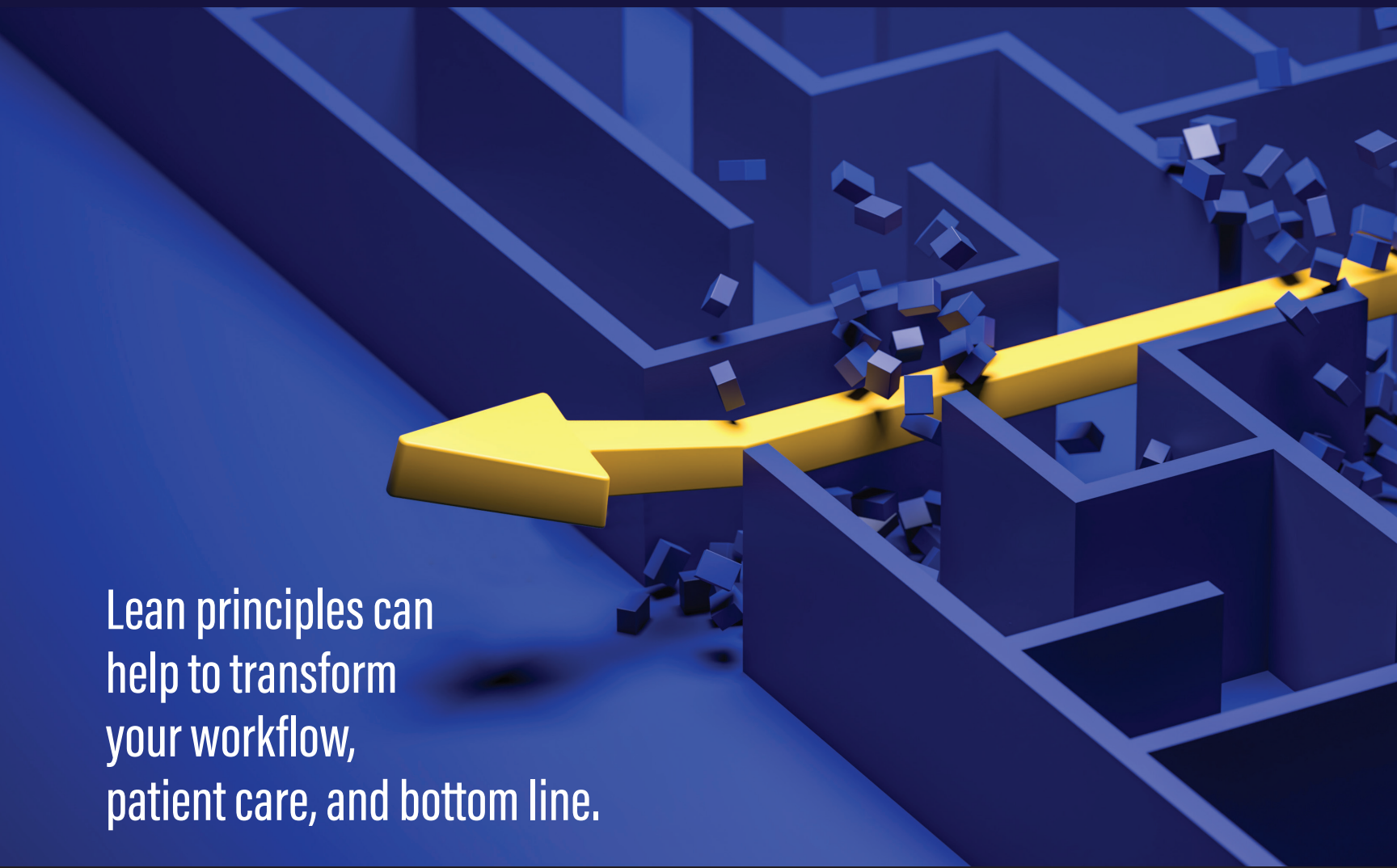


BUSINESS MATTERS

RT
Retina Today

IMPROVING EFFICIENCY IN YOUR RETINA PRACTICE



Lean principles can
help to transform
your workflow,
patient care, and bottom line.

WET AMD EYE

ANTI-VEGF

Therapy yields better long-term VA results when wet AMD detected with good VA¹

FELLOW EYE

20/79 VA

Mean VA of fellow eyes at wet AMD diagnosis according to real-world data¹

Over 60% of wet AMD “fellow eyes” lose too much vision¹—
even with frequent treatment visits

Detect Early. Treat Early.

ForeseeHome is a **remote monitoring** program for at-risk wet AMD fellow eyes that helps **detect conversion** at 20/40 or better in 83% of patients.²

✓ FDA Cleared ✓ Medicare Covered

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AMD Monitoring Program



Introduce your patients to ForeseeHome during an injection visit and offer them an extra level of protection.

Our Monitoring Center works with your staff to easily implement an “inject and protect” protocol into your practice workflow that requires minimal effort or additional time.

The Key to Successful Home Monitoring

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Verification &
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Continuous
Monitoring



Practice Workflow
Implementation

Remote Patient
Management

Vision Alert
Management



ForeseeHome is a registered trademark, and the ForeseeHome AMD Monitoring Program and logo and the Notal Vision logo are trademarks of Notal Vision. © 2021 Notal Vision, Inc. All rights reserved.

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See website for FDA Indication for Use.

