The old saying “If you can’t measure it, you can’t improve it” certainly holds true in medical practices today. With falling payer reimbursement it is more important than ever to collect every single dollar your practice is due.

Most practices have sought additional income streams by adding ancillary services. Paying close attention to data can improve decision-making for such services and can dramatically improve revenue without adding any providers or even new patients!

Having ready access to the elusive data within practice management systems can be difficult, but most systems can report the basics. It is imperative that data is trended over a period of time so that trends can be spotted, benchmarks compared, and improvement plans developed. Measuring data and comparing it to the MGMA Cost Survey (find it at mgma.com) is one of the best places to start.

1. **Collection Rates/Ratios:** Two collection rates are measured in medical practices. One is gross collections and the other
is net collections, the latter being the most important.

A gross collection rate is payments divided by charges and will depend on an artificial number – how high the charges are set above negotiated allowables – making it not particularly meaningful.

A net collection rate, however, provides a means to benchmark the health of collection efforts. Net collections, simply stated, demonstrate what percentage of collectible dollars (after negotiated contract write-offs) a practice is actually collecting. A net collection rate above 95 percent “when calculated correctly – denotes a healthy practice.

2. **Denials:** Denials are a significant portion of the cost of running a practice in that services that are provided but not paid for reduce the profitability of those that are. Accurately identifying denials and the reasons for them can help prevent them in the future, thus increasing productivity and lowering expenses. Identifying denial trends by specific payer or payer group, by CPT code, and by origin “whether at the front desk, with coding errors, or in credentialing “is equally important.

3. **Evaluation & Management (E & M) Bell Curve:** “Overcoding” and “undercoding” are commonly used terms, but how are they measured? Bell curve trending of E&M data can quickly identify areas where providers may be under coding, resulting in lower revenues, or over coding, resulting in the potential for audits. The difference between a Level 2 and a Level 3 E&M code can mean thousands of dollars in losses per provider per year. Documentation is critical to demonstrating the level of care provided to each patient.

The traditional primary care bell curve below demonstrates that level 3 visits typically comprise about 50% of your established patient encounters, level 2 and 4 visits together about 20% each, and level 1 and 5 visits together about 10%.
When plotted on a graph and drawing a line between each, the shape resembles a bell.

4. **Bad Debt:** Bad debt is defined as dollars that could have been collected, but were not. Break this category into controllable factors and non-controllable factors. Issues that you should have been able to control are timely filing write-offs, credentialing errors, lack of follow-up, and incorrect information provided by the patient. Non-controllable issues are bankruptcy, patient failure to pay, and payers retroactively denying coverage due to unpaid premiums.

Reducing bad debt by just two percent can mean tens of thousands of dollars to the bottom line of a practice. The ability to quickly identify bad debt trends facilitates the development of an improvement plan.

5. **AR Days:** AR (accounts receivable) days are a measurement of the average time a dollar stays in an accounts receivable before being collected. The ability to measure, benchmark, and lower AR days provides a means to a significant increase in revenue. Some best practices that reduce AR days are filing insurance daily, sending statements daily, collecting appropriately at check-in and check-out, working denials quickly, discounting self-insured for time of service payment in full, and using an eligibility tool to check every single
patient’s insurance.

6. **Encounters:** Accurately reporting and separating encounters for most practices is an arduous task of counting fee tickets or using tick sheets. Few practice management systems accurately provide this information. An encounter is much more than a service code. Being able to segregate office encounters from surgical cases, and reporting by payer, time, and location can help identify opportunities for improvement.

7. **Referral Sources:** It is fundamentally prudent for specialty practices to know the origin of patient referrals. This data is rarely reliable or easily created in most practice management systems. Practices need to know not only the source of patient referrals, but also what type of patients (by insurance, by procedure, etc.) are being sent by those sources, and if the referrals from a particular source have increased or decreased over time.

