Getting Paid in 2018

What Independent Medical Practices Need to Know

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Introduction

Independent medical practices have a level of autonomy that is priceless. Unlike providers employed by larger networks, independent practices retain control and authority over business decisions. In fact, half of all family medicine physicians, as well as half of recent graduates, still choose to care for patients in practices with five or fewer physicians.[1]

Yet, today's turbulent reimbursement environment situates roadblocks in the pathway to self-reliance. With planning, focus and fortitude, however, weathering today's reimbursement landscape is not only possible for an independent practice, but can absolutely result in financial success.

[1] Annals of Family Medicine. The Paradox of Size: How Small, Independent Practices Can Thrive in Value-Based Care. 2016.

PART ONE

Finding New Revenue Paths

Look for Legitimate Opportunities for Reimbursement

Independent practices are in the ideal position to glean additional payments from payers. That statement may shock you, but let's understand the context. There are many legitimate opportunities for providing services that patients need, from the familiar menus of ancillaries to the once esoteric-sounding services like telemedicine and group visits.

Unlike practices that are owned by or closely tied to hospitals or other organizations, independent practice innovators don't have to watch their ideas wait in line for months or years behind other organizational imperatives (often, with goals that have little to do with day-to-day practice). There are many realistic and achievable strategies to increase payments without the need for a large cash investment. Let's take a look at six areas where many of today's independent practices are excelling, both financially and medically.

Home Visits

As payers seek more effective strategies to reduce the utilization of high-cost settings like the ER, commercial and government payers are turning their attention to treating patients in their homes. Reimbursement opportunities vary greatly, but there is, at least, a standard method of billing for home visits now. A series of CPT codes that commence with "993" can be applied in a pattern similar to office visits, with various levels and different codes for established and new patients as well as the place-of-service code –12. Reimbursement rates for these codes are typically higher than similar office-based encounters. Review state law and payer requirements and assess your technology needs – like a mobile, cloud-based EHR – to enhance the value proposition of home visits.

Preventive Services

Patient cost-sharing is a challenge. However, payers cover many preventive services in full. (See **Figure 1** on page 4.) Much of the time involved in these services can be performed by other members of the clinical team, so take the opportunity to review the services and determine whether a lower-credentialed member of staff can assist with them. If so, he or she can work to the top of his or her license, allowing physicians and advanced practice providers to optimize their time in performing services that require their levels of expertise and skill.

Find out which preventive services can be performed by other members of a clinical team in order to optimize physician time.

FIGURE 1

Common Preventive Services Covered by Medicare, With No Patient Financial Responsibility

Depression screening: once annually, provided in a primary care setting

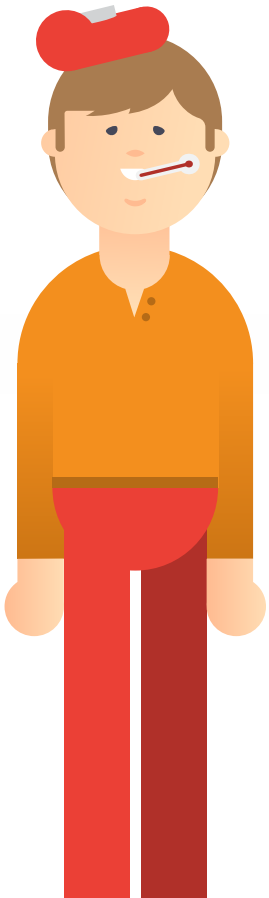
Smoking cessation counseling: eight sessions per year (two attempts, four sessions per)

Face-to-face behavioral counseling for obesity: individual and/or group, 22 sessions per year

Face-to-face intensive behavioral therapy for cardiovascular disease: once annually, provided in a primary care setting

Annual wellness visit (AWV): noting the Initial Preventive Physical Examination is to be provided during the initial year of Medicare coverage

Advance care planning: once annually; no cost sharing when performed with AWV



Visit the CMS website to read more about coverage of these selected services—and other Medicare preventive services that are covered in full.