SM-125.3



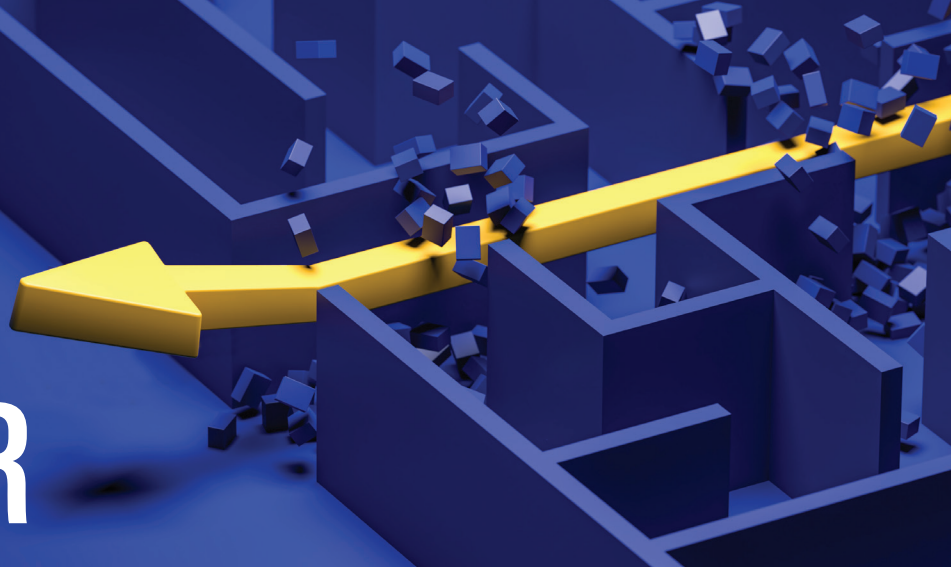
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SMARTER, NOT HARDER



The retina community met the FDA approval of pegcetacoplan (Syfovre, Apellis Pharmaceuticals) for the treatment of geographic atrophy with applause and sighs of relief—followed quickly by sparks of panic. The therapy is yet another long-term intraocular injection (so is the next drug under review, avacincaptad pegol [Zimura, Iveric Bio]). Many of our clinics are already straining under the injection burden, and finding storage space might as well be an Olympic sport with competition between branded therapies, biosimilars, and now this new therapeutic.

So, we must find ways to improve our scheduling, clinic workflow, back-office routines, and any number of other areas of our businesses. Efficiency has always been the name of the game in retina, but now more so than ever. But being more efficient doesn't mean you have to limit patients to one personal story per visit, jog between examination rooms, or brush up on your stenography skills. Instead, you can work smarter, not harder, and that's what the lean approach is all about.

This month, our featured article identifies a few simple steps to help you embrace the lean philosophy in your clinic. This approach can help you reduce waste in your daily routine, eliminate errors, improve patient care, and boost your return on investment—without requiring Olympic speed. Sounds great, doesn't it?

It does come at a cost, though. Luckily, the cost is little more than your time, some organization upfront, and a willingness to change. The last of these requirements should be easy for us because change practically defines the field of retina these days. We have become quite adept at synthesizing clinical trial data to inform our decisions to recommend new therapies or try out novel surgical techniques. So, if I had to guess, using data to help inform our decisions to adjust our business approach and office workflow should come as second nature. It's certainly worth a try, as we are already adjusting our clinics to accommodate an entirely new patient population in need of care.

If you and your team are already working together like a well-oiled machine, a few other articles in this issue might be of interest. Experts discuss harassment and discrimination in the retina practice, including how the COVID-19 pandemic brought to light new issues we all must address. Our financial gurus touch on estate planning and why it's important to start thinking—and planning—now, long before true end-of-life decisions must be made. Finally, Joy Woodke, COE, OCS, OCSR, has a fun coding quiz to help test your coding prowess.

The dust never seems to settle in our field, and the best way we can stay agile is to stay efficient. Keep it lean, and you will be ready for whatever our researchers have in store for us. ■

ALAN RUBY, MD
SECTION EDITOR

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CODING ADVISOR

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CRACKING THE CODE: FIVE RETINA CASES TO TEST YOUR KNOWLEDGE



From vitrectomy to internal limiting membrane peeling, can you identify the correct way to code these procedures?

BY JOY WOODKE, COE, OCS, OCSR

Coding retina case studies can often be difficult, especially when it comes to identifying the correct answer. For example, when multiple procedures are performed on the same day, National Correct Coding Initiative (NCCI) bundles should be considered. Unique payer policies may also affect correct coding. Here are five scenarios that have stumped your peers. From commercial carrier denials to missing information, these scenarios present a variety of coding challenges that require careful consideration. Can you identify the correct answer?

CASE STUDY NO. 1

The following current procedural terminology (CPT) codes were billed for the same surgical session:

- 67036, vitrectomy, mechanical, pars plana approach
- 66985, insertion of IOL prosthesis (secondary implant), not associated with concurrent cataract removal
- 66682, suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)

These three codes are not bundled under NCCI. However, the commercial carrier denied CPT code 66682. Why?

- A. The payer does not cover this procedure.
- B. There is separate procedure language in the CPT code descriptor.
- C. The procedure is incidental to the secondary implant.
- D. The payer bundles this procedure with the vitrectomy.

CASE STUDY NO. 2

The superbill states an injection of triamcinolone (Kenalog) was performed in the right eye. What else do you need to know to code this case?

- A. The type of injection.
- B. The medication dosage.
- C. If it was single-use or a multidose vial.
- D. All the above.

CASE STUDY NO. 3

Medicare denied the removal of silicone oil in the global period of retinal detachment surgery in the same eye. The case was reported as CPT code 67036–78-RT, pars plana vitrectomy (PPV) and ICD-10 code T85.39XA, other mechanical complication of ocular implants. Why was this claim denied?

- A. Incorrect modifier
- B. Incorrect CPT code
- C. The ICD-10 code is not included in the national coverage determination (NCD) for CPT code 67036
- D. Medicare does not cover surgery in the global period

CASE STUDY NO. 4

A patient is evaluated for floaters in both eyes. A medically appropriate history and examination are performed along with bilateral extended ophthalmoscopy, including a detailed drawing and labels of the pathology. The diagnosis is a posterior vitreous detachment in the right eye and a retinal

CODING QUICK LINKS



Medicare Part B Policies



Retina Coding: Complete Reference Guide



Retina Today Coding Advisor Column

tear in the left eye. The plan is to laser to repair the retinal tear. How should you appropriately code this case?

