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Part B News
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In this issue

Practice management

To ease doctor-departing woes, write careful terms into the contract

If you're worried that one of your employed physicians will want to leave before their contract expires, be aware that the best time to handle that problem is when they first sign on. Also, remember that "I quit" isn't always the end.

These days most physician employment contracts are specific as to the conditions for contract termination. In many cases, both the practice and the physician will have the right to pull the ripcord so long as the initiating party meets a specified window of notice, usually in multiples of 30 days. But these contracts will also — if they're carefully drawn — cover a number of financial and procedural entanglements that need to be untied, says Elizabeth L.B. Greene, a partner with the Mirick law firm in Worcester, Mass.

In Greene's view, best practice would include, in addition to notice:

- A cooperation provision (a general requirement for the parties to wind the relationship down in good faith);
- Disposition of compensation and profit-sharing terms and conditions;
- Disposition of contributions to insurance;
- Disposition of malpractice coverage (and tail coverage information, as applicable);
- Non-solicitation and non-competition provisions;

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- Terms for communicating with patients about the physician's departure; and
- Terms for dispute resolution (including waiver of right to trial by jury in favor of alternative dispute resolution, with specificity).

All of this must be in compliance with applicable state and federal laws, Greene adds.

Getting these straight is most of the battle, says Stu Schaff, founder and CEO of health care consultancy The Best Practice in Chicago. "A physician's employment contract and, if the physician is a partner, your practice's partnership and/or operating agreements, should outline everything that will happen if and when that physician leaves," he says. "There should be no surprises nor much need to negotiate."

Notice tricks

It's important for both the physician and the practice to be clear about these terms even on something as apparently simple as a notice. Ericka L. Adler, shareholder and practice group manager with Roetzel & Andress LPA in Chicago, says that she's seen a couple of ways in which inattentive physicians get extra burdens even when they meet the time target.

For one thing, Adler says, physicians may miss "that they can't give 90 days notice until they've completed their first two years or something like that." Also, they may miss a nuance whereby the physician can only give notice of *non-renewal* of their contract, "which can mean, for example, they can give notice 90 days before the contract [automatically] renews, but if they miss that window they have to wait a whole year to give that notice," she says.

Adler also says she increasingly sees health care employers try to write terms whereby "even if the doctor gives proper notice, the employer has a right to 'accelerate' the termination date and just terminate the doctor effective immediately and not pay them another cent." It seems an absurd thing to agree to but, Adler says, it's favored by large employers and "if a doctor doesn't have a lot of options, or otherwise is told by the employer 'we would never use that provision,' they will often still sign."

Schaff thinks acceleration is a bad idea from the practice perspective. For one thing, he's found that "practices tend to select the shortest period in which they feel the physician can transition their panel, the practice can secure coverage, and all the proper notifications can happen." Rushing the departure jeopardizes all of that.

Also, the practice may suffer blowback from its remaining staff and prospects. "If employers choose to accelerate termination and not pay a physician after they give proper notice, they've turned a routine transition into a punishment," Schaff says. "And don't forget, physicians talk amongst themselves. If other physicians catch wind of what happened and feel like giving notice could trigger a financial loss or other consequences, they're less likely to be transparent in the future."

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Non-competes and NDAs

Non-competes or restrictive covenants, which preclude the leaving physicians from practicing medicine within a certain geographical area within a certain timeframe (sometimes with other conditions), are common but can also get sticky, Adler says. Physicians may feel that the noncompete shouldn't apply if their employer lets them go without cause, or if the employer breached the contract. "These are pretty standard carveouts," Adler says. "The reason for termination affects the noncompete."

Also be aware that some state laws affect your ability to enforce such terms. In Maryland, for example, a law going into effect on July 1 will prohibit non-competes in new contracts for licensed health care providers who provide direct patient care and earn $350,000 a year or less. It also restricts their use for some providers who make more.

But if you can have those covenants, Norton L. Travis, of counsel to the health services practice at the Rivkin Radler law firm in New York City, thinks you should hold fast to yours, even if the departing physician wants to negotiate. "If it's known within the organization that Dr. Jones was able to get out of his contract without being held to the covenant, then you don't want to create a precedent where other people feel like they can [get the same terms]," he says. "You may also [want to] have a non-disparagement provision so that the person can't say bad things about you [after they're gone]."

In fact, Greene says, "it is not unusual to condition severance on a release of claims that typically includes a non-disclosure agreement, where such is not prohibited by state or federal law, [as well as] mutual non-disparagement provisions."