Telemedicine

The Society for Human Resources Management (SHRM) reports an 11% increase over the past year in the prevalence of telemedicine as an employee benefit, thanks to more employers offering insurance coverage that includes diagnosis, treatment or prescriptions provided by phone or video (34%).[2]

Most states now have parity laws (or proposed laws) for private insurance coverage for telemedicine. What this means is that providers can now bill insurance for routine and follow-up visits via secure video, which increases revenue while decreasing overhead costs. When searching for telemedicine technology, be sure it syncs with your EHR and billing software, so you can follow the same workflow as in-office visits within the same software platform. And look for options that don't require a large up-front financial investment.

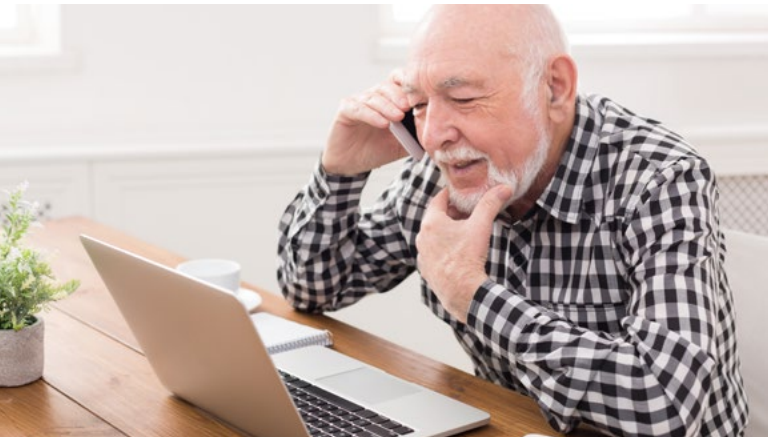
There has been a **34% increase** in employer coverage for telemedicine.

Group Visits

Another opportunity that, admittedly, comes with some pesky billing challenges, is group visits. Depending on the circumstances, payers may allow physicians to bill for each individual encounter they provide in a group setting. Alternatively, one could focus on the services inherently performed in group settings, such as behavioral counseling for obesity, health and behavioral assessment, or diabetes self-management education. These services have pre-determined coding and billing requirements, when performed in a group setting. Simply put, group visits can allow physicians to leverage their time in order to see multiple patients in a short time span while providing an exceptional experience for patients.

For a group visit, payers may allow physicians to bill for each individual patient in the group.[3]

[2] SHRM's 2017 Employee Benefits survey. September 2017.
[3] American Academy of Family Physicians Practice Management, Coding for Group Visits.



Care Management

A significant opportunity in the value-based reimbursement environment is to proactively manage patients' care. Care management CPT codes offer significant reimbursement for managing qualifying patients over the telephone and via secure electronic messaging. They cover services such as transitional care management for post-discharge care, as well as a monthly payment for on-going chronic care management (complex and non-complex). While not all payers offer this coverage, it's steadily spreading throughout the commercial insurance market. The adoption of technology, such as secure electronic messaging, make this an opportunity to leverage existing staff resources to benefit patient care.

Ancillary Services

There are reimbursable ancillary services that require very little capital. Many payers provide coverage for screenings, such as for alcohol abuse, cardiovascular disease and depression, just to name a few. While these screenings do require preparation, they cost little to administer once up and running. Wellness programs are another possible target, thanks to increased attention to wellness-related activities from payers and employers. The financial pay-off is terrific, but the ultimate value is for patients who, with their provider's help, can detect important health challenges at an earlier stage.

The long-term trend of payers using reimbursement policies to favor care in outpatient settings shows no sign of subsiding; if anything, it is accelerating. As it does, independent practices are well positioned to take advantage. Similarly, the growing emphasis on demonstrating the value of services to patients can also benefit independent practices that are nimble and embrace a business model built on value over volume.

PART TWO

Patient Collections in the Era of High Deductibles

Gearing Up for Patient Financial Responsibility

The decision to remain independent is grounded in nurturing cherished relationships with patients. These connections also are key ingredients to success in managing the revenue cycle. Large health systems, hospitals and medical practices struggle at times with today's shift towards consumer-directed healthcare. For the independent practice, successful patient collections is bolstered by a framework of interpersonal relationships that keep patients compliant—and keep them coming back.