- A. 99204–25, 92201–59, 67145-LT
- B. 99204–57, 67145-LT
- C. 99204–25, 92201, 67145-LT
- D. 67145-LT

CASE STUDY NO. 5

The retina specialist performed a vitrectomy with internal limiting membrane (ILM) peel and then placed an amniotic membrane under the macular hole in the right eye. What is the correct way to code this?

- A. 67041-RT, PPV with removal of preretinal cellular membrane (eg, macular pucker)
- B. 67042-RT, PPV with removal of ILM of retina (eg, for repair of macular hole, diabetic macular edema)
- C. 67042-RT and 65778-RT, placement of amniotic membrane on the ocular surface, without sutures
- D. 67042-RT and 67299-RT, unlisted procedure, posterior segment

ANSWERS AND DISCUSSION

Case No. 1 Answer: B

Although Medicare will not deny due to separate procedure language, many commercial plans will. These plans don't expect CPT codes with separate procedure language to be reported when any other procedure is performed on the same day.

Case No. 2 Answer: D

If any of this information is missing, not only do you lack the information necessary to code the case, the documentation is incomplete if audited. First, confirm if an intravitreal injection (CPT 67028) or a sub-tenon injection (CPT 67515) was performed. Next, check the dose of triamcinolone and the vial used, either single-use or multidose. Triamcinolone is reported with HPCS J3301

and the descriptor "injection, triamcinolone acetonide, not otherwise specified, 10 mg." If a multidose vial was used for 4 mg, report 1 unit for the medication used, which would include a dosage of 10 mg or less. For a single-use vial that includes 40 mg and a dosage of 4 mg and 36 mg wasted, report J3301 1 unit and J3301–JW 3 units.

Case No. 3 Answer: C

Per the Medicare NCD for vitrectomy (80.11),¹ T85.398XA is not a covered diagnosis.² Instead, report the retinal detachment ICD-10 diagnosis as the primary diagnosis and the reason for the surgery; report T85.398XA as secondary.

Case No. 4 Answer: A

Extended ophthalmoscopy, CPT code 92201, is bundled the same day as CPT code 67145 with an indicator of 1, comprehensive, which means that there may be circumstances appropriate to unbundle.³ When performed in the fellow eye and pathology is documented, it is appropriate to unbundle with modifier –59, or –XS (separate structure) per the payer preference. Make sure that you link the ICD-10 code for the fellow eye only to CPT code 92201 to justify unbundling the two procedures.

Case No. 5 Answer: D

CPT code 67042 is the appropriate code for a PPV with ILM removal. There is no CPT code that represents the placement of amniotic membrane under the macular hole. Report CPT code 67299 (unlisted procedure, posterior segment) and submit the operative report to the payer for review.

RINSE, REPEAT

So, how did you do? Retina coding is a complex field that requires attention to detail and a comprehensive understanding of coding guidelines. By reviewing these five case studies, you can better understand common coding challenges and the steps required to overcome them. As always, it is important to stay up to date with the latest coding guidelines and seek the advice of a qualified coding specialist when necessary. To review more cases, visit www.aao.org/practice-management/coding-news. ■

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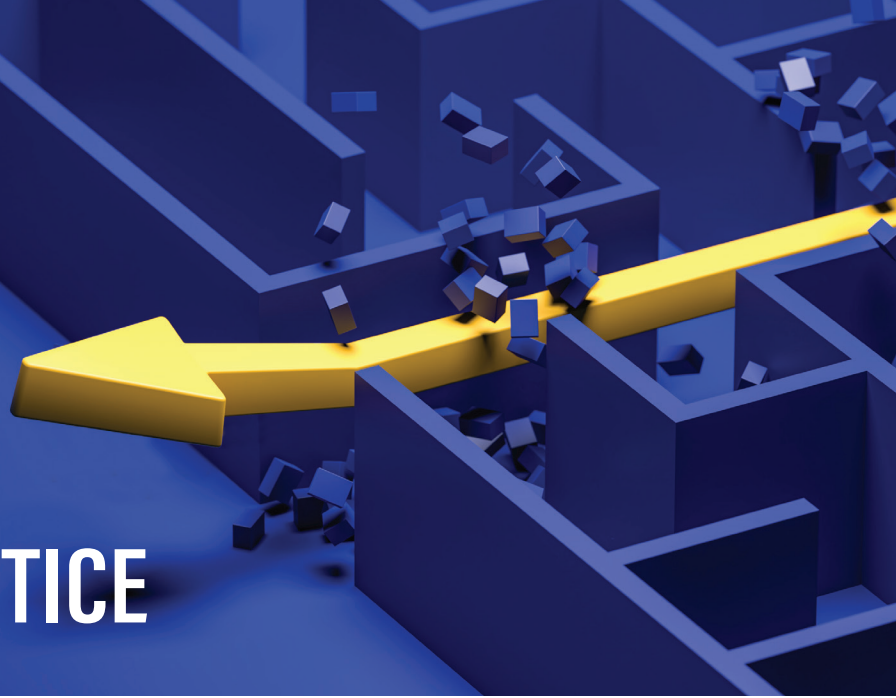
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HOW TO IMPROVE EFFICIENCY IN YOUR RETINA PRACTICE



Use the lean approach to bring significant value to your patients and your bottom line.

