New Physician's Guide to the Future

Resources You Will Need As You Go Into Practice

MICHIGAN OSTEOPATHIC ASSOCIATION
D O
ESTD 1898

MSMS
MICHIGAN STATE MEDICAL SOCIETY

New Physician's Guide to the Future

Resources You Will Need As You Go Into Practice

*Together, the **Michigan Osteopathic Association (MOA)** and the **Michigan State Medical Society (MSMS)** want to make your transition as a new professional into medical practice a smooth one and share with you some of the information we have gathered. In the first-ever MOA MSMS New Physician's Guide to the Future, we have included information about how to obtain your license, contract review basics, information about Michigan's medical structure and much more.*

TABLE OF CONTENTS

We have made this guide as inclusive as possible; however, should you have any suggestions for improvement and/or additions for future editions, please contact Terry Trombley at ttrombley@domoa.org or Rebecca Blake at rblake@msms.org.

Why Join MOA?

The Michigan Osteopathic Association (MOA) is one of the largest statewide osteopathic organizations representing more than 7,000 osteopathic physicians and medical students in Michigan. For more than 116 years, the MOA has been dedicated to the promotion of quality patient care and to the educational, informational and legislative needs of its members.

MISSION STATEMENT

The purpose and mission of the Association shall be to advance the science and art of osteopathic medicine, education and research; to improve health care and promote the benefits of scientific advancement in the treatment, prevention, and alleviation of human ailments; and to strengthen and promote osteopathic medicine in Michigan by shaping the health care delivery system to better serve the community.

MISSION OF QUALITY OF CARE

MOA strives to advance the science of art of osteopathic medicine, education and research. We strive to improve health care and benefits of scientific advancement, the treatment, prevention and alleviation of human ailments; and to strengthen and promote the image of osteopathic medicine in Michigan by shaping the health care delivery system on a national basis to better serve the community.

FORGING SOUND HEALTH POLICIES

Actively working with the state legislature and administration, MOA promotes quality health care for Michigan through the Council of Government Affairs (CGA). As an effective voice for the osteopathic profession, CGA strives to obtain sound medical policy for patients and the osteopathic physicians who serve them. Using a proactive approach to forge legislative support, CGA addresses important issues affecting the osteopathic profession such as licensing, scope of practice, managed care and the patient's bill of rights.

CREATING QUALITY EDUCATION

MOA continues to create continuing medical education opportunities for family practitioners and other specialists throughout the state. Utilizing technology and member support, MOA is providing learning opportunities for physicians planned with the input of physicians to address timely and emerging health care concerns.

PARTNERS IN EXCELLENCE

MOA works closely with the Michigan State University College of Osteopathic Medicine (MSUCOM). Through funding and an administrative partnership, MOA assists the Michigan Osteopathic College Foundation (MOCF) and MSUCOM efforts in preparing future physicians to effectively manage the health needs of their patients.

ENSURING A HEALTHY MICHIGAN

Quality health care is as important to the MOA as it is to the people of Michigan. By promoting effective health policies, quality training, education and regulation of the osteopathic profession, the MOA is enhancing quality health care for the people of Michigan.

MSMS
MICHIGAN STATE MEDICAL SOCIETY

MISSION STATEMENT

The mission of the Michigan State Medical Society is to promote a health care environment that supports physicians in caring for and enhancing the health of Michigan citizens through science, quality, and ethics in the practice

Why Join MSMS?

The Michigan State Medical Society knows your focus is taking care of your patients, which leaves little time to fight the battles that face your profession. That's why MSMS is relentlessly working for you and your patients. Whether it's representing medicine in Lansing and Washington, D.C., meeting with third-party payers to get you paid, developing practice management tools and seminars for you and your office staff, or creating programs to improve public health, MSMS has long been the physician's best advocate. The more members we have, the more we can do on your behalf.

As the oldest and most powerful state medical society in Michigan, MSMS speaks out for more than 15,000 physician and medical student members across the state in our commitment to improve the health of all Michiganders. In partnership with our county medical societies, we have been helping Michigan physicians set high professional and ethical standards since 1866.

THE FIRST 150 YEARS

It was on June 5, 1866, when about 100 physicians traveled from across the state to Detroit to organize the "Michigan State Medical Society."

There had been two previous medical organizations in Michigan, but there had been breaks from 1851 to 1853, and then again in 1860.

So, when the physicians gathered on June 5, 1866, it was appropriate for Morse Stewart, MD, of Detroit, to recall in his welcoming address:

> *"The profession has failed to promote properly the advancement of medical science, individual growth and development, and through these the great and ultimate object of our profession and the welfare of society."*

Doctor Stewart made a strong appeal to the physicans that:

> *"their hearts [be] expanded by an enlarged charity so as to exclude individual selfish aims, should we enter upon the duties which are before us."*

The Michigan State Medical Society, for more than 150 years, has had a leadership role in Michigan.

Because Michigan's potential is our purpose, MSMS serves as the state's major health care hub, linking our resources with the needs of its communities, businesses, universities, and Michigan government. After 150 years, there is more recognition than ever that MSMS can—and must—play a key role in enhancing the quality of life for Michigan citizens and beyond.

The Michigan State Medical Society's world-class members are leading physicians, scholars, and researchers in their specialties, helping address issues locally and globally. MSMS's institutional commitment to public service ignites passion within our members, and puts health and wellness to work in communities statewide and across the globe.

Physician members of the Michigan State Medical Society support quality patient care and are committed to maintaining the highest standards of medical practice.

1. Starting Your Job Search

The best place to start your search is online. If you want to find a position in a specific geographic location it is best to look for employers in that area. Potential employers could be hospitals, group practices or even individual physician offices. Many hospitals have recruitment policies that allow them to recruit for physicians on their medical staff as long as there is a documented community need.

Also look at your professional or specialty association website. Many of these associations have their own job board or have teamed up with a reputable vendor to run a job board within their website.

In addition to online sources you will also want to use your network. While doing your rotations be sure to talk about your geographic and practice preferences with the attending physicians and ask if they are aware of any opportunities.

Personal Assessment

At last you are ready to start looking for a job, right? Not so fast! There is one more step that will help you prepare for your search.

You, your significant other and/or family members should sit down and determine what you really are looking for in a practice and community.

This will allow you to identify your needs and your wants so you can stay focused during your search and help you to be more articulate with potential employers.

SOURCES FOR AVAILABLE POSITIONS

MSMS Medical Opportunities – www.msms.medopps.org.

MSMS Medical Opportunities is a joint partnership between MSMS and the Michigan Health Council, a non-profit statewide organization. With surrounding state partnership, postings or Indiana, Illinois, Ohio and Pennsylvania are also available. MSMS MedOpps is exclusive to in-house recruiters so you will not find any opportunities posted through a recruitment firm. Please note though that this is a paid subscription service for employers, not all employers participate.

MOA's Career Center – www.domoa.org/careers

Your destination for exciting osteopathic job opportunities and the best resource for qualified candidates within the osteopathic industry.

PracticeLink – www.practicelink.com

PracticeLink is very similar to Medical Opportunities in Michigan. One difference, which is a nice perk for those who have broad geographic interest areas, is that PracticeLink is a national job board so you will find opportunities across the country. The other difference is that PracticeLink does not work with recruitment firms. You can tell a posting is through a firm because they will not give you the exact location of the opportunity. Remember, recruitment firms get paid if they place you. Therefore they won't disclose the location so you will not be able to contact the employer directly.

Michigan Recruitment and Retention Network (MRRN) – www.mrrn.org

Many in-house recruiters in Michigan are members of this statewide professional association. Although their website is not a job board it does contain a membership directory with direct contact information. If you are looking to stay in Michigan this is a great resource to a fairly long list of in-house recruiters.

YOUR CURRICULUM VITAE (CV)

This really should be the first step in preparing for you search. Don't be tempted to start looking at positions until you have your CV prepared, polished and ready to send to potential employers. You would hate to get asked for a copy and then have a delay in follow-up because you were not prepared.

There is no magic format or style of CV. Just keep it simple and easy to read. No colors or fancy fonts. Make headings stand out by putting them in bold and/or underlining. Use right and left justification so headings and dates are easy to find. Don't get too texty. Use bullets if necessary to keep items concise.

WHAT TO INCLUDE

Contact information –Name, address, phone number and email address.

Education – This should be in reverse chronological order with your fellowship/residency first, followed by medical school, then undergraduate. Unless you are planning to return to your hometown there is really no need to list your high school. However this could be helpful to include if you are trying to display your geographic tie to the area. It is very important to include dates and make sure there are no gaps. If there are gaps in this section they should be accounted for in your experience section or explained in your cover letter.

"There is no magic format or style of CV. Just keep it simple and easy to read."

Experience – This section could include moonlighting experience or other work experience if you worked during the periods between education.

Personal – Although this is something you would think you shouldn't include, it is beneficial. Recruitment is a family decision and it is important for the potential employer to take your needs into consideration. This information also helps the recruiter plan a meaningful visit for you since they can take your interests and tailor the visit accordingly. In this section you should include your spouse's name and occupation, the names and ages of your children, your hobbies and personal interests and also hometown for you and your spouse, particularly if you are looking for a position in that geographic area.

WHAT *NOT* TO INCLUDE

A photo, date of birth or statements such as:

"References available upon request." Just give them the information, i.e. "See references section below."

"In excellent health."

YOUR COVER LETTER

Although a cover letter is not required, it is highly recommended to include one with your CV. If a recruiter has a stack of CVs to review, a cover letter will bring yours to the top of the stack. Your cover letter should not simply repeat what is included on your CV. Instead use this opportunity to share with the employer what type of opportunity you are looking for, how your interests fit with what they are looking for and to make geographic connections.

You should always personalize your cover letter. Never address it to "Dear Recruiter" or "To whom it may concern." Instead, take the time to look up a direct contact name on the posting or website to address it to. Start your letter by sharing where you saw the job posting and why you are interested in that specific job and location. Then refer to your CV and indicate where you are in training and when you will be available to start practice. After that, write a paragraph that further explains your practice interests, including: whether you want to do inpatient, outpatient, any special procedures or if want to work an alternative schedule. If you have specific ties to the area in which you are sending your CV, be sure to include that in your cover letter. Finish up your cover letter by sharing the how and when the best time is to reach you.

If you are a married physician couple and you are both looking for positions, include information for both of you in the cover letter and include both CVs.