However, given the reliance on patient payments, managing the revenue cycle is getting more difficult every year. A study from the accounting firm Crowe Howarth found that self-pay patients generally compensate only 6.06% on the dollar while the amount of payments after insurance from patients with coverage was a similarly dismal 15.51%.[4] The timeframe to capture even these partial payments is narrow; a report by the payment clearinghouse Instamed reveals that 73% of providers reported that it takes one month or longer, on average, to collect payment from a patient.[5] And, for many practices, one month is considered a positive outcome — often, the collection process drags on for many months.

Ratcheting up the stakes is the trend for more patients to hold high-deductible plans, and for deductibles to be climbing higher than ever. The average annual deductible for an individual policy available

[4] Crowe Horwath. Revenue Recognition and High-Deductible Plans. December 2016.
[5] Instamed. Trends in Healthcare Payments Seventh Annual Report: 2016. May 2017.

through the Affordable Care Act (ACA) is reported to be $4,328, reaching to $8,352 for families.[6] While high deductibles are a widely recognized characteristic of ACA marketplace plans, deductibles in the commercial, non-ACA market show a similar upward trajectory. The average single deductible amount (among privately insured patients facing deductibles) increased from $991 to $1,505 in just six years, largely driven by a nationwide trend of greater enrollments in high-deductible health plans. Looking at this trend from another perspective, since 2012, the percentage of workers paying for single coverage under an employer-sponsored plan featuring annual deductibles of $1,000 or more grew substantially, from 34% in 2012 to 51% in 2017.[7]

Payments from Patients

6.06%
on the dollar from **Self-Pay Patients**

15.51%
on the dollar from **Insured Patients**

Annual Deductibles (ACA)

$4,328
individual

$8,352
families

Average Private Insurance Deductible

$1,505
which is an **51.46% increase in 6 years**

51%
of individuals have $1,000 or higher

[6] eHealth. How Much Does Obama Care Cost? January 2017.
[7] Kaiser Family Foundation. 2017 Employer Health Benefits Survey. September 19, 2017.

With lower operating costs, greater freedom to innovate and the ability to forge tighter bonds with patients, independent practices are in a more favorable position to manage the shifting tide of financial responsibility.

Here are some strategies for promoting greater patient financial accountability:

Pursue Price Transparency

Patients want the truth, and they will respect those who provide information about the cost of their care upfront. Independent practice can realistically provide accurate, timely information about the cost of care at the point of service.

You can start by listing each provider's top 20 (or so) procedure codes, and match them with the prices he or she agreed to receive from the practice's top health plans— in this case, the plans covering most of your patients. Create an agreement to provide to patients at the point of scheduling. You can use a custom spreadsheet or maintain this information in your practice management system.

Arm staff members with knowledge about how insurance works. The insurance scene is constantly changing so never assume that anyone — patients or staff — is keeping up. Patients may have accepted higher annual deductibles in order to lower monthly premiums. They may not realize the actual value of their insurance status — that is, the "discount" the patient receives, known internally as the "contractual adjustment." Not only can price transparency lead to a higher probability of collection, it will produce a better patient experience. Espouses consumer credit reporting agency Transunion:

> **"Patients who experience a clear, transparent billing process are more likely to give higher ratings to their overall quality of care."[8]**

[8] Transunion Healthcare Survey.

Educate and Cross-train Staff

Collecting payments has traditionally been the purview of an employee (or two) in the practice's business office. Today, however, success will be elusive unless the independent practice harnesses and enhances the collection skills of its administrative team at all appropriate opportunities. This means paying more attention to staff training and office technology. Consider the receptionist: perhaps this person was originally hired to simply greet patients. In today's challenging environment, this employee serves not only as the practice's greeter, but also as its "Director of Point-of-Service Collections." This employee is a vital part of whether the practice's providers will get paid.