BY ELIZABETH MONROE, MA, COE, CPSS, PHR, AND LAURIE BROWN, MBA, COMT, COE, CPC, CPMA, LSSYB

In today's environment, retina practices have unique challenges related to operational efficiency and patient flow. These issues emerged when intravitreal injections became the standard of care for specific diagnoses, and it has only increased. Patients require frequent follow-up appointments and ongoing injections, and the newly approved therapy for geographic atrophy now adds a whole new patient population potentially seeking ongoing treatment in your office. As a result, you have probably experienced problems scheduling new patients, adding follow-up injections, and staying on time. To help address scheduling and patient flow, consider approaching your processes from a lean perspective.

Lean is a collection of principles, tools, and methodologies designed to improve process efficiency while minimizing waste and delays. The lean method removes the trial-and-error approach to problem-solving by using data. Applying lean principles can help you accomplish the following:

- find and eliminate causes of errors,
- reduce cycle time and cost of operations,
- improve productivity,
- better meet patient expectations,
- achieve higher asset use, and
- provide an improved return on investment.

In this article, we outline some lean process tips so you can implement continuous improvement in your busy practice.

IDENTIFY PROCESS WASTE

To begin, consider these two ways to measure patient value: 1) The patient perceives that the service or activity brings them value, and 2) the patient is willing to pay for it. All other clinic activities are considered waste under the lean methodology.

With that mindset, can you consider a few improvement areas to minimize waste and delays in your retina practice? For examples, see *Common Issues That May Lead to Waste*.

AT A GLANCE

- ▶ Lean is a collection of principles, tools, and methodologies designed to improve process efficiency while minimizing waste and delays.
- ▶ If the patient doesn't perceive a service or activity as valuable, and they aren't willing to pay for it, it's considered waste under the lean methodology.
- ▶ The DMAIC framework (define, measure, analyze, improve, and control) assists in an orderly, logical flow when improving a process.

WITH LEAN PRINCIPLES, YOUR RETINA PRACTICE CAN IMPROVE ITS PROCESSES AND PATIENT WAIT TIMES, BUT IT IS A MULTI-STEP UNDERTAKING.

BUILD YOUR BUSINESS CASE

Once you identify an area in your practice that needs attention, build a business case to improve the issue. Ask yourself these questions: Why should we improve this process? How will this improve the patient experience? How will this benefit us financially (ie, lower costs, increase

efficiency, improve quality, achieve consistency, or improve patient throughput and experience)? Again, you do not want to spend time on things that do not add value. As you build your business case for improvement, consider the following:

- the risks associated with the project,
- the human resources investment,
- the feasibility of success, and
- the schedule or timeline for completion.

Common Issues That May Lead to Waste

-  Delays in completing work
-  High wait times in some process steps
-  Too many staff errors
-  Unutilized or underutilized staff skills
-  Unnecessary movements or steps (patients, doctors, or staff)
-  Loss of patients due to them walking out or requesting to be rescheduled
-  Outdated or overly complex processes
-  Too much time being spent on manual processes
-  Uneven workloads
-  Poor scheduling
-  Not enough staff or those with insufficient skills

BUILD YOUR TEAM

As you progress in your improvement process journey, ensure you listen to your team's various viewpoints. Each person has a unique perspective and can help you update or change a process. Groups to involve in your review include:

- **Patient:** What is the patient's attitude to this process?
- **Practice executive team:** How does a change affect the business?
- **Management:** Is the process realistic or feasible?
- **Employee:** Will staff be willing and capable of making the change?

Ensuring that each group is heard can lead to better-designed processes and outcomes. Depending on which procedure needs your focus, we recommend that you form a four-person team. One employee can represent the patient's view. A physician or administrator may define the practice or business opportunity. A manager might join in and reflect on process needs, and a staff member can lend insights from the employees' perspectives.

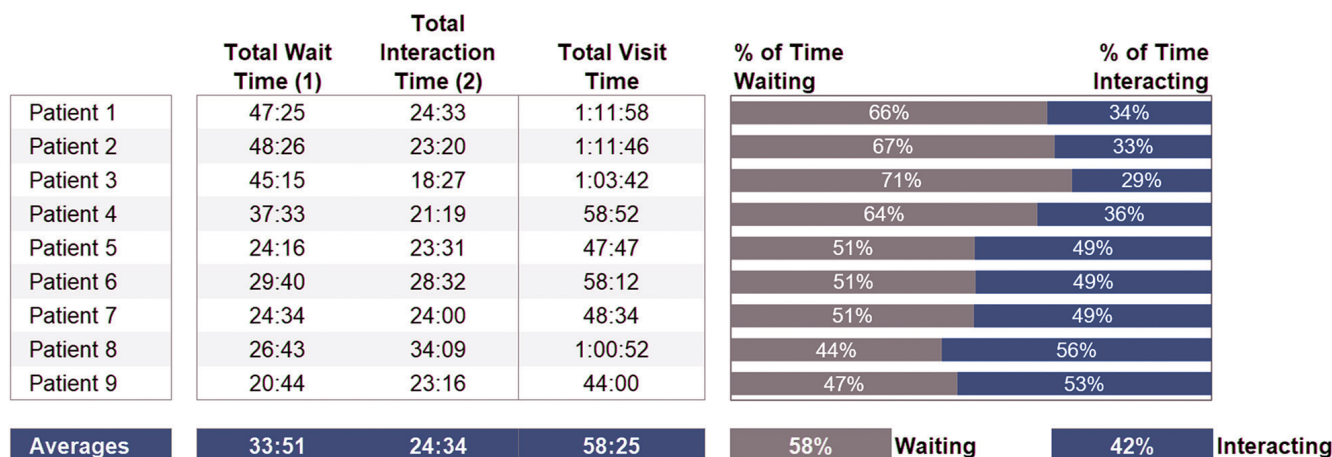
INCORPORATE THE DMAIC PROCESS

At the center of the lean process is the DMAIC framework, a system designed to assist in an orderly, logical flow when improving a process.¹ The DMAIC framework stands for define, measure, analyze, improve, and control.

Define

Start by comprehensively describing the problem. Answer these questions:

- What is the issue?
- What is your team's input?
- What effect is the problem having on the clinic, staff, and patients?