8. **Payer Mix:** It is not uncommon for practices to drop payors due to perception, and not because of actual data or trends. Emotions sometimes come into play and can result in a provider demanding that a payer be dropped because their rates have changed (or other perceptions). This simply does not make sense. Being able to accurately produce and graph data on major payers without hours and hours of work is of high strategic value to a well-planned business decision. It can answer questions about the impact on a practice if a particular payer is dropped, or how those patient slots would be filled. Remember to keep adding payers to the practice when feasible; the loss of your largest payer can be minimized if many smaller ones are on board.

9. **Under Payments:** One of the more significant ways to improve a practice’s revenue is the swift and accurate identification of carrier underpayments. Identification of underpayments is not simply comparing the payment to an allowable fee schedule. Practice management systems that have
any type of payment audit functionality commonly do not take into account circumstances such as modifiers, or multiple surgical procedures that payers routinely inaccurately apply, causing underpayments. Having a system to automatically and systematically apply these rules is essential. MGMA states that providers are underpaid an average of six percent of revenue. What does that mean to a practice? The numbers can be astounding to a surgical group, and the identification and collection of those underpayments can be insurmountable.

10. **Fee Schedule Comparison:** It can be difficult to determine what payers are reimbursing by contract for specific codes or ranges of CPT codes. The ability to have immediate and accurate access to this data is crucial in payer negotiations. It is important to remember that the payer already has this information and is betting that the practice does not!

It is now more important than ever for practice managers to have access to the critical information outlined above. It is also important to note that not just any one of the above Key Practice Indicators should be used to determine the financial health of your practice, but all, or a combination of them.

The buzzword among practices today is “Dashboards.” The ability to have these Key Practice Indicators in one simple report is proven to increase efficiency, as well as provide a meaningful way to present information to providers. One example of a dashboard is below.
About the author: Frank Trew is the Founder and CEO of DataPlus and has over 25 years of practice management experience and has served in executive positions in large and small practices. In 1999, as the COO of a large orthopaedic group in Nashville, he was frustrated by an inadequate access to data that limited his ability to measure and improve the bottom line. The development of a data warehouse was the solution.

In 2000, after hearing how this data was a key practice management tool, many of Frank’s peers also wanted to use it to improve their practices. DataPlus was formed as a result and has been providing MegaWest, HealthPort, and Centricity users with this unique tool ever since.

Employing a simple to use “point and click, drag and drop” reporting tool, along with an advanced Contract Management and Revenue Recovery System, DataPlus provides key management data across all specialties and throughout the United States.

Frank invites readers to visit the DataPlus website at www.mydataplus.com. Frank may be contacted via email at ftrew@mydataplus.com or by telephone at (888) 688-3282.
Safety Net Hospital

Safety net hospitals are defined as providing a “disproportionate share of services to Medicaid and uninsured patients.”

CMS Releases Record Retention Guidelines

A updated post on record retention with a simple record retention schedule can be found here.

State laws generally govern how long medical records are to be retained.

However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later. HIPAA requirements preempt State laws if they require shorter periods. Your State may require a longer retention period.

While the HIPAA Privacy Rule does not include medical record retention requirements, it does require that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such
information is maintained by a covered entity, including through disposal.

The Centers for Medicare & Medicaid Services (CMS) requires records of **providers submitting cost reports to be retained in their original or legally reproduced form for a period of at least 5 years after the closure of the cost report**.

**CMS requires Medicare managed care program providers to retain records for 10 years.**

![Image via Wikipedia](image)

**Additional information:**

1. Providers/suppliers should maintain a medical record for each Medicare beneficiary that is their patient.
2. Medical records must be accurately written, promptly completed, accessible, properly filed and retained.
3. Using a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries is a good practice.
4. The Medicare program **does not have requirements for the media formats for medical records**. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by
authorized entities.
5. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.
6. Providers may want to obtain legal advice concerning record retention after CMS-required time periods.

350

350 is the number that leading scientists say is the safe upper limit for carbon dioxide””measured in “Parts Per Million” in our atmosphere. 350 PPM””it’s the number humanity needs to get back to as soon as possible to avoid runaway climate change. (Defintiion courtesy of 350.org.)