Important skills for receptionists and administrative staff to master include:

Knowing how to ask patients for money: It may be as basic as remembering to say: "How would you like to pay?" while making eye contact with the patient and stating his or her name politely but firmly. Don't let the privacy needs of a small reception area undercut this essential task; in those situations, the employee can record the due amount for the patient to read – or hand the patient a tablet displaying the information.

Understanding insurance basics: Collection efforts also hinge on whether employees can interpret insurance cards and eligibility reports from payers, in addition to routinely confirming important patient demographics such as current address and contact info. Employees must be equally adept at computing or accessing accurate current balances, including those already transmitted to a collection agency because bad debt can be reversed and payment applied.

Using insurance data: A vital prerequisite to getting paid is the capacity of the practice's administrative and billing staff to read and understand an explanation of benefits or benefits summary (available from most clearinghouses) and then put that information into context for the patient. These explanations and summaries can help patients understand their coverage, as well as their financial responsibilities for unmet deductibles before they leave the office or schedule the procedure.

Allowing (some) flexibility: As appropriate, employees at the point of contact—whether scheduling, greeting or discharging—can inform patients about the payment plan policy. Payment plans must include a measure of flexibility to be successful. For example, the practice should offer bi-monthly installment payments that coincide with its patients' paycheck cycles. For patients who qualify, extend a financial hardship policy. Writing off a balance for charity should not be done on a whim, however. Set up a policy, vet it with current payer agreements and restrictions, put it in writing and apply it consistently. Some patients may at times need relief from or more room to meet their financial obligations; sincere efforts to offer that respite can produce a grateful, loyal patient who ultimately pays the bill.

With the advance of high-deductible health plans and other trends that are shifting more financial responsibility to patients, maintaining a successful patient collections process has become a must-have skill set for independent practices. Investing in staff training, software automation and process revisions that invigorate collections efforts revitalizes the bottom line and secures the financial future for the practice.

For more guidance and resources, visit kareo.com/patient-collections.

PART THREE

Mastering Insurance Reimbursements

Managing Denials to Get Paid What You Deserve

Payers may deny payment for any number of reasons -- some reasonable, others arguably a bit arcane. Revamp workflow to include a process that will not only identify denials but will provide a firm footing to get them reversed. Integrating denial prevention into this strategy can do more than assure payments now; it will equate to long-term success for the independent practice.

If the services provided were medically necessary and coded correctly, don't take the payer's "no" for an answer.

Appeal denials by presenting evidence to support reversing the determination. Most practices don't take the time to contest a denial, but those that do bring in a lot of money in exchange for a relatively small amount of effort. Managing denials isn't rocket science but success hinges on understanding the workflow related to claims payment.

Common Rejection Scenario: Your clearinghouse likely "scrubs" and rejects claims even before it is processed by the payer. For example, this could happen if the date of injury is not on the Workers' Compensation form. In this case, the clearinghouse generates a rejection report indicating the reason(s) why the claim was refused. Many practices simply fix the problem and resubmit it. Clearinghouse rejections are typically easy corrections, but too many practices fail to address the source of the

problem—why was the incomplete claim submitted in the first place? Practice leaders should set an expectation with employees that rejection reports must be worked by the end of the day on which they are received. Furthermore, any rejections without resolution within a week should be flagged for the practice manager or other leader to review.

Best Practices for Rejections

- Work rejection reports by the end of the day
- Unresolved rejections flagged for practice manager after a week

Common Denial Scenario: In another familiar scenario, the claim is released by the clearinghouse and processed by the payer. During the adjudication of the claim, however, the payer determines a problem and denies payment. The denial is returned as a $0 payment, with a code(s) attached that identifies the reason for the denial. Fortunately, these codes emanate from a standard dictionary. (See **Figure 2** on page 13 for common denial codes.) Recognize that while these denials most often are revealed on the electronic remittance, they may also be relayed on paper. Often referred to as "correspondence," these denials may come in the mail via a letter.

Denial Best Practice

Regardless of how the payer conveys the information — electronically or via paper — it's vital to address denials at the level of the service (the so-called "line item," which is the CPT code).