1. Total wait time includes time spent waiting in the lobby, waiting for testing (if applicable), waiting for the physician, block time, injection setup, and medication set-time.

2. Total interaction time includes time spent at check-in, technician workup time, testing time, total time spent with the physician during the examination and/or injection, and time at check-out.

Figure 1. Lean analysis of the entire patient visit for nine patients.

When defining the problem, it is essential to identify the real problem to address. It's easy to focus on symptoms or issues rather than root causes. By conducting a root cause analysis, you may find that more than one issue needs to be addressed. After this self-reflection, let's say you define your issue this way:

Your two-doctor retina practice is struggling with patient wait times. The appointments for intravitreal injections typically take 1 to 2 hours from start to finish. Patients have been complaining, and staff members are frustrated by the lengthy appointments.

Measure

The next step is to measure. To begin measuring a process, answer these questions:

- What is the process?
- How can the process be measured?
- What are the moving parts (inputs and outputs) and how can they be measured?
- Do patient satisfaction and accuracy need to be measured?
- What is the difference between the old and new processes?

To adequately measure a process, you may need to gather data from your electronic health record; spend time in clinic observations; or conduct surveys with your providers, staff, and patients. Knowing this, you and your team decide to take the following steps to measure your patient flow problem:

Your staff and physicians start documenting the process for intravitreal injections. The team tracks time-in-motion, detailing the start/stop times for every step in the patient journey. They also measure the amount of time patients are waiting during each segment of their visit.

Analyze

Analyzing is about finding out what is going on. To do this, you may need to further evaluate your root cause analysis, outline a process map, or look at charts and statistical data to better understand what is happening. During your analysis, consider as many issues as possible, the cause of the problem (there could be multiple), and the tools you will need to analyze improvement.

Going back to the patient flow scenario, your measurements and subsequent analysis revealed the following:

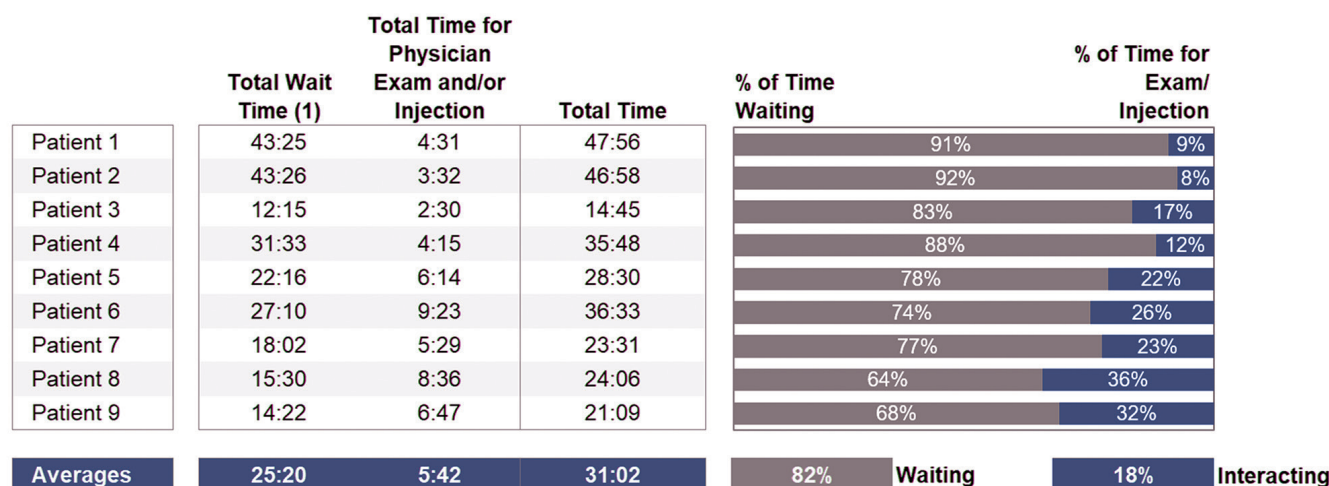
The practice documented nine unique injection patients and timed every step (Figure 1). The time-in-motion studies focused on value time (time spent with a staff member/physician) and non-value time (sitting and waiting). The analysis revealed that your injection patients spent 58% of their time waiting and 42% of their time interacting with the staff or physicians.

In addition to analyzing the entire visit from start to finish, data was further studied to compare the same wait time versus interaction time as it relates specifically to the injection portion of the visit—after testing is completed and before the check-out process begins. In that study, 82% of the patient visit was spent waiting, and only 18% of the patient's time was spent interacting with the physician or staff (Figure 2).

Improve

Now that you understand the challenges, you must produce a plan to improve. In other words, work on refining the process to make things better. Improvements such as eliminating a step or purchasing new equipment may be simple and easy. Alternatively, modifications such as redesigning an entire process from start to finish may be complex.

Whatever the solution, you may encounter resistance to change from physicians or staff during improvement efforts. When working on improvements, explain why the



1. Wait time includes time spent waiting for the physician, block time, injection setup, and medication set-time.

Figure 2. Lean analysis of the patient wait times during the injection process.

process needs improvement, listen to other perspectives, and discuss the best and simplest solution. Remember, you do not want to add waste or unnecessary steps to a process. Lastly, document both the old and new ways of doing things, provide staff training, and outline implementation and timelines.

For this patient flow issue, your team comes up with the following improvement tactics:

- Ensure that the injection tray is set up with the correct medication before the physician walks into the room, enabling the doctor to move faster through the injection process.
- Analyze patient templates to ensure that the doctor can move easily between injections.
- Always ensure that the doctor has a scribe to assist in the room.
- Streamline the authorization process to avoid delays when verifying authorizations for medications.
- Move emergencies toward the end of the morning or afternoon to ensure that injection patients are not waiting longer due to work-in patients.