REFERENCES

Though your cover letter is written and your CV is prepared, you still aren't quite ready to start looking for a job. You should ask three to five individuals if they would be willing to serve as a reference for you. Tell each person what type of position you are seeking so they are familiar with your interests and can be prepared when contacted by potential employers. Determine who you should ask to be a reference based on the type of position you are seeking. You should always use someone from your training program but also include physicians from rotations that you particularly enjoyed or hope to model your practice after. It is acceptable to include individuals as references who are not physicians. You want to include a midlevel provider if you know the position you are seeking includes working with midlevel providers. If you are applying for a surgical position you may want to include someone from the OR where you trained. If you are a applying for a hospitalist position perhaps an ICU nurse would be appropriate.

Once you have your references secured, you should prepare a reference page that looks similar to the format of your CV that lists each reference's name, title, address, phone number and email address.

You may be wondering if you should seek recommendation letters. Don't bother. Most employers have a form that they require and want that same form to be completed by all your references. Even if you had a recommendation letter chances are that your reference would also have to complete the form.

It is most likely that you will be emailing your information to potential employers so it is ideal to prepare and save your cover letter, CV and reference page as one document rather than three separate documents. It also might be wise to convert the document to a .pdf so you can be sure it prints nicely.

IN-HOUSE RECRUITMENT VS RECRUITMENT FIRMS

There are two different types of recruiters you could work with when looking for an opportunity. An in-house recruiter is typically someone that is employed by the hospital, health system, group or practice. In-house recruiters are usually paid a salary. Depending on the size of the employer, the person responsible for recruitment may also have a title different than recruiter and also other responsibilities within the organization.

A recruitment firm is a third party that has been contracted to help an employer fill a specific position. Firms work either on a contingency basis or a retained basis. Contingency firms only get paid if they place you in a job. Retained firms usually charge a monthly fee to source and screen candidates and then an additional fee when they find a suitable candidate who accepts the position. Regardless of the type of firm, the employer always pays the fees.

Ideally it is best to work directly with an in-house recruiter. These individuals tend to know the employer, the opportunity and the community much better. Although in-house recruiters are motivated to fill positions, they typically do not have a financial incentive to do so. Therefore you may find you get less pressure when you work with in-house recruiters. In addition, in-house recruiters are always concerned with retention of physicians so they are likely to be better matchmakers than someone without long-term ties to the employer.

INTERVIEW *(See list of potential questions to ask on page 12.)*

In the recruitment industry, interviews are commonly called site visits. Site visits are truly a two-way street. Not only is the employer interviewing you, but you are really interviewing them, too. A typical site visit will span across a day or more and will include hospital and office tours, meetings with providers and administrators, a community tour and often times some sort of social activity. If you are considering an opportunity closer to where you are training, however, you are more likely to have an individual meeting or two with a prospective employer rather than a longer, more inclusive visit.

Although a site visit is really essentially an interview, it is unlikely that you will get asked tough interview questions. What you will most likely experience is the employer sharing information regarding the organization, facility, the service area, the patient population, the types of services they offer, current practices and how they operate their practices, and likely even some information regarding their strategic and recruitment plan. Many employers consider the site visit as their one chance to give you the best idea of what it would be like to practice in their area, be employed by their organization and live in the community. Therefore, it is not unusual for employers to introduce a contract, including compensation plans and benefits, during this first visit. Very seldom would an employer make an actual offer during the visit. Instead they are providing you with information relative to employment so that that process can move forward faster if there is mutual interest.

You need to be prepared to share with them your background, experience, practice preferences, special interests and why you find their opportunity appealing.

THE IDEAL CANDIDATE...

LISTENS, CARES, AND COMMUNICATES.

Hospitals are looking for doctors who listen to patients, who are invested in their health, and who know how to clearly communicate about their care.

PLAYS NICE WITH OTHERS.

Hospitals not only want doctors who can communicate well with patients, but who can get along with each other and who are willing to be part of the team.

COMES HIGHLY RECOMMENDED.

Make sure to give some thought to the professional recommendation you list on your job application.

IS EHR-READY.

Facilities will train new physicians on their EHRs, and that is easier if the doctor is already familiar with the particular software, or is at least willing to learn without complaining.

IS HIGHLY ADAPTABLE.

Recruiters love candidates who are open to change and who will adapt to new systems, policies, patient volumes, or anything else that may pop up.

IS WILLING TO SHARE IDEAS.

Every hospital wants a doctor who will come in and make positive change — but not necessarily on the first day. Sharing new ideas is a good idea, but generally only after there has been time for the existing team and the new doctor to get to know each other.

Visit www. physicianspractice.com/blog/six-characteristics to see more.

SAMPLE CV

NAME A. LASTNAME, MD

Street Address
City, State zip code
Cell Phone: (Area code) fax number
Email: email@address.com

EDUCATION

B.S. Degree, 1984	Biology, Wayne State University, Detroit, MI
M.D., 1988	Wayne State University, Detroit, MI
M.H.S.A.	University of Michigan, Ann Arbor, MI

TRAINING

2001-2001	Holy Grace Hospital, Cleveland, OH, internship
2004-2004	Smith Eye Clinic, Philadelphia, PA, Ophthalmology residency under Reknowned Expert, MD
2004	Chief Resident
2005	Ophthalmology Associates, Detroit, MI, Retina fellowship

PROFESSIONAL DEVELOPMENT

American Academy of Ophthalmology Annual Meeting, Miami, FL, October 2003
American Academy of Ophthalmology Mid-Year Forum, Washington, DC, April 2004
Michigan Ophthalmological Society Annual Conference, Mackinac Island, MI, Augus, 2004
Basic Billing and Coding Seminar, Lansing, MI, September 2004

PROFESSIONAL MEMBERSHIPS

Oakland County Medical Society
Michigan State Medical Society
American Medical Association
Michigan Ophthalmological Society
American Academy of Ophthalmology

LICENSURE AND BOARD CERTIFICATION

2005	Physician License, State of Michigan, #0123456
2006	Board Eligible

HONORS AND AWARDS

Outstanding Medical Student Scholarship, 1987
First place, Michigan Ophthalmological Society Resident Paper Competition, 2004

PUBLICATIONS

Fletcher, J.B.; Cummings, Robert; Hall, Arthur; Lastname, Name A.: "Efficacy of Vitamin Therapy for Diabetic Retinopathy." *Ophthalmology Today*, May 2004, p. 4

PRESENTATIONS

"Breakthrough in Diabetic Retinopathy Treatment Options," Michigan Ophthalmological Society Annual Conference, August, 2004

"Basic Ophthalmology Issues for Family Physician," Michigan Academy of Family Physicians, September 2004

COMMUNITY SERVICE ACTIVITIES

Volunteer, Michigan Ophthalmology Society, Senior Eye Evaluation Day, June 2003
Volunteer, Detroit Free Clinic, one half-day per month

ADDITIONAL SKILLS

Fluent in Spanish

SAMPLE COVER LETTER

NAME A. LASTNAME, MD

Street Address
City, State zip code
Cell Phone: (Area code) fax number
Email: email@address.com

Month xx, 20xx

Name of Recipient
(Get the person's name, NOT To Whom It May Concern)
Title
Address
City

Dear Mr./Ms.Name:

It seems as though the course of my life and professional career up to this point has been in preparation for (job title, or words to that effect. Tell exactly how you heard about this position or where you saw it advertised).

My first love is health care (or words to that effect). From the time I was (explain your initial interest in medicine with passion. Don't rehash your resume, make a personal connection).

In addition to my education and health care experience listed on my enclosed/attached resume, (tell a little personal information about yourself that might not jump off your resume).

The opportunity to apply for the position of (job title) is a dream come true (or words to that effect). I believe my experience will (explain why all of your life lessons, education, and experience make you the perfect candidate).

Please feel free to contact me at any time at 777-777-7777 or by email at myemail@address.com. I look forward to hearing from you soon.

Thank you for your consideration.

Sincerely,

First M.I. Last Name

Potential Questions to Ask

ASK A PHYSICIAN

- What's the call schedule?
- How many calls and admissions do you handle on a typical call night or weekend?
- What hospital(s) are you affiliated with?
- Are patient charts well organized? Are they dictated or handwritten? Do they include problem and medication lists, flow sheets or other reminder forms?
- Is the practice computerized? What are the future computerization plans?
- How would you describe your level of autonomy?
- How many patients do you see per day?
- Who decides how much time you spend with each patient?
- Do you receive appropriate feedback about performance quality?
- How would you describe your relationship with the staff?
- What are the staff's foremost concerns?
- Are you satisfied with the current compensation package?
- How is productivity measured?
- How would you characterize the pressure to produce?
- How would you describe the practice's relationship with third-party payers?
- Is the administration responsive to your concerns?

ASK AN ADMINISTRATOR

- Does the organization have a mission statement? If so, what is it?
- What are its goals?
- How would you describe the organization's overall financial health? How is this clinic doing financially?
- What is the business plan for the next five to 10 years?
- What is the overhead?
- Is any expansion, integration or corporate rearrangement currently being considered?
- How would you describe the practice's relationship with third-party payers?
- Is the practice computerized? What are the future computerization plans?
- What's the payer mix?

- How long does it take to get credentialed with the major plans in your area?
- How much autonomy do physicians have in this organization?
- Do physicians choose their own hours?
- Do physicians determine how much time they spend with each patient?
- Do physicians work any evening or weekend office hours?
- Do physicians receive feedback or education regarding performance quality, billing and coding?
- Do physicians receive feedback regarding patient satisfaction?
- Do physicians hire and fire their own staff? Do physicians have the authority to hire more staff, if needed?
- Do physicians conduct performance reviews for staff?
- Is there an office manager for the clinic or is the office manager in a centralized location?
- What is the compensation plan (i.e., salary, benefits, vacation, time off for CME, maternity leave)?
- Is compensation tied to productivity?
- Is there any money allotted for continuing medical education?
- Are bonuses given?
- Who pays for cell phones, professional dues and licenses?
- Are moving expenses covered?

ASK EVERYONE

- How long have you worked here?
- What do you like best about the organization?
- What would you change if you could?
- How much turnover has occurred during the past 12 months?
- Why have people left?
- Have you ever considered leaving?

2. Accepting a Position

Contracts

In an employment or partnership situation, always get the contract and details in writing. No matter how much you trust an individual or group or organization, there is always potential for failure to meet the agreed-upon terms. If that occurs, you need to have a written, legal document. Always consult an attorney before signing any type of contract.

The Employment Contract - The typical components of an employment agreement covers issues related to compensation, employee benefits, working conditions, termination of the relationship, conditions for future partnership (if any). Keep in mind that you needn't accept everything the employer puts into a contract. Virtually everything is negotiable. Before you begin, take inventory of your requirements for employment. Which items are deal breakers? Also, on which items can you compromise?

Term - The term of the contract refers to the length of time it will be in force before it expires or has to be renewed. The contract should detail the possible reasons and procedures for termination of the agreement.

