21 Common Sense Rules for Medical Offices

Image by George Eastman House via Flickr

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.

Image via Wikipedia

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.
9. Wash your hands. Often. No matter what you do in the practice.
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."**

UPDATE: SubroShare® Focuses on Payers, Not Physicians

I received an email today from SubroShare® founder and CIO Stephen Ambrose, letting me know that SubroShare® has changed its marketing model from what he described in his **recent interview here.**

He describes the new model:

> ***It was thought at one time that the health providers, by knowing about when a payer PURCHASED CRRs, could thereby use such information to effect reimbursement. However, this has proven to not be applicable on an individual provider to payer basis – and actually a hindrance to interested payer clients.***

Steve goes on to say that it is now clear that the two clients of SubroShare® will be **payers** and **outsourced provider networks** such as third-party administrators (TPAs), repricing agencies and preferred provider organizations (PPOs). Physicians and care providers will not be marketed to as:

> ***In fact, there are NO benefits to the Provider "" they are simply mandated to participate. The information that is submitted by the Provider is known as ROI Data, and is simply an extension of the obligation they already have to provide the patient's payer with TPL/COB information.***

Coming soon to a contract near you: a clause requiring you to submit attorney requests for medical records to the payer.

SubroShare®: Is This the New Way to Bring Value to Payer Contract Negotiations?

Click here for the December 9th UPDATE I posted on SubroShare's announcement that they will not be focusing on physicians as clients.

I recently interviewed Stephen Ambrose, the Founder and CIO of SubroShare®, a database of medical record requests. Steve has a lot of passion for his innovative product and envisions SubroShare® playing a starring role in payer contract negotiations.

Mary Pat: Steve, what is subrogation?

Steve: Subrogation is a legal right and necessary tool used throughout the insurance industry with many types of policies. It allows insurers to recover part or full amounts of claim monies, which they have previously paid out to, or on behalf of a claimant.

In certain circles, subrogation is considered the "great equalizer" because it allows insurers to reduce or eliminate the passing of unnecessary cost related to third-party liability (TPL) claims, to policyholder premiums and provider

reimbursement rates.

Overpayment of health care claims is a form of “waste” in cases where previously paid health care claims are re-billed to a third party and subsequently paid for again as part of a successful injury claim settlement.

Mary Pat: How does your product SubroShare® relate to subrogation?

Steve: First, apart from Medicare’s MSP (Medicare Secondary Payer) program, I know of no law or obligation where injury claimants or their attorneys must proactively volunteer information to a health payer, alerting them of a case, where the payer has a right to recover. For this reason payers have always been responsible for data mining claim form information, and to this end, use software products and vendor services to do so.

SubroShare® recognizes that the claim form/data itself is limited in holding the correct, identifying data for third party cases. In many cases, the use of the claims data results in payers having false positives or dead end investigations. Even claims vendors who claim to use the ”˜latest and greatest’ tools, freely admit that they do not find all of the cases available to the payer.

Our company has developed a new patent-pending technology in Collaborative Subrogation®, **where we work to connect just one small part of a health provider’s record department with an applicable payer.** This is only for certain ROIs (Release of Information) made by the patient or their attorney involved in a patient’s injury claim.

Mary Pat: What is the physician's office or healthcare provider's role?

Steve: In most payer agreements, the health provider has a contractual obligation to provide coordination of benefits (COB) and third party liability (TPL) information to the payer, when known. This is reflected in certain sections of the CMS 1500/UB-04 forms and their 837 data record electronic counterparts.

The SubroShare® exchange handles non-billing TPL data, specific ONLY to those times where a record request is made on a patient of the provider. This ROI Data, is submitted to SubroShare® at the time of record request fulfillment, by **the provider submitting either a one or two page fax / secure email attachment.** The first page is typically only a ¼-page section and the second page is a copy of the request letter, sent by an attorney (if applicable).

Providers can learn more by watching the provider tutorial **here.**

Mary Pat: How does this sharing of information work within HIPAA rules?

Steve: Under 45-164.501 of the Health Insurance Portability and Accountability Act (HIPAA), the ROI data that is collected and shared between health providers and payers, through the SubroShare® network, is specific to insurance subrogation operations and falls under the HIPAA provision of "Payment", in the automatic exclusion of "Treatment", "Payment" and "Operations".

This means that patient authorization is not necessary, nor can the patient request to withhold the limited disclosure of their PHI to SubroShare and eventually, to their health insurance company.

Finally, every health provider who participates with SubroShare® must sign a HIPAA Business Associate agreement, which is signed digitally on the joining section of our website.

Mary Pat: What is the health plan or payer's part of this?

Steve: Payer members or Subscriber Entities of SubroShare® login and freely search for established Certified Recovery Reports® within our system. Once found, the payer downloads the information, which both guarantees policyholder involvement and uniqueness from any existing payer's claims management software and vendors.

Mary Pat: I can see how this benefits the payer, but how does it benefit the physician practice?