Control

Once you have the new procedure in place, you must perform the control process by developing monitoring and control systems to ensure your changes are working. This step means that you must compare actual results against expected results, make adjustments, and take remedial action when necessary. Questions that you and your team must answer for this step include:

- How can you control/measure the improvement?
- Can you chart control measures?
- Are you documenting the outcome?
- Are you continually improving?

As it relates to the patient flow scenario, the team conducted the following control process:

First, they started by ensuring that every injection tray had the ordered medication ready to go when the physician walked into the room. The team only made this one change at first to ensure they could accurately determine if this led to improved patient wait times. Once they determined the results, they implemented another improvement, systematically working to make the injection process seamless and efficient.

ONE STEP AT A TIME

With lean principles, your retina practice can improve its processes and patient wait times, but it is a multi-step undertaking. It involves identifying your challenges, building your business case, listening to the team around you, and measuring and committing to improvement efforts. By following this approach, you can make incremental changes that bring significant value to your patients—something always worth your time and effort. ■

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HARASSMENT AND DISCRIMINATION IN THE RETINA PRACTICE



An overview of the current legal landscape and how the COVID-19 pandemic has affected issues that employers face.

BY MEGAN E. GEHRET, ESQ. AND NICK R. MASINO, ESQ.

Everyone is familiar with the terms *harassment* and *discrimination*, although they are often used to describe varying degrees of behavior. While not all seemingly discriminatory conduct rises to the level of illegality, there are numerous legal, business, and ethical considerations to keep in mind when evaluating whether your practice is taking adequate steps to prevent such conduct in the workplace.

THE LEGAL LANDSCAPE Discrimination

Federal regulations lay the foundation for antidiscrimination laws in the United States. Generally, these laws make it illegal to discriminate against someone based on their inclusion in certain categories of identity, called protected classes. These laws have been interpreted and amended by court cases and legislative action, often expanding the scope of the protected classes (Table).

To better understand how these laws apply, consider the following example: Under Title VII, it is unlawful for an employer to make adverse decisions related to hiring and firing, compensation and benefits, promotions, and other employment-related decisions based on an applicant's or employee's race.

Employee discrimination can also occur through other job-related actions, including unfair treatment, denial of a reasonable workplace change, improper questioning or disclosure of

TABLE. SUMMARY OF FEDERAL LAWS AND THEIR
RESPECTIVE PROTECTED CLASSES

Law	Protected Classes
Title VII of the Civil Rights Act of 1964	Race, color, religion, national origin, or sex (including pregnancy, sexual orientation, and gender identity)
Americans with Disabilities Act (ADA)	Individuals with disabilities
Age Discrimination in Employment Act (ADEA)	Employees 40 years of age or older
Equal Pay Act of 1963	Sex-based wage discrimination
Genetic Information Nondiscrimination Act (GINA)	Genetic information in health coverage and employment

medical information, sexual harassment, or failing to provide a reasonable accommodation to employees with disabilities.

Patients may also assert claims against a practice if they are denied medical treatment, receive substandard care, or are harassed by staff or other patients based on their inclusion in a protected class.

Harassment

Harassment is a specific type of discrimination regulated under the same federal law referenced in Table 1 (except for

the Equal Pay Act of 1963). Harassment is defined as unwelcome conduct that is based on the recipient's status as a member of a protected class. Harassment becomes unlawful when (1) enduring the offensive conduct becomes a condition of continued employment or (2) the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive. Such offensive conduct may include, but is not limited to, offensive jokes, slurs, epithets, name calling, physical assaults, threats, intimidation, ridicule or mockery, insults or put-downs, disseminating offensive images, and interference with work performance. By contrast, petty slights, annoyances, and isolated incidents (unless extremely serious) do not typically rise to the level of unlawful harassment.

Check Your State Laws

Many states have supplemented existing federal protections with their own laws, which often further expand the protected classes, broaden the scope of employers covered, and/or lower the standard by which such behaviors are deemed illegal. While state laws may provide additional protections above and beyond those afforded under federal law, state laws cannot provide any less protection than federal laws.

WHY FOCUS ON PREVENTING HARASSMENT AND DISCRIMINATION?

Retina specialists, like all physicians, have a duty to uphold the American Medical Association's Principles of Medical Ethics. These principles include dedication to providing competent medical care with compassion and respect for human dignity and rights, as well as supporting access to medical care for all people. While moral and ethical obligations alone may be motivation enough, there are also numerous legal and business considerations that may inspire your practice to take additional steps to prevent harassment and discrimination.

Avoid Legal Trouble

When evaluating which prophylactic and remedial measures may be worth implementing, it is important to consider the legal risks involved. Under the legal theory of vicarious liability, an employer can be held liable for the wrongful acts of its employees if those acts are carried out during the course of employment. This theory extends to claims of harassment and discrimination. As such, in a case where an employee of your practice commits a discriminatory act while employed by you that leads to a lawsuit, if the facts support a finding of vicarious liability, the court may impose liability directly on the practice—as though the practice committed the discriminatory act itself. This can happen even if the practice owners weren't aware of the discriminatory conduct.

To best prevent and/or defend any such claims of vicarious liability (because, unfortunately, prevention of any wrongful acts from ever happening is not always attainable),

DOCUMENTATION IS KEY

The most important thing to remember when addressing a complaint is to document everything. The practice's representative should document the date, time, and manner in which the individual filed the complaint, details of the interactive process that took place, the plan of action that was agreed upon, if any, and the resolution of the complaint.

In addition to all conversations with the complainant, the representative should document all correspondence with other parties related to the complaint. All information disclosed throughout the interactive process should remain confidential between the complainant and the individuals involved in the interactive process. If the designated practice representative is the individual about whom the complaint is being made, the practice must provide the complainant with an alternate contact to whom the complaint may be submitted.

your practice must be able to show that preventative measures were taken against such conduct, as well as remedial measures to address any alleged incidents that may have already occurred. The upfront expenses associated with such preventative and remedial measures may not be appealing, but the cost of responding to a lawsuit, however frivolous, soars in comparison.