FIGURE 2

Codes for Common Claim Denials [9]

Code	Description
1	Deductible Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
11	The diagnosis is inconsistent with the procedure.
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.
22	This care may be covered by another payer per coordination of benefits.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
31	Patient cannot be identified as our insured.

[9] Claim Adjustment Reason Codes • X12 External Code Source 139, Washington Publishing Company.

Yet another common scenario for a denial scenario: the partially paid claim. In these situations, the payer pays for one service but not for another service rendered to the same patient during the same encounter. A well-designed, and well-executed, workflow helps prevent this type of claim from passing through your system without being flagged. A "partial" denial is still a denial that requires management. Use the rejection and denial management features within your practice management system to identify and manage these and other scenarios.

Payment challenges emanate from pre-adjudication clearinghouse rejections, as well as payers' claims processing denials. Here are some quick strategies for independent practices to address the most common sources of non-payments:

Confirm Coverage

The most common denial relates to insurance eligibility; it's not uncommon for the insurance to have lapsed or the patient to have switched policies without informing the practice. In order to avoid these denials, it's vital to confirm insurance coverage and benefits eligibility prior to patients being seen. Integrate this financial clearance process into the scheduling workflow for optimal results.

Anticipate Referrals and Authorizations

Make sure physicians and staff understand payers' requirements in this area, and prepare to meet and even exceed them. Most payers allow for authorizations to be granted via an online request process; regardless, save all correspondence in the patient's account; for telephone communications, keep copious notes, including the reference number for the call, as well as the date, time, name and extension number of the payer representative who was contacted.

Recognize Medical Necessity

Be aware of payers' medical necessity policies, and prepare to discontinue, write off or have patients pay for services that a payer won't cover (unless contract restrictions disallow this tactic). Consider these questions:

- What services are payers denying for medical necessity?
- Are they valid denials?
- If appealed, does the payer reconsider payment?
- Does the payer outline any policies that will reveal a potential denial for medical necessity *before* they are performed?

Engage the patient in a three-way call with the payer; patients can be the practice's number-one advocate for obtaining payment.

Understand Coding

Determine the payers' coding policies, and learn what to expect. Consider these questions:

- What services are the payers denying due to incorrect coding?

- Does the payer follow the prevailing national coding guidelines, such as recognition of modifiers and the Correct Coding Initiative?
- Does the payer outline any policies that can reveal in advance that a service will be denied because the payer considers it bundled with something else?

Understanding payment policies — from multiple procedure reductions to payment for unlisted procedure codes — for the services commonly rendered by providers in the practice is vital for success.

The majority of denials are caused by errors made at the front desk. (See **Figure 3 for a Denial Checklist.**) The single task that a receptionist can perform to reduce denials is to capture the correct insurance and demographic information from patients. If they don't get this right, the claim can go to the wrong party. Plus, denials based on incorrect insurance or demographic information are high-probability candidates for write-offs because the effort to re-work them often drags on past the payer's timely filing deadline.

A staff member should be held accountable for determining the nature of each denial, contacting the insurance company to discuss it, gathering more information (e.g., an office note to substantiate a -25 modifier) and resubmitting the claim with any new data obtained.

There's not one ideal route to implementing denial prevention and remediation. One can take the do-it-yourself (DIY) route or seek the assistance of software that provides standard appeal letters to use. Some practices have developed sophisticated denial management systems that are automated to send claims appeals based on the payer's reason for denial code. Whether one is a DIY-er or relies on intricate tools, never automatically write anything off! If the providers did the work, they deserve to get paid; it's up to the practice team to doggedly pursue payment while repairing the internal causes.

FIGURE 3

Denial Checklist

Use these questions to analyze – and improve – your denial rate:

1. What is the percentage of claims denied by the payer on first submission? What is the percentage of line items within each claim that are denied?
2. What are the major reasons for denials by category, for example, coding error, incorrect/incomplete registration, patient not eligible on date of service, no referral or authorization, lack of medical necessity and so forth?
3. Are the denials due to payer error, practice error or a combination?
4. From where are these denials originating?
5. What actions can you take to reduce the denials?
6. What actions can you take to prevent the denials?
7. What feedback loop can you implement to provide information to the person(s) who originated the denial? Who should be involved in these communications? How often should they occur?
8. What steps can be implemented to hold person(s) responsible for preventing and managing denials?

kareo Go Practice

You can printout and share a copy of the Reducing Denials Checklist. Also, visit kareo.com/resources for more educational resources.