Guest Author Lee Barbieri:
Six Skills of a High Performing Manager

If the topic caught your eye it’s likely because medical practice managers are practical people. Our job is to get things done and we do it with a passion for being efficient as well as effective. So you are on the lookout for tips and advice to help you do your job, and (admit it) to confirm that your skills match those of recognized high performers.

But my goal today is to help you value certain skills you
already have but may not appreciate their value to you. These are my concepts of valuable skills. I’m going to miss someone’s favorite, so when I do, send a comment, list your skill and share your knowledge.

The first skill is thievery; the honest kind.

The best managers I know are quick to recognize an idea and steal it to use in their own practice. We expect to do this at the organized idea swaps we call conferences. But I’ve watched managers scribble notes at a dinner table or at a sidewalk conversation when another manager offers an idea. Good managers know that a manager-tested idea is worth twice that of a concept proposed in a research article. I’m not denigrating research. I love research; I read journal articles for fun. (My son says that proves only that I am a nerd.) But nothing beats a peer tested concept. So listen carefully to your peers, subscribe to your state and national MGMA listservs and steal those ideas. And then pass them along to the rest of us. And ALWAYS give credit to the person whose idea you stole.

The next skill is impatience.

While good managers analyze, research and cogitate looking for a solution, they don’t wait for the perfect one. High performing managers instinctively use the try and adjust method, formalized in operational improvement programs as PDCA (Plan, Do, Check or Correct, Act) or PDSA (Plan, Do, Study, Act.) They try the best solution at hand, check to see if it is working, adjust it, refine it and then implement it. Then they check it later to see if it is still working. Good managers don’t wait for the perfect plan. They go with a good plan and have the courage to improve it on the fly.
High performing managers are patient.

I know what I just told about being impatient, but good managers are patient. They dig deep enough into a problem to know the real causes. They ask why enough to get past the obvious. In Operational Improvement the technique is called The Five Whys. High performing managers use this without even knowing it has a name. It requires patience. It pays big dividends “fewer wrong moves and less stuff to redo. Those without patience act on the first cause they find, and then have to undo the solution and start over. You may have heard this described as: “There’s never time to do it right. There’s always time to do it over.”

High performing managers share recognition and accept blame.

This can be tough, especially in a highly competitive profession. Advancement as a healthcare executive often comes when a colleague is replaced. Even if you work in a large organization with clear advancement tracks, you have to compete for the opportunity. The result is a temptation to avoid blame and to hoard recognition. But the best managers share recognition with their team. They are in touch with their own leaders and keep those leaders aware of their efforts. That is prudent and fair. But no one succeeds without the help of those around them. Good managers recognize that and share credit. As for the blame “it was your team. If they failed, then you failed as the leader. Accept it, correct it, learn from it and move on. My first mentor reminded me that if I was right one time in three and I was playing baseball, I would have a .333 batting average and be my team’s MVP every year.
High performing managers are curious.

The best are curious about everything. The Greek poet Pindar said “There is no knowledge without profit.” Good managers consume information. This serves to keep them aware of possibilities that others will miss. It improves their luck factor. It gives them the ability to be first with the great ideas that advance their practices.

High performing managers love to teach. Having knowledge is not nearly as much fun as sharing it. Good managers help their teams improve. They share their knowledge. They are enthusiastic when they do it. They are excited when others gain new skills. It’s not totally altruistic either. Skilled teams take on more work, are more efficient and more effective. This creates additional time for the manager to do things beyond extinguishing fires. That’s a great thing.

And last, high performing managers are realistic.

They know there are limits to what they can accomplish alone. They know that life is not all work. The very best find ways to be involved with their community. They make time for their families and friends. They participate in the world around them. They are refreshed by their non-work life, so they can enjoy the work day.

What have I missed? What have you admired in others or found in yourself that are important skills in your success?
Please welcome my long-time colleague and friend Lee Barbieri. I am hoping Lee will be a regular contributor as he has a lot of interesting ideas and experience to share with MMP readers.