Big payback

As with many other kinds of highly paid professionals, doctors are sometimes lured to practices by signing bonuses, which can become a point of contention when the physician seeks an early departure. Though these are sometimes portrayed in contracts as forgivable loans, practices may choose to be less forgiving if the physician bolts. A possible compromise would be a pro-rata formula; for example, if the physician got a $60,000 bonus and leaves two-thirds of the way through their contract term, they give up $20,000.

It's also advisable to have not only the formula for recoupment outlined in the contract, but also the method. For example, you might stipulate that a portion will be held back from the physician's last paycheck, with anything owed back thereafter within a specified period of time.

The softer side

Getting all this nailed down up front is necessary "risk management" for the practice, Schaff says. But when the physician actually turns in their stethoscope, he thinks that you should take it as an opportunity: First, to find out whether the physician can be dissuaded — assuming, of course, you aren't happy to see that particular physician go — and, perhaps more importantly, to also find out whether there isn't something you can do to make your practice a place physicians want to stick with.

Travis admits that "usually, by the time somebody gets up the courage to submit a termination notice they probably already either have a new opportunity to pursue or their mind is made up." But he still thinks that, as a "business matter," if a resignation "comes as a surprise and it's someone you really prefer to keep," you should sit down with the physician and talk through their reasons.

Though the chances of keeping the employee are slim, Travis says, "you want to know what's going on with your own organization." The conversation may reveal issues with "recruitment of support staff, marketing of the physician's services, poor billing/collections or something that is negatively impacting the practice" that you didn't know about.

"Again, my advice is to [use these situations] as a basis to understand other issues going on within your business, and as a constructive tool to improve," Travis says. "You might find you're doing everything fine and it's just not a good fit, but then you might learn something else." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCE

- §3—716, Labor and Employment, Annotated Code of Maryland: *https://mgaleg.maryland.gov/mgawebsite/laws/StatuteText?article=gle&section=3-716&enactments=false#:~:text=(3)%20A%20non-compete%20or%20conflict,as%20being%20against%20the%20public*

Physician payments

Budget bill would peg physician pay to MEI; might mean raise in 2026

The budget bill passed on May 22 in the U.S. House of Representatives, now being considered by the Senate, has a proposed change to the physician fee schedule conversion factor (CF) that, while it doesn't appear to do anything about low reimbursement rates in 2025, promises some relief in 2026 and possibly in years to follow. But experts caution that the gains may not be what they at first appear.

Section 44304 of the 1,082-page "One Big Beautiful Bill Act," as it is officially called, changes the method of calculating changes in the CF from the current method, which uses several economic factors to come up with a dollar amount, to a more direct relationship with the Medicare Economic Index (MEI).

The MEI, as described by CMS, is "a bundle of inputs used in furnishing physicians' services such as physician's own time, non-physician employees' compensation, rents, medical equipment." Since it tracks strongly with inflation, it has typically grown faster over time than CMS' physician reimbursement rates. Congressional Medicare watchdog MedPAC recommended a switch from the present CF method to an MEI-based one in 2023 (*PBN 4/3/23*).

Under the bill as currently written, for 2026 the CF will be "75 percent of the Secretary's estimate of the percentage increase in the MEI … for the year" and "for 2027 and each subsequent year is 10 percent of the Secretary's estimate of the percentage increase in the MEI for the year."

As the AMA reads the math, this would be an improvement on recent payment adjustments, which have not been more than 1% positive since 2015 and for five of the past six years have been negative, with the 2025 adjustment of -2.8% (*PBN 11/11/24*).

"Under current law, Medicare physician pay is set to rise 0.25% in 2026 and top out with a 2.5% annual increase in 2035," AMA says. "If section 44304 of the House budget bill is enacted, doctors would see their annual Medicare payment rise to 4.3% by 2035."

But Khaled J. Klele, a partner with the McCarter & English law firm in Newark, N.J., is not so sure.

"Even if pinning the conversion rate for the physician fee schedule to the Medicare Economic Index becomes law, it may not lead to increased rates, considering that Medicare is still constrained by budget-neutrality requirements," Klele says, referring to features of the Omnibus Budget Reconciliation Act of 1989 that keep Medicare expenditures on a tight fiscal leash.

Daniel B. Frier, Esq., co-founder of the Frier Levitt law firm and chair of its health care group, has been following the bill on behalf of clients, and finds it "difficult to say whether the MEI methodology will ultimately be adopted," but thinks it likely that "there will be some increase in the Medicare physician fee schedule."