Compensation - Consider the entire compensation package, not just the salary. The package may consist of salary, employee benefits or productivity incentives.

Employee Benefits - A typical employee benefits package may include:

- Paid leave for vacation, sickness, continuing education
- Reimbursement for continuing education programs
- Medical, dental and vision insurance
- Life insurance
- Disability insurance
- Medical liability insurance
- Retirement plan
- Professional society dues
- Journal subscriptions

Duties of the Job - The responsibilities of the job should be clearly defined including clinical or teaching duties, performance standards, clinical autonomy, office hours, call coverage, office space and resources and any restriction of income from outside activities.

Future Partnership - The avenues and timeline for partnership should be spelled out in the agreement or in a separate letter of intent.

CONTRACT BASICS

Regardless if you are considering an opportunity with a private practice, a group, an individual hospital or a health system it is highly likely that you will be employed for your first position. Employment contracts vary in length, but are typically 18-22 pages long. Contracts with private practices tend to be shorter than those with hospitals. Don't let the length of these agreements frighten you. Within a 20-page agreement, chances are that just a handful of pages have been tailored just for you.

Partnership or Shareholder Agreement

A partnership contract should spell out clearly the structure of the buy-in including price, percentage of ownership, value of the practice, decision-making authority, income distribution, resource allocation, expense allocation, partnership termination and buy-out arrangements. As mentioned, you should always consult an attorney before signing any contract.

Here is a list of standard provisions that you will see in most contracts:

TERMINOLOGY

Parties - This will be the opening paragraph of the contract and it simply identifies who the parties are (the employer and you).

Recitals - This is where you will often see WHEREAS…keep reading, it really isn't that bad. There are usually just three or four recitals in a contract and they are simply stating some basics, such as what is the employer in the business of doing, what are you qualified to do and what the two of you are trying to accomplish by entering into an employment agreement.

Duties of Physician - This will be a fairly long list of things that you are responsible for, but don't be shocked that it is not specific. These are usually big picture items and do not contain details about days and hours you will be working on a regular basis. Some contracts will refer to an attachment that will have an actual job description. Again, this will not be specific but more likely a canned human resource-type description.

Obligations of Employer - After reading a rather long list of things you are responsible for you may be surprised when you read about your employer's responsibilities. It usually will say that they will provide you with space to work, staff, supplies and equipment.

Compensation - Believe it or not, compensation comes up quite early in a contract, usually around page four. However, what you typically will find in the body of the contract is a small provision that says you will be paid according to the compensation plan outlined in an attachment. Many employers do this because the language of their agreement is standard and applies to all physicians regardless of their specialty. This allows the employer to maintain that template and simply develop different attachments tailored to each physician's specialty and specific package being offered. Later in this handbook you will find a much more detailed description about compensation.

Benefits - Similar to the Compensation section, you likely will see a fairly short provision regarding benefits that refers to the physician getting the same benefits as all other employed physicians and that they may change from time to time. Many times, it will refer to an attachment or summary of benefits. Benefits are an extremely valuable part of an employment package, so you will want to understand what is offered so you can make appropriate decisions as you transition from residency to practice. As a rule, most benefits are not negotiable. Later in this handbook, you will find a detailed description of the benefits you should get as part of your employment.

Term - This is simply the length, or duration, of the contract – when does it start and when does it end. Dates in contracts can sometimes be confusing because they are referred to differently. For example, you will see the words "Effective Date" and "Commencement Date." Effective date is usually the date the contract is signed and is typically referenced in the first paragraph of the contract where the parties are defined. "Commencement Date" is usually the date that refers to the beginning of the term.

"TERM is simply the length, or duration, of the contract – when does it start and when does it end."

Some contracts have automatic renewal. These contracts are called evergreen, as they never expire unless the contract is terminated by one of the parties under one of the termination clauses. See below for more information about termination clauses.

Don't get too hung up on the term of the contract unless you have specific requirements relative to a visa or obligation from another organization (National Health Service Corp). The reason being, most contracts have ways for both the employer and the employee (the physician) to get out of the contract prior to the expiration. So, in that sense, although you might have a multi-year contract, your true contract is really only as long as the notice requirement in a termination clause.

Instead of the length of the term, what really should be on your mind is the length of the salary guarantee that you are offered. More to come on that in the Compensation section.

Termination - Most contracts have multiple ways the contract can be terminated. These are typically organized by how the Employer can terminate and how the Employee can terminate.

The longest clause in this section will be how the employer can terminate with cause. You will see a list of several items. Ideally what you want to see are fairly black and white things. For instance, if you lose your license, if you are not able to maintain medical staff privileges, if your employer can not insure you under their professional liability insurance, or if you are convicted of a felony, and so on. It is not ideal to have items that are extremely discretionary, such as "at the Boards discretion." If an employer is going to terminate a physician under the "for cause clause" they will need documentation to justify the cause for termination.

The provision where the employee can terminate with cause is usually brief. In this provision, if an employer is in breach of the contract, the physician is required to give the employer notice and the opportunity to cure the breach. If the employer does not cure the breach within the notice period, usually 15-30 days, the employee can terminate the agreement with cause.

What you want to look for with a termination "without cause clause" is where either party (a two-way street) can terminate by giving the same amount of days notice. Ninety (90) days is the most common notice period for "without cause clauses." Anything less than 90 days gives the physician a fairly short lifeline (meaning the time in which you will be paid) and you really should try to negotiate at least 90 days. Although not real common, from time to time you will see a "without cause" provision call for 120 to 180-days notice. Consider

that a gift. Also, look for equal notice clauses. Occasionally you will see where the physician has to give 120 days and the employer has to give 90 days. That doesn't seem equitable and we recommend trying to negotiate an equal notice provision.

Termination clauses, with cause and without cause, by the employer and by the employee, are in every contract. Just as important as understanding how the agreement can be terminated is to understand the effect of termination. Most importantly, if you terminate or are terminated, what are the restrictions (see the section regarding non-compete clauses) and what obligations survive the agreement (see the sections regarding signing bonuses, educational stipends, loan repayment and relocation).

Signing Bonus

You can thank the physician shortage for the increase in signing bonuses that are being offered these days. Often, but not always, they are part of the package or can be negotiated into the package. The amounts of the signing bonus and the strings attached vary greatly based on the specialty and the geographic area. In the past year I have read contracts that have no signing bonus at all and others that were in the range of $5,000 to $75,000. Typically the higher the need, or the harder the recruit, warrants a higher signing bonus.

Things to keep in mind with signing bonuses:

- Not all signing bonuses are paid when you sign the contract. Some employers hold onto the bonus, or a portion of the bonus, until you complete all of your paperwork necessary for medical staff credentials, third party payer enrollment and malpractice insurance application. Some may even require you show up at work and see your first patient before you get the bonus.
- This is taxable income. You need to find out when the money will be taxed. Sometimes taxes are taken out when you receive the money and other times you will receive a 1099 at the end of year in which you get the bonus or when it is forgiven.
- There are usually strings attached to these bonuses. Some employers structure them as a loan (you will sign a promissory note and will accrue interest), which will be forgiven as you fulfill a commitment period with them. Typically, the larger the bonus the longer the commitment period.

Non-Productivity Incentives

Many employers are offering non-productivity-based incentives as well. These incentives are usually a smaller overall percentage of your total compensation and may be in the range of $10,000 - $15,000 per year. These incentives are usually based on things such as patient satisfaction, quality indicators or citizenship (attending meetings and participating in committee work).

Again, you should ask if the current providers are earning these incentives so you can determine if these dollars can be expected or if it is unlikely that you will earn them.

Educational Stipends

Stipends have become another popular incentive to entice residents to make early commitments to employers. How these work is that employers are willing to supplement your residency or fellowship salary by sending you a monthly stipend from the time you make a commitment to them until the time you finish your training. These stipends are most likely associated with hard to recruit specialties, recruitment to geographic areas that are hard to recruit to, or in instances where an employer is trying to recruit someone back to their hometown.
The stipends vary in amount, ranging from $1,000 - $3,000 per month and typically offered for one to two years.

Your first concern regarding benefits should be to understand WHEN they will go into effect.

Often there will be a waiting period. You should be interested in minimizing the time you are without benefits between residency and practice. Since most residents take a couple of weeks to begin their position, you have to watch for provisions that call for benefits to 30 days after you begin working and then not until the first of the next month, which could really put you without benefits for two months or more. Once you understand when the benefits will start you need to determine your options during any potential gap.

The second focus relative to benefits should be to understand WHAT the benefit, or coverage, is and if there is any cost to you.

Below is a hit list of typical benefits that you should understand, whether or not it is provided or if you need to determine if it is something you will need to obtain on your own.

General Benefits

As was described, most contracts have a very short provision in the contract addressing benefits that typically refers to an attachment, or a summary.

Please be aware that benefits offered for a hospital-employed position are usually more inclusive than what you will find in a private practice employed arrangement. Hospitals, or health systems typically have a benefit package that applies to all employees who work a certain number of hours per week. Private practices, however, don't take the same cookie cutter approach and instead create earning potential so that the provider can tailor their benefits based on their individual needs.

HEALTH, DENTAL AND VISION

Health and dental are fairly standard benefits, but vision is not always part of the package. Most employers will offer a couple of different plans, and you can pick the plan that best fits you and your family. It is highly likely that you will be paying part of the premium for your coverage, so be sure to ask what your contribution will be each pay period.

In the event there is a waiting period before your benefits go into effect, you should look into COBRA insurance that will be offered through your training program. You even may be able to negotiate having your new employer reimburse you for the cost of COBRA insurance during your transition.

SHORT-TERM AND LONG-TERM DISABILITY

Short-term disability insurance coverage typically covers up to the first 90 days, or 12 weeks, of an illness. You need to understand if there is an elimination period before your coverage kicks in. Elimination periods are fairly typical, but are usually not longer than a week. If you have an elimination period and you don't want to go without pay, you may need to take days from your paid time off bank.

With both short-term and long-term disability you will want to understand what percentage of your pay you will get. Typically, short-term disability will pay you a higher percent of your pay than long-term disability. Some short-term disability plans will actually provide for salary continuance, meaning 100% of your pay. This is a great benefit, but before you get too excited, look to see if there is a maximum monthly payout. It is not unusual to have the coverage capped at $10,000 to $15,000 per month.

Long-term disability will go into effect after short-term disability expires, usually around the three month mark. The coverage again will be a percentage of your pay, but it usually less than short term disability. Most long term disability plans will cover 60-65% of your pay up to a certain age ranging from 59-65 years of age.

Other things to note about disability…

- Maternity leave is often considered short-term disability. If that is not clear from the summary description, you will want to ask to make sure it is covered.
- Watch for eligibility for disability plans. Some employers will not offer this benefit until you have been employed for a certain period of time, sometimes months.
- You may have an option to purchase supplemental disability insurance through your employer to increase the percentage of your pay you will receive.