Lee Barbieri is a Medical Practice Management Executive with over 25 years experience, and is a graduate of Va Tech, a medical laboratory technologist, MT(ASCP), and an avid reader. Lee has worked in both private practice and in hospital networks, in healthcare IT and has also worked in a university hospital, managing diagnostic laboratory services. Lee says “I am a native of Virginia but I have been a happy North Carolinian for 30 plus years. My wife and I have two sons and four grandchildren. I support my alma mater and still find time to be a Duke Blue Devil fan.”

21 Common Sense Rules for Medical Offices
There seem to be a lot of people searching for rules for medical offices. I’ve never heard of such rules, but since people are looking for them, I thought I’d write some.

1. Medical offices are professional workplaces and staff need to dress, speak, and purport themselves professionally.

2. Patients are customers and customer service should be paramount. Give all patients the utmost respect and practice compassion, compassion, compassion.

3. If it didn’t get documented (on paper or electronically), it wasn’t done. If it didn’t get documented, you can’t charge for it.

4. HIPAA. First of all, please spell it correctly. One P, two As. Secondly, know what it means and make it so!

5. Never enter an exam room without knocking.

6. Confirm patient identity (name, date of birth, etc.) before giving injections, taking specimens or performing a procedure.

7. Remove very sick or very angry patients from the front desk immediately. Take the sick ones to exam rooms and take the angry ones to the manager’s office.

8. Do not use medical jargon with patients. If they don’t know what you’re talking about, they might be too
intimidated to ask.
10. The office should be CLEAN, fresh and up-to-date. No dying plants, no magazines more than 9 months old, no dust bunnies behind the doors, no stained seating or carpets.
11. Train staff to apologize, and to apologize sincerely.
12. Complaints from patients and staff need to be addressed in 2 weeks or less.
13. Medical equipment is to be maintained and tested annually for safety and performance.
14. Once a medical record is finalized, the only changes to a paper record are single line strike-throughs with corrected information and initials, or addendums. There are no changes to electronic records, only addendums.
15. Patients don’t understand insurance. Be the expert.
16. Shred confidential practice paperwork and patient-identified information on-site.
17. Keep medications (including sample medications) in locked cabinets and use a good inventory system to log the use and replacement of stock.
18. Strive to meet patients at their communication level. Use graphics, translated materials and interpretive services when needed.
19. Don’t expect patients to be on time for their appointments when the provider isn’t.
20. Don’t make copies from copies.
21. Give everyone the benefit of the doubt. There’s always more to the story. Okay, this is really a rule for life in general, but it works in medical offices too.

Leave a comment and tell me what rule you would add.

For more medical office rules, read “Ten Golden Rules for Your Medical Office Staff.”
CMS Delivers Additional Information Regarding Medicare Timely Filing Rule

In the MLN Matters dated July 30, 2010, Change Request (CR) 7080, CMS gives additional instructions on the timely filing rule*:

- For **institutional claims** that include span dates of service (i.e., a “From” and “Through” date span on the claim), the “Through” date on the claim will be used to determine the date of service for claims filing timeliness.

- For **professional claims** (CMS-1500 Form and 837P) submitted by physicians and other suppliers that include span dates of service, the line item “From” date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items). For physicians and other suppliers that bill claims with span dates, **these span date services cannot exceed one month**.

Image by bookgrl via Flickr
BE AWARE: If a line item “From” date is not timely, but the “To” date is timely, Medicare contractors will split the line item and deny untimely services as not timely filed.

Claims having a date of service of February 29th must be filed by February 28th of the following year to be considered as timely filed. If the date of service is February 29th of any year and is received on or after March 1st of the following year, the claim will be denied as having failed to meet the timely filing requirement.

*Change request (CR) 6960 specified the basic timely filing standards established for FFS reimbursement, which are a result of Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA) that states that claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare.

The Cohen Report: Medicare Part B NCCI Update 16.2 for Providers Effective July 1, 2010

Here’s your pop quiz:

The NCCI edits are:

A. pairs of services that should not be billed by the same
physician for the same patient on the same day.

B. definition refinements for HCPCS codes.

C. diagnosis codes (ICD-9) that cannot be billed together on a CMS 1500 claim.

The answer is below the picture.