But Frier cautions that this change would mainly mean keeping pace with inflation — a key factor in the MEI — and that "is not viewed by physicians as a panacea, though it would be an improvement." He also shares Klele's concern with budget neutrality limits on payment adjustments.

A previous proposal in the House to raise physician payment by a straight percentage, similar to other congressional "fixes" in the past, failed in March (*PBN 3/24/25*). Follow further developments on this bill in *Part B News*. *— Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- House Rules Committee Print version of the "One Big Beautiful Bill Act," May 18, 2025: *https://rules.house.gov/sites/evo-subsites/rules.house.gov/files/documents/rcp_119-3_final.pdf*
- AMA, "May 30, 2025: Medicare Payment Reform Advocacy Update": *www.ama-assn.org/health-care-advocacy/advocacy-update/may-30-2025-medicare-payment-reform-advocacy-update*

Benchmark of the week

Survey: Patient wait times rising across specialties, except ortho

You may have suspected as much, and now a survey of 1,391 physician offices located in 15 metropolitan areas offers evidence that wait times for patients to get physician appointment have gone up substantially in recent years, at least in many metropolitan areas.

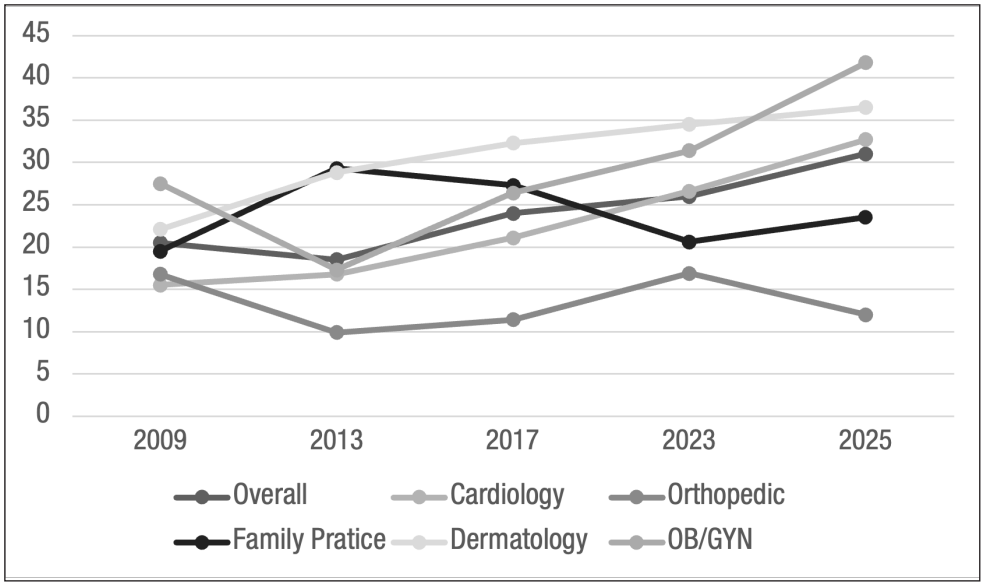
AMN Healthcare's survey, taken in January and February of this year, and picking up from a survey begun years earlier by its former physician solutions division, Merritt Hawkins, shows that the overall average wait time among selected specialties has increased to 31 days from 26 days in 2023 and from 20.5 days in 2009. (Gastroenterology, not on this chart, was added in 2025; a gastro appointment takes 40 days on average per the survey.)

These averages vary widely across individual practices in specific metro areas. Among 12 cardiology offices surveyed in Atlanta, for example, appointments took as little as one day to book and as many as 76 days, for an average of 15 days, which is still below the 36.5 average across all 15 metros. Across 12 Boston cardio practices, the range is 17 days to 135 days, and the overall average is 72 days.

As the chart shows, cardio has been trending up across this entire 16-year range, while orthopedic surgery and OB/GYN wait times took a dip in 2013 before rising; in 2025 ortho wait times took a fall, from 16.9 days to 12 days, while OB/GYN leapt from 31.4 days to 41.8 days.

AMN finds Boston with the highest average physician appointment wait time across all specialties, at 65 days, and Atlanta the shortest with 12. The other metros included in the study are Dallas, Denver, Detroit, Houston, Los Angeles, Miami, Minneapolis, New York, Philadelphia, Portland, San Diego, Seattle and Washington, D.C. — *Roy Edroso* (roy.edroso@decisionhealth.com)

Average new patient physician appointment wait times in 15 major metropolitan areas, 2009 to present



Source: AMN Healthcare, "2025 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates": https://online.flippingbook.com/view/83050962/

Ask Part B News

Consult the details for MDM discussions for accurate E/M coding

Question: *When our doctors requests a consult from another doctor, how can we tell whether our physician can count the conversation toward "discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)" in the data review column for medical decision-making (MDM)? Do we need to coordinate with the other physician's practices that the consulting physicians work for to make sure they aren't counting it too?*

Answer: Your physicians or qualified health care professionals (QHP) can count the discussion when they apply the information to their MDM for the visit. You do not need to contact different practices, review another provider's charts or race to submit your claim first.