LIFE INSURANCE

Not all employers offer life insurance and when it is offered it varies widely. If offered, you will likely see either a flat dollar amount benefit, such as $50,000 or $100,000, or a dollar amount relative to your salary, such as one times or two times your base salary.

Typically, if you are offered life insurance you will have an option to purchase supplemental insurance to increase your coverage. If you find the benefit insufficient, this is a very cost-effective way to add increased coverage.

RETIREMENT

The days of employer sponsored, or defined, retirement programs are almost gone. These are plans that the employee does not contribute to or get to determine the investment vehicle. These plans typically have a specific vesting time required before an employee can take the retirement funds with them if they leave the employer. If your employer offers one of these plans, great. If not, don't sweat it because it is no longer typical.

Tax deferred retirement plans are the most common retirement plan offered by employers. These are the 401k and 403b plans that you are familiar with already. In case you are wondering, these plans, which are named after provisions in the IRS code, are virtually the same plan, but the 401k is for for-profit organizations and 403b plans are for non-profit employers. These plans allow the employer to save money from their compensation on a tax-free basis. The IRS sets the limits and for 2015 it is $18,000, unless you are over 55 years olds old, at which age you can save $5,000 more under a catch-up provision.

For these programs you want to know if you are eligible to start contributing immediately or if there is a waiting period. You want to specifically ask if your time as a resident counts toward your tax deferred retirement plans; and, if there is an employer match.

PAID TIME OFF

Paid time off, or vacation, is sometimes listed in the benefit section and at other times it is within the body of the contract itself. The amount of time allowed off with pay will vary, but a good package will include a total of around 30 days, inclusive of vacation, days for CME and holidays. Sometimes the time off will be divided out and other times it will be in one bank of time off.

This is an area that you will likely see a difference between hospital employment and private practice employment. Private practitioners usually have less time off (in exchange for higher earning potential).

CALL SCHEDULE

Most employment contracts include language about expectations or schedule of taking call for the practice. Physicians should pay close attention to the call policy to decide if it fits with the industry standard.

CME

If your paid time off is not inclusive of Continuing Medical Education (CME), you may have a specified amount of days off to use for CME. If CME is separate, it will likely be in the range of five to seven days.

In addition to time off for CME, you should be given an allowance for CME. To determine if the CME allowance is sufficient, you really need to understand what is included. If it is just for CME (registration fees, travel and accommodations), you should be looking for a allowance of $2,500 or more. If this pot of money will also be used to pay for licenses, board certification courses and exams, dues and subscriptions, it should be higher.

Again, this is an area where you will find smaller allowances in a private practice arrangement than in hospital employment.

What to Look Out For

LIQUIDATED DAMAGES

Although not extremely common, some contracts have a liquidated damages clause. Basically, this is a provision that would allow the physician to pay a sum of money to continue to practice in the restricted area of the non-compete. This is really meant to be a deterrent for the physician to stay in the restricted area and the employer's way of trying to recoup some of the potential loss of business if the physician stays in the restricted area and patients follow the physician to the new practice. Liquidated damages clauses can range from $50,000 to a year's salary and they really need to be evaluated on a case-by-case basis to determine if it is worth "buying" yourself out of your non-compete.

MISCELLANEOUS

Every contract will contain several pages of provisions that are standard in every contract, although the language will vary from contract to contract, and are usually the last provisions before the signature lines. They are provisions such as Notices, Assignment, Entire Agreement, Waiver, Governing Law, Severability and Amendments. Nothing to worry about in particular with these provisions, other than to read and understand them.

Non-Compete Clause

To understand non-compete clauses, often called a covenant not to compete, it is important to understand their purposes. The fact is that employers invest a fair amount of resources, time and money into recruiting physicians. Because of that, they do not want to make it too easy for you to take a practice that they have helped build and perhaps financially support, across the street to a competitor. However, in trying to protect themselves, employers cannot restrict your livelihood to practice medicine.

Most non-compete clauses include a restricted time and a restricted territory, but unfortunately, they vary greatly depending on the specialty and geographic location. Generally, the broader the area from which you pull patients, the broader the scope of your non-compete. Therefore, specialists will tend to see longer and larger non-competes than a primary care physician. To give you an example, a primary care physician practicing in a large metropolitan area might have a non-compete for six months and five miles while a primary care physician in a more rural area might have a non-compete for two years and 25 miles.

Malpractice

Sometimes malpractice coverage is addressed as a benefit and other times it is in a separate provision in the contract. You mainly need to be concerned with the type and limits of the coverage, with a focus on understanding who is responsible for tail coverage (also called reporting endorsement).

There are three main types of coverage: occurrence based, claims made and modified claims made.

- **Occurrence based coverage** - is seamless and if you have this type of coverage, it covers any claim that occurred while you had the coverage. If your employer provides this type of coverage, you will not need to purchase tail coverage.
- **Claims made coverage** - covers you when the claim is made. Therefore, if you leave an employer with claims made insurance, you need to purchase tail coverage.
- **Modified claims made coverage** - is where the employer pre-buys the tail coverage. So, if your employer provides this type of coverage, you do not need a separate reporting endorsement.

The cost of malpractice insurance varies greatly depending on the geographic location of your practice, your specialty and your scope of practice. Typically tail coverage costs 1.5 to two times your annual premium.

Limits of malpractice coverage are also a consideration. Again, these policies will vary greatly depending on your location and specialty and could range from $100,000 to $1 million per occurrence and $300,000 to $3 million in the aggregate per year. Although Michigan does not require a minimum liability insurance limit, many hospital bylaws do have a minimum required limit in order to gain privileges.

Compensation

As described, most contracts have a very short provision in the contract addressing compensation that typically refers to an attachment. The attachment will then go into great detail about the guaranteed compensation, a shift to productivity compensation, non-productivity compensation and other recruitment incentives such as signing bonuses, educational stipends and loan repayment.

BASE SALARY

Most employed positions will offer you a guaranteed base salary for a period of time before shifting to a productivity based compensation plan. Ideally, the guarantee will be for at least two years. This will allow you to ramp up your practice for year one, then your year two productivity will be used to determine your compensation for year three. In addition to a two-year guarantee, it is ideal to have the ability to earn incentives based on productivity if you exceed expectations or to shift to the productivity based compensation prior to the end of two years if you can earn more under that formula.

Residents are always looking for a guideline to use to determine if the base salary guarantee they are being offered is fair. Unfortunately, salaries vary drastically depending on the location and duties, which makes it difficult to compare opportunities. It is most important to consider the job requirements (schedule, call, etc.) and full package (base salary, earning potential, benefits, incentives, etc.) to fully evaluate an opportunity.

Once your salary guarantee comes to an end, you will shift to a productivity based compensation plan. These plans also vary greatly and are often difficult to understand. Below are three examples of productivity based compensation plans.

NET INCOME

This method is where an employer incentivizes or compensates you based on the net profit of the practice, after all money comes in and all bills are paid. This method is not very common in hospital employed practices. This is because hospitals want physicians to focus on their individual productivity and not to focus on maximizing reimbursement and controlling expenses. This method, however, is more common in private practices where physicians are more engaged in the operations of the practice and what you earn is whatever is left over after all the expenses are paid.

GROSS CHARGES

This is a more common method than net income, but still not the most common method of calculating compensation after the salary guarantee ends. This is where the employer tracks all the charges generated by the physician and pays them a percentage or increases their compensation as they reach new levels of charges. This method is nice in the sense that it removes the physician's worry about how well the employer is doing in collecting money, how well the employer is doing in controlling the expenses and even removes the need to monitor the payer mix closely. It is important to understand that only services the physician personally provides are tracked. In other words, the physician is not given any credit for injections done by a nurse or ancillary services (labs, xrays, etc.) that a patient needed.

WORK RELATIVE VALUE UNITS

Work Relative Value Units, or WRVO, is one of the more common methods of calculating compensation based on productivity. Each patient visit is assigned a value based on code the visit was given, which combines the charge that was produced and the time spent with the patient. For example, a 99214 would have a higher value than a 99213. Once all the physician's wRVUs are tracked, they are multiplied by a conversion factor (a dollar amount) to arrive at the compensation. wRVU values and conversion factors vary from employer to employer, but many use values published by CMS (Centers for Medicare & Medicaid Studies) to develop the values used in their compensation formulas.

Compensation plans based on wRVUs do get complicated and sometimes are difficult to get your mind around. It is wise to ask for an example (literally an equation) that will help you determine your earning potential.

Regardless of what method an employer uses, it is most important that you get a good understanding of what you will have to do to maintain your initial guaranteed base salary. Ask the employer if the current physicians in the practice are maintaining their salaries on the productivity method and to walk you through an example on how you will be able to maintain that salary after your guarantee ends.

3. Licensing, Credentialing and VISAS

State Licensure

All Michigan physicians in training are required to hold an Educational Limited License. This is the license you hold as a resident. Your application for an educational limited license also includes a controlled substance license.

All Michigan physicians in training are required to hold an Educational Limited License. This is the license you hold as a resident. Your application for an educational limited license also includes a controlled substance license.

At the end of the second year of postgraduate training you may apply for a full license. Once granted a full license, you may practice outside of your training hospital.

The Board of Medicine may grant a full license to individuals who have successfully completed a minimum two years of postgraduate clinical training in an active residency program approved by the Board.

To apply for a full license, the following documentation is required:

1. A completed application for a medical license, including a check or money order for the appropriate amount, drawn on a U.S. financial institution and made payable to the STATE OF MICHIGAN. An application accompanied by the appropriate fee is valid for two years. If you fail to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
2. A medical school certification form completed by the Dean or Registrar of the medical school and forwarded directly to the Board of Medicine from the medical school (unless the certification is already on file with the Board).
3. Certification of your examination scores submitted directly to the Board by the Federation of State Medical Boards (FSMB) at 817-868-4000 or www.fsmb.org.
4. Certification of successful completion of two years of postgraduate clinical training in an active program approved by the Board. The Certification of Postgraduate Training Form, which is included in the application packet, must be submitted directly to the Board by the Director of Medical Education where you completed your postgraduate training.
5. If you have ever held a permanent license in another state, you will need to request official verification of that license from the other state. The verification must be submitted directly to the Board by the licensing agency in the other state.

Original licenses will expire on January 31 of the following year. Subsequent renewals are for a three-year period.

Find more information and helpful resources online at www.msms.org/licensure.