PART FOUR

Focus on Staffing

Reduce Turnover, Optimize Time

Good employees are a critical resource for physician productivity and patient relations. Unfortunately, staff turnover in the medical field is high, particularly in lower-paid areas like the front office and the billing office. How high? For receptionists in medical practices, the median annual turnover is 33.33%, according to the Medical Group Management Association.[10]

For receptionists in medical practices, the turnover rate is **33.33%.**

The costs of advertising, background checks and so on are the visible costs of frequent staff turnover. Less obvious is the extra time and decreased production experienced by other staff as the new person is trained and gets up to speed. Furthermore, the constant introduction of new employees into the front office means that the most inexperienced and, initially, least-effective staff members are handling key tasks such as scheduling appointments, registering patients, collecting patient payments at the point of service and more.

Effective independent practices take a multi-pronged approach to staffing needs by seeking to reduce turnover and optimize time.

Reduce Staff Turnover

Paying salaries at the local market rate is a good start, but the cornerstone of successful employee retention is a structure in which employees perceive

[10] MGMA 2016 Practice Operations Report.

that they are needed and can succeed. This means providing tools, resources, training, continuing education and, most of all, respect.

Overhaul the hiring process: When reviewing likely candidates for administrative and clinical support openings, most practices look for experience in the specialty as well as familiarity with information systems. Don't overlook other qualities, such as attitude and personality. Are they able to juggle conflicting demands on their time? Can they deal successfully with cranky patients? Hire for aptitude and temperament. Enthusiastic, service-oriented people are motivated from the moment they enter the office. Make sure your resume screening and interview processes include a focus on the person, not just their skills and experience.

Motivate employees: Large cash bonuses and hefty annual raises aren't the only routes to inspire employees; taking the opportunity to tell employees that they are appreciated is an effective motivation strategy. Recognize good performance by presenting non-monetary honors, such as a "job well done" award to deserving staff members each month. Deploy spot rewards; popular incentives can include extra time off (approved ahead of time, of course), movie tickets, gas coupons, or gift cards.

Cross-train: Today's practices need employees to do more than ever before. Establish a framework of tasks and responsibilities for each position—and empower employees to perform those jobs. Getting employees cross-trained in additional tasks allows the team to always function at a high level to support clinicians and serve patients. Cross-train-

ing helps cover important administrative functions when other staff members take leave; it can also be an opportunity for employees who want to advance their skills and take on new responsibilities.

Set expectations: Job descriptions are great but what's really important to employees is knowing in detail what's expected of them. Is there a written explanation of the most important functions of each job in the practice? For example, those assigned to answer phone calls should be provided with a checklist of expectations for how to answer, document messages, transfer calls and other key tasks.

Remove the bad players: Even in a large office, one person with a bad attitude or poor work habits can bring everyone else down. When the negative conduct cannot be remediated, it's time to let the person go. This can be difficult when it's the employee who's been on staff "forever" or is especially loyal to a particular physician. But the alternative is to watch higher-performing employees leave.

Get a great manager: Make sure supervisors know that in addition to their primary assignments, they are expected to be visible and available to employees, not sequestered in an office all day. Supervisors also must show respect and fairness, whether that is addressing the poor behavior or performance of a favored employee or helping them identify resources to overcome barriers to better performance.

Optimize Time

Physicians may feel they are working at high speed but looking at what they are actually doing minute to minute reveals important details. A study found that during the office day, physicians spent 27% of their time in direct clinical encounters with patients and 49.2% of their time on tending to the electronic health record and desk work[11] — an indication that there is plenty of room for more support from administrative staff to address many tasks that do not require licensure. Here are some ways to optimize the efficiency of staff which, in turn, will allow physicians and other providers to spend more meaningful time on billable activities.

Physicians spend **27%** of their time in direct clinical encounters with patients and **49.2%** of their time on tending to the electronic health record and desk work.