Grow Your Business

In addition to ethical, legal, and financial considerations, there are several business considerations to keep in mind. Providing a safe workspace boosts employee morale and can cut down on employee burnout, which retina practices are experiencing across the country. Happy employees are more likely to stay long-term, which reduces the turnover costs associated with hiring and training new staff. Also, patients are more likely to continue returning to your practice if they feel safe and are attended to by happy staff members. It goes without saying that patient retention is essential for growing a healthy business.

Protect Your Reputation

Finally, your practice's reputation, which is highly influenced by patient and staff experience, directly affects your referral relationships. The more positive the experience of each patient sent your way, the stronger your referral relationships become. Keeping employees, patients, and referral sources happy is an essential component of building and maintaining a successful retina practice.

STEPS YOU CAN TAKE

To minimize the occurrence of harassment and discrimination in your practice, implement measures to both prevent harassment and discrimination and respond

to alleged incidents in a productive and compliant manner. Consulting with an attorney to ensure compliance with relevant federal and state laws is always a good idea. Other steps you can take include the following:

1. Outline procedures and policies for handling workplace issues in an employee handbook. The handbook should provide details regarding how the practice expects employees to treat each other and patients, what conduct will not be tolerated, and the disciplinary action associated with failure to comply. The handbook should also provide a detailed procedure that employees can use to report and escalate complaints of harassment and discrimination, as well as the dispute resolution process that follows.

2. Hold annual harassment and discrimination training to educate staff about their rights and responsibilities in the workplace. Even the most well-intentioned employees can sometimes unknowingly act in a manner that could subject both the employee and the practice to liability for discrimination. Often, these instances of discrimination occur because of rapidly changing social norms and expectations. Due to generational and cultural differences, employees and patients from different backgrounds may have differing expectations of what is appropriate in the workplace. Offering annual training can help to reconcile these differences and educate your employees about what conduct is and is not acceptable.

3. If a complaint does arise, engage in an interactive process with the complainant through a practice representative. During this interactive process, the representative should gather as many details from the complainant as they are comfortable disclosing. The representative should work with the complainant to find an agreeable resolution, within reason, and formulate a plan of action. It is essential to keep a thorough record of the entire process (see *Documentation Is Key*).

While all instances of discrimination cannot be prevented, you must demonstrate that your practice has taken reasonable steps toward prevention and remediation. Diligent efforts can go a long way, both in avoiding issues in the workplace and supporting the defense of any alleged claims that may arise in the future.

UNIQUE ISSUES PRESENTED BY COVID-19

The COVID-19 pandemic brought new legal issues related to harassment and discrimination to the forefront. These issues will persist as employers deal with the lasting effects on the workplace, especially in the health care setting. Employers should find comfort in knowing that the measures described above remain good practice in dealing with the unique issues presented by the pandemic.

While the nationwide mask mandate was lifted in 2022,

several states continue to require masks in health care settings. Similarly, many practices ask that their employees be vaccinated for COVID-19. While your practice may feel it is best to require masks and/or vaccines in the office, there have been cases where patients and employees do not agree with such requirements for different reasons. When the individual's reason for refusal to comply relates to their status as a member of a protected class, claims of discrimination may surface. In any such instance involving an employee, the practice should engage in the interactive process detailed above to determine whether a reasonable accommodation may exist that permits the employee to continue working, while preserving the integrity of the employee's reason for refusing to comply.

Regarding patients, the practice need not always engage in an interactive process. However, it may be in the practice's best interest to work with the patient to find an accommodation that allows the patient to be seen, while accommodating their refusal to comply, within reason.

It's important to note that COVID-19 has not changed the legal obligations of employers to prevent and address harassment and discrimination in the workplace. Rather, it has brought about a new wave of issues that have increased discrimination claims in the health care setting. Many of these new issues are due to controversial political views, which do not fall under a protected class, but they can still lead to complaints. That is, even if the initial complaint may appear to be based on something unprotected (such as political views), it could still be a sign of an underlying issue involving the individual's inclusion in a protected class. Therefore, it is paramount that each complaint is thoroughly investigated and addressed.

GET AHEAD OF THE ISSUE

To avoid claims of harassment and discrimination in your practice, you must maintain current policies and procedures, offer annual employee training and, when necessary, consult an attorney to remain apprised of applicable laws and measures available to create a safe workplace for employees and patients alike. ■

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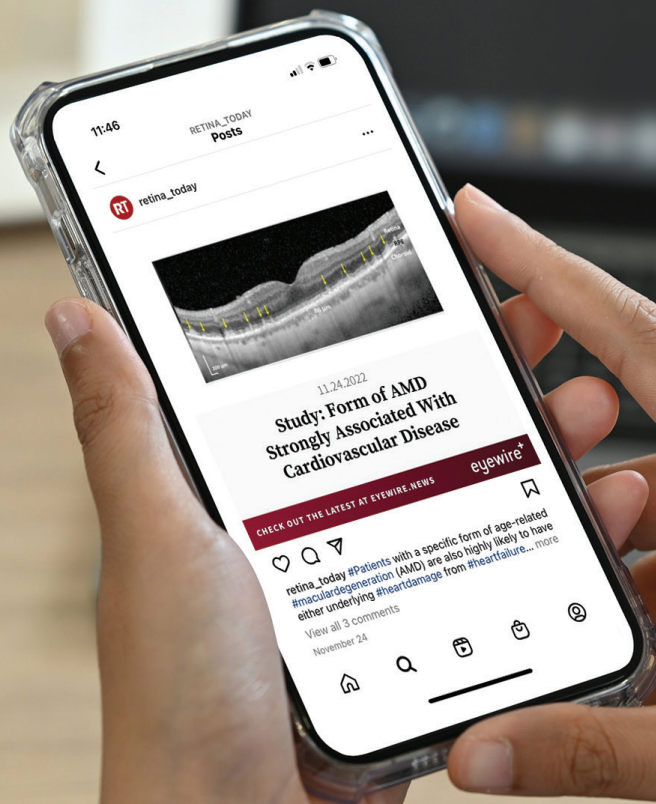
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THE WHY BEHIND ESTATE PLANNING



Like it or not, you need to be ready for the future—here's how to get started.