GRADUATES OF FOREIGN MEDICAL SCHOOLS

If you are a graduate of a medical school outside the U.S. or Canada applying for a full license, you must submit the following:

1. The completed application form and payment.
2. A completed Certification of Medical Education for Graduates of Foreign Medical Schools, submitted directly to the Board of Medicine from the medical school you attended.
3. Certification of examination scores submitted directly to the Board of Medicine from FSMB.
4. A completed Certification of Postgraduate Training Form attesting successful completion of at least two years of postgraduate clinical training in a Board-approved program. The form must be submitted directly from the Director of Medical Education where you completed your postgraduate training.
5. Verification of your Educational Commission for Foreign Medical Graduates (ECFMG) certificate must be electronically submitted directly to the Board from ECFMG. Go to www.ecfmg.org/cvs for information and instructions on how to apply for your ECFMG status report to be sent to the Board.
6. If you have ever held a permanent license in another state, you will need to request official verification of that license from the other state. The verification must be submitted directly by the licensing agency in the other state.

It is the physician's responsibility to have all required documentation sent to the Michigan Board of Medicine at the following address:

Michigan Department of Licensing and Regulatory Affairs
Board of Medicine
P.O. Box 30192, Lansing, MI 48909

Processing of an application takes approximately six to eight weeks. If there are delays in receiving transcripts, verifications or test scores, or the information submitted is incomplete, the process may take longer.

As part of the application process, you will receive a customer number that can be used to check the status of your application online at www.michigan.gov/appstatus. Questions regarding applications can be directed to the Michigan Board of Medicine at 517-335-0918 four weeks after the date the application was submitted.

Individuals applying for a full medical license may apply and make payment online at www.michigan.gov/mylicense. At that time, you will be able to print all of the supplemental documents that must be received by the Board in order to process your application.

DEA REGISTRATION

To apply for a new Drug Enforcement Administration (DEA) registration, you will need to request the DEA 224 application form. Applications for registration may be obtained from the state field office, DEA Headquarters at 800-882-9539 or online at www.deadiversion.usdoj.gov.

The average processing time for a new DEA registration is four to six weeks, provided that the application is complete. To avoid delays in processing your application, verify all information before submitting.

CONTROLLED SUBSTANCE LICENSE

There is a separate application and fee to apply for a Controlled Substance License. However, the application for a full medical license includes the option to apply for a Controlled Substance License on the same form. For more information, go to www.michigan.gov/healthlicense. For a downloadable application packet, click the "Boards for Professions Licensed/Registered/Regulated" link in the Resources section, then select "Board of Medicine."

Credentialing and Privileging

Credentialing is the jargon used for the process that hospitals, health plans, insurance companies and medical centers use for the application process to be a part of their organization. Privileging defines a physician's scope of practice and the clinical services he or she may provide. Both involve the organization determining what your credentials and skills are, making sure that you have stated them accurately and then deciding if your qualifications fit their need. It's like any other job that you've applied for but, because of the nature of the work you will be performing, extra measures are required to assure patient safety.

The Universal Provider Datasource (UPD), an online credentialing application service provided by the Council for Affordable Quality Healthcare (CAQH), can be used to apply to most Michigan health plans and many Michigan hospitals. This convenient tool enables physicians to fill out a uniform application that can be saved for future use and updated at any time. More information and access to UPD is available at www.caqh.org.

Credentialing is the jargon used for the process that hospitals, health plans, insurance companies and medical centers use for the application process to be a part of their organization. Privileging defines a physician's scope of practice and the clinical services he or she may provide.

Many Michigan health plans and hospitals once widely used the Michigan Association of Health Plans Standard Practitioner Application. Some plans still accept this standardized credentialing application form, but with the advent of CAQH's UPD, its use is limited.

Documentation required for credentialing includes, but is not limited to:

- Proof of application for board certification
- DEA and Controlled Substances license
- State medical license
- Proof of malpractice insurance
- Residency certificate
- Medical school diploma

TIPS FOR CREDENTIALING

1. Answer all questions on the credentialing form. Do not leave blank spaces and do not leave unexplained gaps in time.
2. Compare your application, CV and all certificates to make sure the information does not conflict.
3. Request only those privileges in which your competency can be proven.
4. Make copies of everything when it's ready for submission before you sign it.
5. Once you've submitted your application, check the status periodically. Your first application with an entity could take several months to be approved.
6. If you are denied membership, ask about the appeals process. All entities offer this process.

Re-credentialing is a process that takes place at least every three years, as mandated by accreditation requirements. You will need to gather and submit updated information about your qualifications that will be used to determine your ongoing participation in the institution. The CAQH Universal Provider Datasource can handle re-credentialing processes, as well.

More information is available at www.caqh.org.

VISAS

All graduates of international medical schools need a visa in order to practice within the United States.

J-1 VISAS

J-1 visas are generally granted to non-immigrant visitors to the U.S. who have no intention to abandon their overseas residence. If you have a J-1 visa and want to stay in Michigan to practice or do a fellowship, you must get a waiver. There are two ways to do this.

CONRAD 30 WAIVER PROGRAM (STATE SPONSORED)

This program is named after Senator Kent Conrad who sponsored the 1994 amendments to the Immigration and Nationality Technical Corrections Act that created the program. All U.S. states except Idaho have such a program, and each state has 30 such waivers to use. To qualify for a waiver under this program, the international graduate must work a minimum of 40 hours per week providing direct clinical care in internal medicine, pediatrics, family practice, OB-GYN, or psychiatry for three years in one of these geographical areas:

1. A Health Professional Shortage Area –Defined annually according to a prescribed physician/patient ratio considering the number of primary care, dental care, and mental health care physicians available in a geographic area.
2. A Mental Health Professional Shortage Area – Defined annually according to the number of psychiatrists.

INTERESTED GOVERNMENT AGENCY WAIVERS (Federally Sponsored)

Unlike the Conrad 30 waiver program, these federally sponsored waivers are available only to primary care physicians (i.e., internal medicine, general/family practice, pediatrics and psychiatry). Any international physician in the U.S. pursuant to one of these federally sponsored waivers may not be subject to "non-compete clauses" in their employment contract with the sponsoring facility. For an overview of the federally sponsored waiver program, visit the HHS Community Based Waiver Program webpage at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html.

H-1B VISAS

The H1-B visa is a non-immigrant classification used by a foreign national who will be employed temporarily in a specialty occupation. A specialty occupation requires theoretical and practical application of a body of specialized knowledge, with a minimum of a bachelor's degree, such as medicine. H1-B status requires a sponsoring U.S. employer and, under current law, may remain in H1-B status for a maximum of six years at a time. MOA and MSMS advise anyone contemplating any type of visa to secure an attorney who is knowledgeable in immigration law.

4. Medical Liability Insurance

Both the Michigan Osteopathic Association and Michigan State Medical Society have exclusively endorsed The Doctors Company. The Doctors Company was founded in 1976 in response to the medical liability insurance crisis in California that closed thousands of physician offices and threatened patient access to affordable care. After leading the charge for comprehensive tort reform, their founders established The Doctors Company to continue the cause of advocating for physicians and advancing the practice of good medicine.

As the nation's largest physician-owned medical liability insurer, The Doctors Company is committed to defending, protecting, and rewarding its members with the industry's most aggressive claims defense, unrivaled protection, and innovative rewards.

The sequence of events that often leads to a medical liability claim includes:

1. Doctor-patient relationship compromised
2. Patient anger
3. Unanticipated medical event, complication, or outcome
4. Physician nondisclosure of the event
5. Communication breakdown

Virtually all physicians are aware that practicing medicine in the United States is impossible without some form of medical liability insurance. The vast majority of hospitals and other health care institutions mandate that medical staff members be insured. However, many physicians have a limited understanding of how professional liability insurance works. It is important for every practicing physician to become familiar with both the business principles underlying insurance and the types of insurance coverage available.

To learn more about medical liability and/or become a member of The Doctors Company today, please contact :

MOA Insurance Team
1-800-657-1556

OR

MSMS Physicians Insurance Agency
877-PIA-ASK-US (742-2758)

5. Billing and Reimbursment

A very important part of medical practice in today's world is getting reimbursed for services. Following are the general categories of physician reimbursement relationships.

Traditional Indeminity Insurance

The Michigan market is dominated by Blue Cross Blue Shield of Michigan, which offers traditional indemnity insurance, PPO and HMO plans. Much of the Blue Cross PPO business is administered for self-funded employer groups.

Preferred Physicians Organizations

MANAGED CARE PLANS

There are a variety of managed care plans that offer HMO and PPO products. All of the commercial (non-Medicaid) plans in Michigan are not-for-profit. In 1997, the State of Michigan created a managed care program for the Medicaid population. Qualified health plans (QHPs) are plans that are authorized by the states or administer Medicaid managed care benefits.

WORKERS' COMPENSATION

The Michigan Workers' Compensation program pays physicians on a fee for service basis, with a fee schedule set by the state and benefits administered by various workers' compensation carriers.

Contracting with Health Plans

Almost all physicians are presented with and asked to sign contracts of one type or another with health plans. Contracts and the terms they contain are important. Unfortunately, their importance is often not known until there is some sort of dispute or the contract is terminated or expires without being renewed. Particularly troubling to physicians in recent years have been "managed care" type contracts. The terms of one managed care contract versus another can vary considerably. However, they are all similar in that they all involve your agreeing to discount the fees you charge in exchange for the managed care plans' agreement to allow you to provide your services to the patients they have enrolled in their plans. Even if you believe that you have no choice but to sign the agreement (given the market share of the HMO in your area or due to other forces), you still should make sure that you understand all of the contract's terms. This is the only way to know for sure what you are getting yourself into.

You should always be provided a reasonable amount of time to review a contract prior to being expected to sign it. You also should be provided with all attachments, exhibits, schedules, etc., to which the contract refers so that you can review these documents before having to sign the contract. If you are given an unreasonably short period of time to review a contract, and/or are given the contract without an exhibit it mentions (such as the fee schedule), you should immediately demand copies of any missing addenda and sufficient time to consider all the materials thoroughly. Being expected to sign a contract without adequate time to review it with your attorney, and/or not being supplied with all the information to which you are agreeing in the contract is an unacceptable business practice and should not be tolerated.

Top Ten Contracting Issues

There is no substitute for understanding the entire contract. Your associations provide a detailed inventory of key elements contained in most managed care contracts in their Managed Care Contracting Checklist (www.msms.org/GuidesChecklists). What follows is a list of ten typical managed care contract issues that you should pay particular attention to:

1. The Term

How long will you be bound to the contract? Is it a one-year contract that automatically renews? What if you do not want it to renew? Are you entitled to advance written notice of non-renewal?