The AMA has addressed when and how to count discussions for the third category for moderate or extensive data review. For example, the CPT Assistant for June 2020 includes a scenario where Dr. Jones, a family practitioner, consults with an endocrinologist from the same practice about managing a diabetic patient's care.

"The results of the discussion factor into how Dr. Jones will counsel the patient on diet and adjustment of medications. This discussion of management is counted toward MDM when Dr. Jones is selecting a level of E/M office or other outpatient service," according to the article.

As a separate article highlights, an emergency room physician can count a discussion with the admitting physician toward their MDM "[if] the conversation is required to determine the next steps in how the patient will be treated (eg, admission, outpatient visit, additional testing/imaging)," according to CPT Assistant, Aug. 2023. The article also clarifies that providers should not count conversations that are "solely administrative (eg, notification of consult request)," and not used for MDM.

Your treatment and coding team members should understand how the CPT manual defines the discussion category to ensure accurate coding.

Start with a discussion about discussion

The CPT E/M guidelines define a discussion as a direct, interactive exchange with another provider or appropriate source. The discussion doesn't have to be in person, but it can't take place through intermediaries such as clinical staff, or by exchanging information through chart or progress notes.

In addition, the guidelines state that the discussion doesn't have to be on the same day as the E/M visit, but it should be "initiated and completed within a short time period (eg, within a day or two)."

Internalize the definition of external

The category requires a discussion with an external physician or QHP, which the CPT manual defines as provider "who is not in the same group practice or is of a different specialty or subspecialty," including licensed professionals who practice independently. Discussions between providers who are both members of your group and of the same specialty and subspecialty can never count toward this data review category.

Don't double count or double dip

You can only count a discussion toward MDM for one visit, according to the CPT Manual's definition. In addition, you can't count the discussion toward MDM if the provider billed for that time or work with a separate code on the same day as the E/M visit.

For example, if a family practitioner billed **99452** (Interprofessional telephone/Internet/electronic health record referral service[s] provided by a treating/requesting physician or other qualified health care professional, 30 minutes) for work associated with communicating with a specialist, you can't also count that work toward the discussion category, according to CPT Assistant, June 2020.

Have a question? Ask PBN

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email askpbn@decisionhealth.com with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

Create documentation clues for your staff

Use the guidelines and guidance to give your whole team tips on how to create complete documentation and spot documentation gaps.

1. Who did the provider have the discussion with? This will help confirm that the consultant is external and ensure that they are an external provider. Coders should watch for signs that it wasn't a discussion, such as a note that the billing provider spoke to the "consultant's office" or "the charge nurse." They need to see that the providers communicated directly.
2. When and how did the discussion take place? The provider doesn't need to document the time, but they should include the date or dates to show that it happened within a short period of time. The CPT Manual does not spell out the communication methods that are allowed, but your treating providers and coding team should remember that "[s]ending chart notes or written exchanges that are within progress notes" does not qualify.
3. What did the provider do with the information? The physician or QHP must document how they applied the discussion to their MDM. Providers and coders should understand that if a provider only documents that they discussed a patient's test results with an external provider, that does not qualify as a data review-worthy discussion. Providers can help coders by clearly connecting the dots between discussion and decision-making, which can be done with a few words. For example, "Discussed patient's test results with Dr. Bombay. No change to prescription," forces the coder to guess the connection and could give an auditor an excuse to downcode. But writing "Based on discussion of patient's test with Dr. Bombay, I will not change the prescription," clearly connects the two actions. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCES

- CPT Assistant, June 2020
- CPT Assistant, August 2023

Compliance

Dissect comments on the proposed HIPAA Security Rule update

As medical groups and the larger health care industry await the final version of HHS' proposed HIPAA Security Rule update, over 4,600 comments met the March 2025 deadline (*PBN 1/22/25*). Below is a summary of the most notable comments from leading health care organizations.

AHIMA

Comments from the American Health Information Management Association (AHIMA) call on federal regulators to take a balanced, supportive approach to implementation — especially for smaller and under-resourced health care providers.