BY DAVID MANDELL, JD, MBA, AND CAROLE FOOS, CPA

For most retina specialists, estate planning is likely one of the least attractive of all areas of wealth management. Building assets through investing or reducing taxes bring to mind more excitement than stopping to consider what will happen when you pass away or become incapacitated. Despite the distasteful subject matter, estate planning is a crucial area of your financial health and something all physicians, regardless of their stage in life, should address.

ESTATE PLANNING DEFINED

The term *estate planning* refers to three different categories of planning:

- **Incapacitation planning:** decision-making regarding legal, financial, and medical issues if you are unable to make decisions for yourself.
- **Estate distribution planning:** deciding what happens to your assets upon death.
- **Transfer tax planning:** address and plan for the various gift, estate, and other taxes that may be triggered under state and federal law when transferring wealth during life or at death.

In this article, we dive into the details of the first two areas of estate planning.

INCAPACITATION PLANNING

Planning for your own potential incapacitation (ie, when you are not able to make decisions for yourself) is never a pleasant endeavor, but it is always important.

As an example, consider what might happen if you are hospitalized and cannot express your wishes regarding decisions that need to be made about your medical care. Many people assume that their family members would automatically be able to make decisions in this scenario. However, rules surrounding this decision-making process vary significantly from state to state. In some cases, the health care providers and institutions in charge of your care are the ones tasked with those decisions. Also, consider what may happen if such decisions can be made by your family members but they do not all agree on the best course of action.

There are several key documents that every physician should have in place to address these concerns. The exact names and requirements of these documents can vary because they are controlled by state law. Typically, estate planning attorneys prepare these at the same time they draft other important documents, such as wills and trusts. These documents should be part of every doctor's overall planning and might include the following:

- A **living will** is a written record of the type of medical care you would want in specific circumstances.
- A **health care proxy** is a document that names someone you trust as your proxy, or agent, to express your wishes and make health care decisions on your behalf if you are unable to speak for yourself.
- An **advance directive** often refers to a combination of the living will and health care proxy documents.
- A **power of attorney** is a document that names someone you trust as your agent to make property, financial, and other legal decisions on your behalf.

ESTATE DISTRIBUTION PLANNING

Before we address the foundational estate planning documents most physicians should employ, consider what occurs if you die without any will or other estate planning document in place. You might be surprised to find out that you already have a will, even if you have never written one or had an attorney draft one. If you die without a will, your property will pass down based on the scheme that your state legislature has written for its citizens. This is known as dying *intestate*.

There are various negative consequences of dying intestate. While the precise rules vary between the 50 states, the overarching laws are rigid and formulaic. Usually, your nearest relatives get a certain portion of your property and no one else—not friends, cousins, or charities. Furthermore, no one gets more than the state-allotted share, even if that seems unfair.

Often, this all-too-common scenario ends up hurting a surviving spouse. For example, the decedent's grown children may get some of the money meant for the surviving spouse,

even if it means the surviving spouse has too little to live on. With larger estates, this could have the impractical effect of creating an estate tax payable when the first spouse dies, if the children's share of the estate exceeds the federal or state exemption amount. Moreover, intestacy may lead to expensive and lengthy court battles between family members contesting the division of assets.

Perhaps the most upsetting thing about intestacy occurs if the scenario involves children who are minors. In this case, if both parents die intestate, the courts decide who becomes the legal guardian of the children. What parents would want to have an unknown judge decide who will care for their children after they pass away? Furthermore, any minor children will receive their share of the estate when they turn 18, rather than at an age that you deem appropriate and can specify with proper planning.

Wills and Living Trusts

While estate planning documentation is completely state-dependent, having a will is always better than not having a will, regardless of the state in which you live. However, in many states, your entire estate will be stuck in the probate process if a will is all that you have prepared. Probate is the court-controlled process by which the state administers your will.

In most states, knowledgeable estate planning advisors recommend combining a living trust with a short will called a "pour-over will"; this combination ensures that much of an estate avoids probate. Depending on the state, probate can be time-consuming, public, and very costly. In many states, the goal is to avoid this process as much as possible.

The Living Trust: A Foundational Document

Living trust is a common term used to describe a revocable trust (meaning you can revoke it or amend it at any time during your life). Such trusts are also sometimes called family trusts or revocable family trusts.

Regardless of its name, the living trust is a revocable trust that provides direction for the use of your assets while you are alive and at the time of your death. During your life, you control the assets transferred to the trust, as the trustee, just as if you owned them in your own name. When you die, these trust assets automatically pass to whomever you designated in the trust, without having to go through the probate process. Other benefits of the living trust include:

- avoidance of the unintentional disinheritance caused by joint tenancy;
- prevention of court control of assets if you become incapacitated;
- protection of beneficiaries with special needs; and
- the ability to nominate guardians to take care of your children if you are incapacitated (but still alive) or if you die while they are still minors.

For these reasons, many physicians should use a living trust as the foundational document in their estate planning.

ESTATE PLANNING IS A MUST FOR ALL PHYSICIANS

Incapacitation planning is essential for physicians of any age, and estate distribution planning is valuable for those with even minimal assets. Every retina specialist should engage in basic estate planning as soon as they begin practice. ■

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