2. Fee Discounts

All managed care contracts will contain a term that requires you to limit the fees you charge for the services you provide to patients who are enrolled in the managed care company's plan. The identity of the enrollees, the plan(s) and the services for which the fee limitation applies should be clearly set forth in the contract. If the contract does not clearly state this information, you may find that the contract is being used by the managed care plan to force you to discount your fees for services you provide to patients who are not a part of the specific plan(s) you anticipated.

3. Fee Schedule

The contract should have a fee schedule attached as an exhibit that presents (preferably by procedure code) the fee limitations. How this fee schedule can be amended should be clearly explained in the contract.

4. Claims Procedure

How do you get paid? How are claims for payment processed? How long does processing take? Are there penalties (e.g., interest) for claims paid later than a fixed number of days after the claim has been properly submitted? Under what circumstances can you bill the patient for the difference between your usual fee and the limited fee the contract requires (i.e., is balance billing permitted)? How are co-pays and deductibles collected from patients?

5. Effects of Termination

Does the agreement contain a term stating that if your contract to participate with an HMO is terminated that a separate contract you have signed to participate with a PPO or other product with also automatically terminate? These "all products" clauses are frequently in the contracts of managed care companies selling several HMO, PPO or other products. An all-products clause is usually present when one product is more desirable than the others due to higher reimbursement, less onerous claims procedures, etc.

6. Access Criteria

Does the contract allow you to participate so long as you meet the managed care company's utilization, quality, peer review and other standards? Does the company have undisclosed criteria for participation (e.g., limitations on the number of physicians or types of specialists in a geographic area, specific referral patterns, etc.)?

7. Amendments

Who can amend the contract? Is your consent to an amendment required? Can any term contained in the contract be amended or just certain terms? Can an amendment be retroactively applied? If you do not agree to an amendment, do you have the right to terminate the contract?

8. Credentialing

How often and under what circumstances are you required to be credentialed by the managed care company? What is involved in this process? Does the contract contain appropriate confidentiality protections covering the material that you will be expected to disclose?

9. Keep a Copy

This sounds awfully simple but is many times not followed in practice. Always keep a fully signed copy of the contract for your records. Many times contracts change while being negotiated and in the absence of a fully signed copy of the final version it may not be possible to determine the final terms. In addition, the contract will have timelines and requirements for the giving of notice to do certain things – you probably won't have these details committed to memory and will need the contract for reference. You should also schedule a time to review your contracts annually to determine if any action is needed and to refresh your memory on the terms of the contracts. Some contracts renew automatically unless you or the health plan makes a change, so it is a good habit to review all contracts periodically.

10. Consult an Attorney

Always have your personal attorney review the contract with you. These and the other terms of the contract should be explained and put in the proper context for you by your attorney.

Medicaid and Medicare

MEDICARE

Medicare is a health insurance program for aged persons to complement the retirement, survivors and disability insurance benefits under Title II of the Social Security Act. Medicare covers persons age 65 and older. Persons under age 65 may be covered if approved for disability or if they have certain diseases.

Medicare consists of hospital insurance (Part A), supplemental medical insurance (Part B), prescription drug coverage (Part D), and Medicare Advantage plans, which offer beneficiaries a private health plan option.

How to enroll in the Medicare Program: Physicians wishing to receive payment for Medicare services must complete Form CMS-855, Provider/Supplier Enrollment application. This form requests payment and other general information and documentation to ensure that an applicant is qualified and eligible to enroll in the Medicare program. The enrollment application may be obtained by calling the Wisconsin Physicians Service (WPS) at 866-234-7331.

Application information is also available under "Provider Enrollment" at: www.wpsmedicare.com/j8macpartb/departments/enrollment

MEDICAID

Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources. The Medicaid program is jointly funded by the federal and state governments to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

With broad national guidelines established by federal statutes, regulations and policies, each state:

1. Establishes its own eligibility standards
2. Determines the type, amount, duration, and scope of services
3. Sets the rate of payment for services
4. Administers its own program

Providers wanting to participate in the Medicaid Program must enroll online through the Community Health Automated Medicaid Processing System (CHAMPS). Visit www.michigan.gov/mdch and click "Popular Links," then "The New Medicaid Processing System."

For more information or to ask questions, call Provider Support at 800-292-2550 or email ProviderSupport@michigan.gov.

Osteopathic Manipulative Treatment

The decision to utilize osteopathic manipulative treatment (OMT) as part of the overall health care of patients is made on a visit-by-visit basis. As such, it is typical that on the initial and interim encounters a history and physical examination is performed. Based on the history and findings of the physical examination, the physician may decide to use OMT as part of the overall management of the patient. OMT is typically provided during return visits based on an evaluation and management (E/M) service provided on the same date. The E/M service is a significant, separately identifiable service above and beyond the work of the OMT.

Find the OMT Coding Instructional Manual at www.domoa.org/?page=240.

National Provider Identifier

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the adoption of a standard unique identifier for health care providers. The National Provider Identifier (NPI) is a 10-digit, intelligence-free numeric identifier. Intelligence free means that the numbers do not carry information about health care providers, such as the state in which they practice or their provider type or specialization.

The NPI replaced health care provider identifiers used in the past. Those numbers included Medicare legacy IDs (UPIN, OSCAR, PIN and NSC). The provider's NPI will not change and will remain with the provider regardless of job or location changes.

You can apply online at https://nppes.cms.hhs.gov or call 800-465-3203 to obtain a paper copy of the application.

Coding and Documentation

Professional services performed by a physician in an office or facility setting must be reported on a CMS-1500 claim form in order to submit to the patient's health plan for reimbursement. These services are reported by assigning procedure and diagnosis codes to the services rendered. There are two types of procedure codes: CPT and HCPCS.

CPT codes: Current procedural terminology codes are sets of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers. Each procedure or service is identified with a five-digit code. The use of the CPT codes simplifies the reporting process.

When reporting, you must select the name of the procedure or service that accurately identified the service performed. Do not select a CPT code that merely approximates the service provided. If no such procedure exists, then report the service using the appropriate unlisted procedure or service code.

You will find the Evaluation and Management (E&M) codes in the first section of the CPT manual. E&M codes are for professional services, such as office visits, consultations, hospital care days, nursing facility, critical care, newborn care, etc. Laboratory and pathology, surgical, radiology and medicine are other sections of the CPT manual that will guide you in finding the appropriate code.

HCPCS Codes: The health care procedure coding system is a uniform method for health care providers and medical suppliers to report professional services, drug codes, DME codes, temporary codes and supplies.

ICD-9/10 CODES

There is only one type of diagnostic code, and it can be found in the International Classification of Diseases 10th Revision (ICD-10). These codes classify morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations for data storage and retrieval.

ICD-9 was used since 1979 and no longer reflects advances in medical treatment. ICD-10 has been updated to reflect the current clinical understanding and technological advancements of medicine, and the code descriptions are designed to provide a more consistent level of detail. It contains a more extensive vocabulary of clinical concepts, body part specificity, patient encounter information and other components from which codes are built. ICD-10 diagnostic codes are alpha-numeric codes and contain more digits than ICD-9 codes to report a higher level of specificity. On October 1, 2015, the ICD-9 code sets were replaced completely by the ICD-10 code sets. After this date, ICD-9 codes are no longer accepted on claim forms. The transition to ICD-10 was required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA).

The important and most basic books you will need are the CPT-4 Procedural Code Book, ICD-10 Diagnosis Code Book and the HCPCS Code Book (drugs, supplies, etc.). These books are available from the American Medical Association and many other sources. It does not matter where you purchase them. Your national and state specialty societies are good sources of coding information specific to your specialty.

MSMS offers assistance to physicians who have coding and billing questions or who experience reimbursement difficulties.

The MSMS Reimbursement Advocate can help with payment rules, billing issues and other technical advice. Contact Stacie Saylor, CPC, CPB, at 517-366-5722 or ssaylor@msms.org.

6. Continuing Medical Education (CME)

The Board of Medicine has established six categories* of approved continuing medical education. On the following pages is a brief description of each category, the number of allowable hours that may be earned in each category during the three-year period preceding license renewal and examples of acceptable documentation.

Three categories for Osteopathic Physicians.

CME Requirements for Allopathic Physicians

The Michigan Public Health Code and Board of Medicine administrative rules require every medical doctor to complete, during the three-year period before the expiration date of the license, not less than 150 hours of continuing education in courses or programs approved by the Board. Pursuant to this requirement, the Board of Medicine has promulgated rules to establish specific criteria for its approval of continuing medical education courses and programs.

The continuing education requirements apply to every physician renewing a Michigan Medical License who held the license for the three-year period immediately preceding the date the license expires. The requirements apply whether or not the physician is actively engaged in the practice of medicine. No one, including medical school faculty and resident physicians, are exempt from this requirement.

Of the required 150 hours of continuing medical education, not less than 75 hours must be earned in courses or programs designated as either Category 1 (accredited) or Category 6 (residency) programs. Every medical doctor who is renewing his or her license should retain records documenting the completion of continuing education. It is recommended that a doctor keep each record for at least six years after the date the education was completed.

CATEGORY 1 – MAXIMUM: 150 HOURS

Continuing medical activities with accredited sponsorship

- Programs must be designated as Category 1 by a sponsor accredited by the Accreditation Council for Continuing Medical Education or a State Medical Society.
- Documentation: Certificate of Attendance.

Tutoring experience

- Must be approved by the Board of Medicine before commencement of the program.
- Documentation: Letter from the tutor.

Specialty board certification or recertification

- Credit may be earned only during the year in which the licensee is advised he or she passed the examination.
- Documentation: Certificate of Completion.

CATEGORY 2 – MAXIMUM: 36 HOURS

Continuing medical activities with non-accredited sponsorship

- The program must be submitted to the board for approval.
- Documentation: Certificate of Attendance.

CATEGORY 3 – MAXIMUM: 48 HOURS

Tutoring medical physicians under Category 1

- Documentation: Letter from a hospital or institution official.

Teaching medical physicians or teaching the allied health services

- The hospital or institution must approve the teaching in an accredited residency program and the board must approve all other hospital or institutional instructional programs.
- Documentation: Letter from the program director.

CATEGORY 4 – MAXIMUM: 48 HOURS

Books, papers and publications

- A maximum of 24 hours may be earned for preparation and initial presentation of a formal original scientific paper before a professional meeting.
- A maximum of 24 hours may be earned for preparation and initial publication of an original scientific article or paper, or a chapter or part of a chapter in a book authored and published in a journal or other periodical publication listed in Index Medicus.
- Documentation: Copy of the document presented or published with evidence of presentation or publication (i.e., meeting and agenda or publication acceptance letter)

Exhibits

- A maximum of 24 hours may be earned for preparation and initial presentation of a scientific exhibit at a professional meeting.
- Documentation: Copy of meeting agenda or letter from professional organization official.