If you answered “A”, you’re on top of your game! The King of the National Correct Coding Initiative (NCCI) quarterly analysis is Mr. Frank Cohen and he provides that analysis free of charge for all. Thank you, Frank! With his analysis, you have the opportunity to see what’s changed and what’s new, to tweak your system to catch the pairs, and to make sure you are providing the right care at the right time as well as maximizing your reimbursement.

The Cohen Report:

In summary, there are 16,843 new edit pairs, bringing the total number of active edit pairs to 653,718. Six of these are backdated to an effective date of January 1, 2010. The majority of these (75.17%) are associated to the edit policy “Misuse of column two code with column one code” with 12.82% associated to “Standard preparation / monitoring services for
anesthesia”. There are 6,042 unique Column 1 codes and 274 unique Column 2 Codes within the new edits.

There are 36 new terminated edit pairs with 12 backdated to January 1, 2010 and two backdated to April 1, 2010. The edit policies associated to these edit pairs are distributed between “Misuse of column two code with column one code” (44.4%), “CPT Manual and CMS coding manual instructions” (33.3%) and “More extensive procedure” (22.2%).

There were 413 edit pairs with modifier changes. Of these, 387 went from 0 (no modifier permitted) to 1 (modifier permitted) and 26 went from an indicator of 0 to an indicator of 1.

There are currently 1,336 duplicate entries; codes that were activated at one point then terminated and then re-activated. There are 5,318 swapped edit pairs; situations where the edit pair was introduced at one point in a specific order (column 1 and column 2), terminated and then re-activated with the edit pair in the opposite order.

I have posted my analysis worksheets for those interested in the details. Go to www.frankcohen.com and click on the Download tab.

Consultant Donna Izor: Ten Tips To Make the Patient Schedule Work for Your Practice

Many practices and providers take their patient schedule for granted. They overlook the opportunity to improve both productivity and effectiveness by managing their schedule. Here are ten tips for office managers to make sure that the
patient schedule works for you and for your practice.

1. **Evaluate the schedule template with the providers and nurse manager quarterly.**

By using actual issues from the previous period, discuss what has worked and what has not. Have providers share their concerns and discuss their recommendations for change. Nursing often has many ideas to improve the flow of patients through the practice and is a valuable source of information. Keep track of changes made and evaluate their effectiveness at the following meeting.

2. **Standardize visits types.**

There are many reasons an individual provider likes their “own” schedule. As managers, we know that this makes it very difficult for the front desk staff to do their jobs. Standardization reduces the potential for errors and disruption that proprietary schedules may cause. Your role in the discussion with providers will be that of facilitator,
staff advocate, and coach.

Bring forward options for standardized visit types. Many practices use a block template based on 10, 15 or 20-minute blocks of time. The number of blocks used per visit type are agreed to and used to fill the schedule. There may be additional restrictions placed on the schedule such as no more than one new patient per half-day session. Minimize the number of restrictions or ideally eliminate them to assure your days are as flexible as possible to meet your patient needs. You may also want to consider open access scheduling. Moving to this system often takes time and effort to eliminate the backlog of booked patients but once fully in place can be very successful.

3. **Track scheduling errors and issues perceived to be scheduling errors monthly.**

Errors in scheduling cause patient dissatisfaction, back up your waiting room, and lead to stress and possibly short tempers. Ask providers and staff to tell you when they think patients are scheduled incorrectly. Track this over time to determine if changes in the system are needed, how visit type use can be improved, and what training may be needed.

4. **Know where scheduling bottlenecks are.**

What is your average wait time in the office per provider? Do a time study on each provider and measure how long it actually takes for a patient to get through an office visit. Note the time they arrive for check in and registration functions, their time in the waiting room, when the nurse completes check in functions in the exam room, when the provider enters the exam room, when the provider leaves the exam room and when the patient exits the office. Overlay this on your schedule.
The information you gather will help you identify bottlenecks and provide meaningful data to share with your providers when recommending a change in the schedule template.