In its official comment letter to the Office for Civil Rights (OCR), AHIMA supported the intent to strengthen cybersecurity protections for electronic protected health information (ePHI) but warned that many of the proposed requirements may be difficult to operationalize without additional resources, clearer guidance, and flexibility based on organization size and risk.

AHIMA supported the proposal to require regulated entities to maintain a written technology asset inventory and network map, updated at least annually or after significant changes. However, the organization cautioned that this requirement may overwhelm smaller clinics and hospitals that already face infrastructure and staffing limitations. AHIMA recommended that OCR accompany the requirement with examples, practical use cases, and additional support tools to help organizations understand expectations and maintain compliance.

While AHIMA agreed with the value of network segmentation in reducing breach impact, it highlighted concerns that rigid implementation could disrupt clinical workflows, especially in fast-paced or emergency care environments. The association encouraged OCR to issue a "decision matrix" that helps organizations assess their need for segmentation based on factors like complexity, risk exposure and volume of ePHI. It also recommended specific case studies to clarify what constitutes "reasonable and appropriate" segmentation strategies.

AHIMA broadly supported the proposal to require multifactor authentication (MFA) but stressed that a one-size-fits-all implementation could present barriers in clinical settings. Some practices lack consistent cellular coverage or reliable Wi-Fi, making common MFA tools impractical. AHIMA strongly urged OCR to allow badge-based "tap-and-go" technologies as compliant alternatives and recommended staged implementation: administrative areas first, followed by clinical access points.

AHIMA took issue with OCR's cost estimates, stating that OCR significantly underestimates the full financial and operational burden of the proposed changes. The costs of staff training, vendor oversight, penetration testing, incident response planning and policy revision will be especially high for smaller physician practices, safety-net providers and rural hospitals.

In its comments, AHIMA called for OCR to revisit the cost modeling and consider phasing in compliance deadlines based on entity size and risk profile.

Texas Medical Association

Representing over 59,000 physicians and medical students, the Texas Medical Association (TMA) expressed strong concerns that the proposed Security Rule updates would impose significant financial and operational burdens on small and independent physician practices.

While acknowledging the importance of protecting ePHI, TMA argued that the proposed requirements go far beyond the original intent of HIPAA and would disproportionately strain already overburdened providers, especially those in rural and underserved areas. They contended that existing tools from CMS and the Assistant Secretary for Technology Policy are sufficient for ensuring baseline cybersecurity, and that OCR's additional mandates — such as asset inventories, policy overhauls and technical safeguards — are costly and duplicative.

TMA strongly recommended that OCR focus its regulatory efforts on high-impact entities like large electronic health record vendors and prioritize scalable, risk-based approaches instead of imposing a one-size-fits-all mandate on all providers.

Greater New York Hospital Association

The Greater New York Hospital Association (GNYHA), which represents 220 hospitals across four states, strongly opposed the proposed Security Rule changes and urged OCR to rescind the proposed rule entirely. GNYHA argued that the proposal abandons a decade of collaborative, risk-based cybersecurity strategies in favor of a rigid, one-size-fits-all model that would create excessive financial and operational burdens, particularly for rural and safety net hospitals.

The association contended the proposal would hinder, rather than help, cybersecurity efforts, complicating compliance while failing to account for real-world hospital workflows, resource constraints, and the evolving threat landscape. GNYHA instead advocated for a modernization approach grounded in the established public-private frameworks such as the 405(d) initiative and Cybersecurity Performance Goals, which emphasize flexibility and strategic prioritization.

Kentucky Hospital Association

The Kentucky Hospital Association (KHA) expressed concern that the proposed Security Rule modifications impose a one-size-fits-all cybersecurity framework that would disproportionately burden hospitals, especially rural facilities already facing financial and workforce constraints.

While KHA acknowledged the importance of enhancing ePHI protections, it warned that requirements like frequent vulnerability scanning, detailed asset inventories, and comprehensive documentation demand substantial IT staffing and financial resources that many hospitals do not have.

The association urged HHS to amend the rule to remove unfunded mandates, relax operational timelines, and better account for the practical challenges of compliance, particularly for smaller health care providers. — *Dom Nicastro* (*pbnfeedback@decisionhealth.com*) ■

RESOURCES

- *www.federalregister.gov/documents/2025/01/06/2024-30983/hipaa-security-rule-to-strengthen-the-cybersecurity-of-electronic-protected-health-information*
- Security Rule comments: *www.regulations.gov/document/HHS-OCR-2024-0020-0001/comment*