Develop checklists: Leave nothing to chance. Create simple checklists for each function— from the beginning of the day and throughout the day — including the duties and tasks for nurses, medical assistants and receptionists. Checklists foster value even for routine tasks.[12] For many functions, a checklist can

[11] Sinsky C, Colligan L, Li L, et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Ann Intern Med. 2016; 165:753–760. doi: 10.7326/M16-0961.

[12] The Checklist Manifesto: How to Get Things Right, Atul Gawande, 2009.

serve as both a statement of expectations and a handy reminder tool.

Delegate appropriately: Increase the amount of time that physicians and other providers have to spend with patients by reducing the time they need to devote to tasks that don't require their involvement. As appropriate, it is important that everyone on staff works to the top of their license, certification, expertise and/or skills. Some practices find that hiring a scribe can boost physician productivity and satisfaction. Typically, a scribe position can pay for itself if it allows an additional two patients to be accommodated each day.*

Allow flexibility: Business office hours don't have to mirror those of the clinical operation. Many employees will leap at the opportunity to work earlier or later hours than the clinicians. Open the door to flex time and regular part-time shifts that can be scheduled around child-care duties and other personal obligations.

Amid the ongoing consolidation and centralization of healthcare services, the independent practice has a secret weapon: the quality of its staff. That said, one cannot just expect a fine-tuned team of high-performing employees to just come about. To stand out in a competitive market and create the practice that patients choose, high-performing practices put the time in to train staff and provide them with the technological solutions they need to succeed.

Flexibility may be an independent practice's secret weapon to attracting and retaining great employees.

Conclusion

Independent practices have innate qualities that allow them to handle the challenges of today's changing reimbursement environment—but only if they are willing to invest time and thought into new revenue opportunities, improving how they collect payments owed by patients, implementing strategies to avoid and manage denials, and deploying staff and technology solutions for optimal efficiency. In order to maximize payments in 2018 – and beyond - independent practices must be alert to recognize the changing currents and nimble enough to successfully execute new strategies to stay on top of the revenue cycle.

* 47 work weeks, $100 reimbursement per encounter, 4-work days in the office per week, 2 patient encounters per day, equates to $37,600 in additional revenue. Because costs are nearly 100% fixed (i.e., they do not proportionately increase based on additional patient encounters), this equates to $32,000 to $35,000 in contribution to the position of a scribe. These data are provided as samples only.

About the **Author**

Elizabeth Woodcock is a professional speaker, trainer and author specializing in medical practice management. Elizabeth has focused on medical practice operations for 25 years. Combining innovation and analysis to teach practice operations, she has delivered presentations at regional and national conferences to more than 200,000 physicians and managers. In addition to her popular email newsletters, she has authored 17 best-selling practice management books, and published dozens of articles in national healthcare management journals.

Elizabeth is a Fellow in the American College of Medical Practice Executives and a Certified Professional Coder. In addition to a Bachelor of Arts degree from Duke University, Elizabeth completed a Master of Business Administration in healthcare management from The Wharton School of Business of the University of Pennsylvania. A mother of three children, she is an avid scuba diver, and a Crossfit enthusiast.

About kareo

Kareo is the only cloud-based complete medical technology platform purpose-built to meet the unique needs of independent practices in more than 45 specialties.

Today Kareo helps over 40,000 providers in all 50 states run more efficient and profitable practices, processing more than 60 million patient records through the Kareo platform. The Kareo platform is the first to help independent practices find more patients, manage their care with a fully certified and easy-to-use EHR, and get paid quickly all in one complete and integrated package.

Kareo has received extensive industry recognition, including the Deloitte Technology Fast 500, Inc. 5000 and Black Book's #1 Integrated EHR, Practice Management and Medical Billing vendor as well as the top of the Leader Quadrant in the Frontrunners Software Analysis of EHR. Kareo's growth further demonstrates the expansion and vitality of the independent practice market in the U.S. With offices across the country, Kareo's mission is to help independent practices succeed in an ever-changing healthcare market. More information can be found at **www.kareo.com.**