5. **Know how much a visit is worth in revenue.**

Adding one visit per day by addressing schedule gaps, clinical start times, no-show appointments or changing the length of visits will increase your revenue. If your provider works four days per week and 48 weeks per year at an average visit reimbursement of $75, one additional visit per day will add $14,400 in annual revenue to the bottom line!

6. **Train your scheduling staff and update the training regularly.**

Training a new staff member often brings up questions the entire staff can benefit from. Be sure to keep track of questions and include answers in future written training materials as well as in staff meeting discussions. Develop a training checklist for scheduling staff and have both the trainer and new employee initial when each area is mastered. This checklist can also be used for annual performance reviews. For current staff, take a look at their computer
terminals and see what “sticky notes” are posted there, indicating areas that need special consideration or additional training.

7. **Have the schedule be a frequent agenda item for staff meetings.**

Get the staff perspective on what is working and what is not on a regular basis. You may find that nursing can provide a great deal of information on how the schedule impacts patient flow from their perspective. Take time for staff to discuss “what if” scenarios and how they would handle a particularly difficult situation. The goal is to have a schedule that staff understands, is user friendly and is consistently used.

8. **Have a policy on the number of providers out at one time for vacation or holidays and follow it.**

Everyone deserves time off but having many providers out at once can lead to a very hectic week for those remaining. Plan as much in advance as possible for time away. If you do end up with a number of providers out at once, remember that the person remaining will also be responsible for reviewing lab
and radiology results for their colleagues as well as answering questions regarding patients that they may not know. Allow extra time in the schedule for this.

9. **Know what changes in demand to expect during the year and plan for it.**

Do you have more requests for acute visits in January, camp physicals in April, or school sports physicals in August? Minimize last minute adjustments to your schedule by knowing any seasonal trends in scheduling. Take a look at the schedules from past years to predict when you need more or less acute slots and adjust your schedule template for this. Manage the time you’ve allotted by marketing efforts in the office and local papers reminding your patients to schedule in advance.

You may also want to consider adding additional clinical hours during this time to make sure you can meet demand. Consider asking part time providers for extra hours per week or using per diem staff.

10. **Deal with your patient no-shows.**

Consider writing a policy on no-shows if you do not have one. If you have one, follow it. Make sure that your policy follows any state regulations to avoid patient abandonment claims.

Educate your patients. Develop a set of professional communications about your visit cancellation and no-show policy that begin with your welcome to the practice letter. Post a notice of your policy in your waiting room. Send letters following each no-show and then the termination letter stating the reason for the termination and that the patient is still responsible for their account balance. Be the contact person on the letter so that if the patient calls with questions, they speak with you rather than take up provider
time or that of your staff.

If you have a patient that consistently no-shows but the providers do not want to terminate them from the practice, determine what other help you can provide to get the patient to the visit on time. Consider additional reminder calls, assistance with other services such as transportation, or offering the ability to come in and wait without a scheduled time. Though this may take more staff time, the revenue from the appointment should make it worth your while.

Donna Izor, MS, FACMPE is founder of West Pinnacle Consulting, LLC. Her 20 years of experience as a medical practice executive lends her special expertise in the areas of primary care and specialty practices, employed inpatient physicians, regulatory oversight, facility design, physician compensation and relations, and new program development. She has worked with academic, community hospital, and private practices. You can contact Donna at donna.izor@gmail.com.

Cloud Computing (also SaaS)

The Cloud

Image via Wikipedia
Computing in the cloud may mean that your application in not housed on your server onsite or may mean that your database is not housed on your server onsite, or both. You or your staff may use software applications or data that is stored in the cloud.

Advantages:

- no server onsite
- no server management (techs) onsite
- no need to increase onsite storage
- transparent upgrades, patches and fixes
- redundancy

Disadvantages:

- You can’t touch it
- You can’t see what’s wrong
- You are trusting others with a most precious asset – your data

Software as a Service (SaaS), another name for cloud computing, means that the software is owned, managed and housed by the vendor, not by your practice or your hospital.

So, just where is this cloud? It’s anywhere else but where you are. It could be in several different places, redundant and backed-up, for protection against downtime or disaster.