CATEGORY 5 – MAXIMUM: 36 HOURS

Self-assessment

- A maximum of 18 hours may be earned for completion of a multimedia program approved by the board.
- Documentation: Licensee's signed statement describing multimedia program.

Self-instruction

- A maximum of 18 hours may be earned for the independent reading of scientific journals listed in Index Medicus.
- Documentation: Licensee's signed statement describing materials read.

Participation on the hospital staff committee dealing with quality patient care or utilization review

- A maximum of 18 hours may be earned in this subcategory.
- Documentation: Letter from a hospital administrator.

CATEGORY 6 – MAXIMUM: 150 HOURS

Full-time participation in a graduate training program

- A maximum of 50 hours per year may be earned for satisfactorily participating in an accredited postgraduate training program with a minimum of 5 months participation per year required.
- Documentation: Letter from program director

CME Credits for Osteopathic Physicians

The Michigan Public Health Code and board administrative rules require every osteopathic physician to complete, during the 3-year period prior to the date of renewal of the license, not less than 150 hours of continuing education. The requirements apply whether or not the physician is actively engaged in the practice of osteopathic. No one is exempt from this requirement.

Each osteopathic physician is required to complete 150 hours of continuing medical education in courses or programs approved by the board of which not less 60 hours of the required 150 hours must be earned in osteopathic related courses or programs designated as either Category 1 (accredited) or Category 3 (residency) programs. Every osteopathic physician who is renewing his/her license should retain records documenting the completion of continuing education. Those documents should be retained for a period of 4 years from the date of application.

CATEGORY 1 – MAXIMUM: 150 HOURS

Formal osteopathic educational programs with accredited sponsorship programs designated as Category 1 with the American Osteopathic Association

- Documentation: Certificate of Attendance.

Scientific papers and publications – Maximum: 90 hours at 10 hours per publication. Development and presentation of scientific papers and electronic communication programs intended for physician education – Documentation: Copy of the document presented or published with evidence of presentation or publication; i.e., meeting and agenda or publication acceptance letter.

Osteopathic medical teaching – Maximum: 90 hours. Participation as a teacher, lecturer, preceptor, or moderator-participant in a medical education program approved by the board. Teaching includes classes in colleges of osteopathic medicine and lecturing to hospital interns, residents and staff – Documentation: Letter from program director indicating role and estimated hours of participation.

Formal inspection of an osteopathic medical educational program – Maximum: 90 hours at 5 hours per inspection. Participation in inspection programs of osteopathic hospitals and conducting clinical examinations of osteopathic specialty certification boards – Documentation: Letter from agency verifying hours of participation and location of inspection or examinations.

Peer review activities in osteopathic medical institution – Maximum: 90 hours. Participation in hospital committees and departmental conferences concerned with the review and evaluation of patient care in osteopathic medical hospitals and colleges or participation on professional standards review organizations – Documentation: Letter from hospital or educational institution official.

CATEGORY 2 – MAXIMUM: 90 HOURS

Formal non-osteopathic educational programs with accredited sponsorship by the Accreditation Council for Continuing Medical Education or of its constituent state medical societies or a program that has Michigan Board of Osteopathic Medicine approval.

- Peer review activities in all allopathic medical institutions – Maximum: 90 hours.
- Participation in hospital committees and departmental conferences concerned with the review and evaluation of patient care in allopathic medical hospitals and colleges and includes serving on professional standards review organizations (PSRO).
- Documentation: Letter from hospital or educational institution official.

Home study – Maximum: 90 hours. Consists of reading journals published by osteopathic organizations or other scientific journals listed in "Index Medicus" or completion of mediated physician education programs in audiocassette, videocassette or computer-assisted format – Documentation: Licensee's signed statement describing materials read or certificate of programs completed.

Scientific exhibits – Maximum: 90 hours at 10 hours per exhibit. Preparation and personal presentation of an exhibit related to the practice of osteopathic medicine at a county, regional, state or national professional meeting – Documentation: Copy of the document presented with evidence of presentation or publication; i.e., meeting and agenda.

Formal non-osteopathic programs – Maximum: 90 hours. Consists of formal educational programs approved by the board which do not include osteopathic principles and practice; the subject matter shall relate to the practice of osteopathic medicine and surgery – Documentation: Certificate of Attendance.

CATEGORY 3 – MAXIMUM: 150 HOURS

Postgraduate clinical training programs - 50 hours per year allowed for full time participation for not less than 5 months per year in a postgraduate clinical training program approved by the board in Rule 339.106(2)

- Documentation: Letter from program director.

7. Laws and Regulations *Affecting the practice of medicine*

For updates on the latest legislative activities visit www.msms.org or www.domoa.org.

Federal Trade Commission Identity Theft "Red Flags Rule"

The "Red Flags Rule" is a Federal Trade Commission (FTC) rule that requires creditors and financial institutions to implement identity theft prevention programs. This is important for association members to be aware of because, while physicians and private-practice doctors' offices are exempt from the Rule, some hospitals and other medical institutions are considered "creditors" who must comply with the regulation. For more information on the "Red Flags Rule" and who must comply, see http://www.business.ftc.gov/documents/bus23-fighting-identity-theft-red-flags-rule-how-guide-business.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is comprehensive legislation enacted to protect the privacy of health care data and to promote standardization and efficiency in the health care industry. There are four parts to the Administrative Simplification portion of the law, the Electronic Transactions and Code Sets requirements.

ELECTRONIC TRANSACTIONS AND CODE SETS REQUIREMENTS

HIPAA requires every provider who does business electronically to use the same health care transaction, code sets, and identifiers. Code sets are the codes used to identify specific diagnoses and clinical procedures on claims and encounter forms, such as the CPT-4 and ICD-10 codes.

- **Privacy requirements** govern the disclosure of patient protected health information, while protecting patients' rights.
- **Security requirements** cover administrative, technical and physical safeguards to prevent unauthorized access to protected health care information.
- **National Identifier Requirements** mandate that health care providers, health plans and employers have standard national numbers that identify them on standard transactions.

For more on HIPAA, see http://www.hhs.gov/ocr/privacy/hipaa/administrative/statute/hipaastatutepdf.pdf

Medicare Billing Compliance

Filing false medical claims is a crime. The U.S. Department of Justice considers combating health care claims fraud and abuse among its top priorities. A false claim is any in which any statement made to secure reimbursement is inaccurate. This includes even seemingly minor errors, such as dates, provider numbers or places of service. The most common types of fraud include:

- Billing for services not provided
- Misrepresenting the diagnosis
- Soliciting, offering or accepting a kickback
- Unbundling charges
- Falsifying any medical documents or records
- Submitting duplicate reimbursement claims
- Billing for higher-level procedure than the one performed

The responsibility for fraudulent claims rests with anyone who "knows or should know" that the services were not provided as claimed, and the penalties can be severe. Just the Medicare audit can be a horrendous experience. Every medical practice needs a compliance plan to guard against fraud, whether intentional or inadvertent.

STEPS FOR AN EFFICTIVE COMPLIANCE PLAN

The Office of the Inspector General suggests seven steps for an effective compliance plan:

1. Develop standards and procedures for billing and coding.
2. Designate a "compliance officer" with oversight and responsibility.
3. Conduct effective training for your employees.
4. Develop a mechanism for employees to report suspected violations.
5. Create monitoring and auditing systems.
6. Investigate problems and take disciplinary action.
7. Initiate corrective action.

Patient Bankruptcy

As people struggle financially, physicians need to understand their rights and responsibilities when their patients are facing the dire reality of bankruptcy and leave unpaid medical bills.

For more information, see "What Physicians Need to Know When Patients File for Bankruptcy" at www.msms.org/legal

Terminating a Physican-Patient Relationship

Occasionally, a physician feels the need to terminate a relationship with a patient. Mutual respect, good communication and a willingness of both parties to fulfill their responsibilities in developing and implementing the treatment plan are characteristics of a successful physician-patient relationship. There are legal boundaries that regulate the termination of this relationship. Before this happens, physicians need to be aware of these boundaries.

For more information, see "Terminating a Physician-Patient Relationship" at www.msms.org/legal

Medical Records Retention

A variety of state and federal laws governs the retention, release and disposition of patien medical records. These regulations cover such issues as:

- Information that must be in a medical record
- Right of access of patients to their medical records
- Release of medical records
- Physician patient privilege
- Retention and storage of medical records
- Disposal of medical records
- Rules governing electronic medical records

For more information, see "Medical Records Guide for Physician Practices" at www.msms.org/guideschecklists

Patients with Impaired Hearing or Limited English Proficiency

Many physicians today have hearing-impaired patients and/or patients with limited English proficiency. The Americans with Disabilities Act (ADA) requires physicians to "reasonably accommodate" hearing-impaired patients. "Reasonable Accommodation" must be determined on a case-by-case basis.

For more information, see "Legal Issues for Physicians Treating Patients with a Hearing Impairment or Limited English Proficiency" at www.msms.org/legal

Federal Antitrust Laws

The U.S. Department of Justice and the Federal Trade Commission enforce the federal antitrust laws, first enacted in 1890. Collaborating with physicians outside your practice about fees, discounts or boycotts is illegal. Violations can result in large fines or criminal prosecution. Some types of antitrust violation are:

- Setting fees with other physicians outside your practice
- Threatening a boycott of another physician or organization, such as an HMO
- Agreeing with competing practices to split up the territory where you will each promote your practices

For more on Federal Antitrust Laws, see https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws.

Stark Laws

Stark I and Stark II prohibit referring Medicare or Medicaid patients for certain designated health services with which you or an immediate family member have a financial interest. Penalties can include fines of up to $15,000 per incident plus twice the reimbursement claimed. You may also be barred from participating in Medicare or Medicaid in the future.

The designated health services include:

- Clinical laboratory services
- Physical therapy, occupational therapy or speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy and supplies
- Durable medical equipment and supplies
- Prosthetics, orthotics and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services
- Parenteral and enteral nutrients, equipment and supplies

The Stark definition of immediate family includes parents, spouse, children, siblings, in-laws, grandparents, grandchildren, stepparents, stepchildren, stepsiblings and stepgrandparents.

General legal questions on a variety of issues of concern to physicians statewide (e.g., medical record retention, medical records charges, privacy issues, Stark, etc.) are answered for FREE as a benefit of MSMS membership.

Public Health Code

The Public Health Code is a compilation of state regulations that affect health care practice in Michigan. Regulations that specifically apply to licensed, registered or certified health professionals are found in Articles 7, 15 and 17 of the Michigan Public Health Code.

For more on Michigan's Public Health Code, see http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-368-of-1978.pdf.

Administrative Rules

The practice of medicine is also governed by the Administrative Rules of the Board of Medicine. Administrative rules are the Board's written regulations, standards, policies, rulings or instructions that help to further define regulations found in the Public Health Code.

For more on Michigan's Administrative Rules, see http://www.michigan.gov/lara/0,4601,7-154-35738_10806-271924--,00.html.

Occupational Safety and Health Administration

The Occupational Safety and Health Administration (OSHA) is the governmental agency that oversees the health and safety of employees within their workplaces. Some of their regulations apply to all business and some apply to facilities only with 10 or more employees. Medical practices must comply with seven different areas of OSHA standards:

- Bloodborne Pathogens Standard
- Hazard Communication
- Ionizing Radiation
- Exit Routes
- Electrical
- OSHA poster
- Reporting Occupational Injuries and Illnesses

For more on OSHA, please visit https://www.osha.gov/.

Medical Marihuana

The Michigan Medical Marihuana Program (MMMP) is a state registry program within the Health Professions Licensing Division in the Bureau of Health Care Services at the Michigan Department of Licensing and Regulatory Affairs. The program administers the Michigan Medical Marihuana Act as approved by Michigan voters on November 4, 2008. The program implements the statutory tenets of this act in such a manner that protects the public and assures the confidentiality of its participants.

Learn more about the Michigan Medical Marihuana Act, see the "Physicians Guide to the Michigan Medical Marihuana Act" at www.msms.org/guideschecklists.

8. Insurance Considerations

Benefits and Insurance

CHOOSING A MEDICAL LIABILITY COMPANY

You may be tempted to go with the medical liability insurance company that gives you the lowest quote on your annual premium, but looking only at price can be a mistake. By doing some research to secure coverage with a financially strong company that is committed to Michigan, you will save yourself possible headaches in the future.

Following are questions you should ask and general guidelines to consider when choosing a company to provide your liability coverage:

1. **How much of the company's business is comprised of medical professional liability insurance?**

   A physician-focused company – one whose primary line of business is medical liability – is more committed to its policyholders and better prepared to deal with the ups and downs of the insurance market.

2. **What is the company's experience in Michigan?**

   A company that is based in Michigan, with a history of doing business here will have more experience in the state. A regional carrier will also have a better understanding of the local culture and legal venues. This knowledge is often crucial in preparing a strong defense in the event of a lawsuit.

3. **What is the company's commitment to Michigan's medical community?**

   Look for a company that has ties to local medical societies and physician organizations. Companies that work with organized medicine on issues of importance to physicians are committed to, and investing in, the future of the company.

4. **Is the company in good financial health?**

   The first thing you should look at when evaluating the financial stability of an insurance company is its A.M. Best rating. Companies with ratings lower than B, or that are unrated, may not have the financial stability to meet their claims-paying obligations.

5. **How does the company handle claims?**

   It is important to understand the insurers' claims management philosophy and process of handling claims. Talking with a colleague who has already experienced a claim and consulting with your local medical society for endorsements will provide good information.

Life Insurance

Everyone needs life insurance and no less so a new-to-practice physician. If you should die, you want to make sure your family is provided for financially, especially if you would be leaving them with large educational loans for which they'd be responsible. The amount of life insurance and the type(s) you need (term insurance, whole life, etc.) depend on your individual circumstances. It's best to consult with a financial advisor to help you calculate life insurance into your overall estate plan.

Health Insurance

If you become an employed physician or part of a group practice, health insurance will be part of your total compensation package. If not, you will need to find suitable coverage for yourself and your family. Options range from traditional indemnity insurance to Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). You will want to evaluate cost versus flexibility and choose the plan that best suits your needs.

Disability Insurance

Contrary to popular thinking, the chance that you will become disabled while young is much greater than the chance that you'll die. You need to provide for a source of income in case of that event. Disability insurance may be one of your employee benefits or you may have to obtain it on your own. When comparing disability policies, be sure to evaluate the amount payable, the length of payout, the length of the waiting period and exclusions.

Some policies provide for coordination of benefits, so that the amount of payments you receive from Social Security or other disability insurance would be deducted. Other questions to consider:

1. What if you become able to work part-time? Can you draw partial disability payments?
2. Are premiums waived while you are disabled?
3. Is there an annual cost-of-living adjustment increase in benefits?
4. Is renewal guaranteed with a re-evaluation of your health?
5. Is there catastrophic coverage that would increase payments if you are cognitively disabled or need paid care?

And if you're in a solo practice, don't forget "overhead" or business continuation insurance, which would allow your practice to continue to operate while you're disabled.

Health, Dental and Vision Insurance from MOA and MSMS

Both the Michigan Osteopathic Association and the Michigan State Medical Society have been trusted providers of health, dental and vision insurance to their respective members, their families and their employees for more than 50 years.

The Michigan Osteopathic Association Insurance Team (MIT) and the MSMS Physicians Insurance Agency offers members competitive rates, support of their respective professional association, superior customer service and unique benefits.

The Michigan Osteopathic Association Insurance Team (MIT) may be reached by calling (800) 657-1556, MIT@domoa.org or by visiting www.domoa.org/Insurance.

The MSMS Physicians Insurance Agency may be reached by calling (877) PIA-ASK-US (877-742-2758), msmsagency@msms.org or by visiting www.msmsinsurance.org.

9. Financial Planning and Loans

Financial Planning

Because your retirement planning is so important to your future well-being, you should ask questions about the retirement plans available to you and how they work, as well as how to best use your retirement dollars.

Members of the Michigan Osteopathic Association, please contact:
Morgan Stanley at (800) 248-0487.

Members of the Michigan State Medical Society, please contact:
WealthCare Advisors at (248) 971-7509 or visit their website at http://wealthcareadvisors.com. WealthCare Advisors is the only wealth advisory firm partnered with the Michigan State Medical Society. They were established by Michigan physicians to serve Michigan physicians.

Loan Repayment

There are a few different opportunities to get assistance with your student loans. The funding and criteria for each program varies. Below is an introduction:

NATIONAL HEALTH SERVICE CORPORATION (NHSC)

The NHSC loan assistance program is a federal program available for primary care providers (family medicine, pediatrics and internal medicine) who commit to working in a Health Provider Shortage Area (HPSA). The funds available for this program as well as the application time frame and required criteria for this program vary from year to year. It is a very competitive, laborious process with no guarantee that you will get the funding. Currently the program offers up to $50,000 for a two-year commitment in their Tier I priority areas, which is a location with a HPSA score of 14 or above. The other benefit of this loan repayment program is that the money is tax-free.

For full details about this program, visit the National Health Service Corp website at: www.nhsc.hrsa.gov\loanrepayment

MICHIGAN STATE LOAN REPAYMENT PROGRAM (MSLRP)

This program is funded by a combination of funds from the federal government, the state government and the local employer. Like the NHSC program this program is only available for primary care providers who work in an HPSA, although there is not a priority based on the HPSA score. A difference from the NHSC program is that with MSLRP the employer is required to commit to a 20% match of the federal/state funds. Currently the program offers up to $25,000 per year for a two year commitment and like the federal program this money is tax-free.

For full details about this program, visit the MSLRP page on the State of Michigan website: www.michigan.gov/mslrp

EMPLOYER FUNDED LOAN ASSISTANCE

Some employers are able to offer self-funded loan assistance. These plans are typically structured as a loan to the physician that is forgiven over a period of commitment to stay in the community and work for that employer. Things to consider when being offered employer funded loan assistance:

When is the money received? Some employers provide the money up front. That is nice, but keep in mind that it is a loan – you will have to sign a promissory note and it will accrue interest from the time you receive the money. Others may pay it in monthly installments for each month that you work. In this case it is not a loan and there is no forgiveness period because you are earning it as you go. Another possibility would to receive it in a lump sum at the end of year you work, more like a retention bonus. Again, this would not be a loan.

What are the forgiveness terms? Typically the larger the amount the longer the string. For instance, if you are being offered $50,000 in loan assistance, you may have a two or three-year commitment period whereas if you are offered $100,000, you may have a four or five-year commitment period. When looking at the forgiveness terms it is ideal to have a prorated forgiveness or payback. In other words, if you were to make a three-year commitment, you would like to have 1/36th forgiven each month you work. This reduces your risk if you leave within a year where as it might not be forgiven if they only forgive it for year full-year commitment.

How will you be taxed? Sadly, there is no such thing as free money. Although it will be very helpful to get assistance with paying back your loans, it will be taxable income. So that you can plan accordingly for the tax consequences, you will want to find how the money will be taxed. Taxes may be taken out when you receive the money or you may get a 1099 on the dollar amounts (principal and interest) as it is forgiven.

10. At-A-Glance

Contact information for associations, state boards, IRS, etc.

Michigan Osteopathic Association
2445 Woodlake Circle
Okemos, MI 48864
800-657-1556
www.domoa.org
moa@domoa.org

Michigan State Medical Society
120 West Saginaw Street
East Lansing, MI 48823
517-337-1351
www.msms.org
msms@msms.org

Michigan Board of Medicine
Bureau of Health Care Services
Health Professions Division
P.O. Box 30670
Lansing, MI 48909-8170
517-335-0918
www.michigan.gov/healthlicense
bhpinfo@michigan.gov

Michigan Board of Osteopathic Medicine and Surgery
Bureau of Health Care Services
Health Professions Division
P.O. Box 30670
Lansing, MI 48909-8170
517-335-0918
www.michigan.gov/healthlicense
bhpinfo@michigan.gov

Michigan Bureau of Health Care Services Administration
517-335-1980
bhcsinfo@michigan.gov
Michigan State Licensing
(Hospitals,Hospice, FSOF, Psych) 517-241-4160

Michigan Substance Abuse Facilities
517-241-1970

Federal Certification (Hospitals, ESRD, Surgical Centers):
517-241-4160

Federal Certification (Hospice, HHA, Psych, RHC)
517-241-3830

Michigan Health Facilities Engineering Section Plan Review and Construction Permits
517-241-3408

Hospitals and Specialized Health Services
517-241-3830

Lab Improvement (CLIA)
517-241-2648

American Medical Association
800-621-8335
www.ama-assn.org

American Osteopathic Association
800-631-2771
www.osteopathic.org

Drug Enforcement Administration
800-882-9539
www.deadiversion.usdoj.gov

Internal Revenue Service
800-876-1715
www.irs.gov

Internal Revenue Service Forms
800-829-3676

OSHA Compliance
800-475-4019
http://www.osha.gov

Michigan Osteopathic Association

2445 Woodlake Circle, Okemos, MI 48864

Phone: 800-657-1556 Email: moa@domoa.org

Website: www.domoa.org

Michigan State Medical Society

120 West Saginaw St., East Lansing, MI 48823

Phone: 517-337-1351 Email: msms@msms.org

Website: www.msms.org