Steve: Under the new HITECH guidelines to go into effect in later 2010, health providers cannot receive compensation from the transfer of PHI. Therefore, we felt it prudent to be able to create financial transparency on both the payer and provider sides of SubroShare®.

Essentially, providers will know the specific payers who downloaded their submitted ROI data, as well as the date of download and patient referenced. This data, coupled with a provider's analysis on the amount of paid claims for such patients, provides a clearer picture on the fact that a provider is now becoming a new type of asset to the payer and to an extent, which can be measured by the provider, as well as the payer. We believe such a change in value could denote an improvement in reimbursement levels within various payer relationships.

Mary Pat: Could payers use this information to deny payment or request a refund for payments already made?

Steve: There are numerous laws and rules, inherent to different states, communities and health plans, allowing for cost avoidance. This term denotes when a government, commercial or self-insured payer determines that a policyholder's care should be or will be covered by a payment party other than themselves.

Unfortunately, we cannot keep a health payer from pursuing cost avoidance policies, which they have in place. However, I'd like to mention that not all plans have this provision; and for those which do, **this simply makes the point that it could be a future point of provider-payer negotiation,** perhaps with relation to all such claims, not just the ones from SubroShare®.

Mary Pat: If the practice uses an outsourced company to copy medical records, can the medical records company send the information to SubroShare®?

Steve: Yes, provided two conditions are met.

First, the health provider is the one, which joins SubroShare® – not the outsourced company. Health providers can give their login details and appropriate permissions to their ROI or outsourced information vendor.

Second, the outsourced vendor MUST have an existing HIPAA Business Associate Agreement with any applicable health providers. I assume this is the case anyway, but if I didn't mention it the answer would be less than complete.

Mary Pat: It's a leap of faith you're asking a medical practice to take, isn't it? Is there any way you give the practice a guarantee of negotiating better fee schedules with payers, or any way you could compensate them for their time?

Steve: I don't think the leap is that large…here's why. Its becoming increasingly obvious that past provider strategies on reimbursement rates will be largely overshadowed and trumped by a tightening healthcare system and monies, which are drying up for many of its participants. If the monies are not there for payers, they won't be there for providers.

SubroShare® creates revenue, without charging higher premiums to policyholders, but rather, in redistributing monies, which are generated through the legal industry and might never make their way back into the healthcare arena. Providers need to look at the information, which they are already holding. Can it help their valuation and reimbursement with payers? I suppose that's up to each payer. Medicare already has demo programs, which trade off payment for valuable data submission and we expect that to find its way into the private payer sector as well.

Our President and both sides of Congress have made it very clear that finding and reducing waste is one of the top priorities. Therefore, we want our collaborative model to demonstrate to today's leaders that payers and providers CAN work together for the good of the system.

Mary Pat: What would you say to a

practice manager to convince them to work with SubroShare?

Steve: As a practice manager, if you are bitter about "what insurers have done TO you?", then you are not the right practice for SubroShare®. You'll probably be coming on through payer mandate, as your payers adopt these measures. I will state that voluntary participation will offer you the ability to proactively come to the negotiating table with results in hand.

If you understand that it's about future positioning and NOT the payer taking advantage of you, then you'll begin to understand the importance of positioning and collaborative strategy. We're in a whole new arena of healthcare and old models and adversarial relations will not do well.

There is no cost to join, no cost to participate, no software to buy or integrate and no patient authorization necessary. All that is required is a fax and a simple internet connection. Please visit us **here** or call (804) 750-1389 for more information.

What Does a Medical Practice Manager Do?

Whether the title is manager, medical practice manager, physician practice manager, administrator, practice administrator, executive director, office manager, CEO, COO, director, division manager, department manager, or any combination thereof, with some exceptions, people who manage physician practices do some combination of the

responsibilities listed here or manage people who do.

Human Resources: Hire, fire, counsel, discipline, evaluate, train, orient, coach, mentor and schedule staff. Shop, negotiate and administer benefits. Develop, maintain and administer personnel policies, wellness programs, pay scales, and job descriptions. Resolve conflicts. Maintain personnel files. Document Worker's Compensation injuries. Address unemployment inquiries. Acknowledge joyful events and sorrowful events in the practice and the lives of employees. Stay late to listen to someone who needs to talk.

Facilities and Machines: Shop for, negotiate, recommend, and maintain buildings or suites, telephones, hand-held dictation devices, copiers, computers, pagers, furniture, scanners, postage machines, specimen refrigerators, injection refrigerators, patient refreshment refrigerators, staff lunch refrigerators, medical equipment, printers, coffee machines, alarm systems, signage and cell phones.

Ordering and Expense Management: Shop for, negotiate and recommend suppliers for medical consumables, office supplies, kitchen supplies, magazines, printed forms, business insurance, and malpractice insurance as well as services such as transcription, x-ray reads/over-reads, consultants, CPAs, lawyers, lawn and snow service, benefit administrators, answering service, water service, courier service, plant service, housekeeping, aquarium service, linen service, bio-hazardous waste removal, shredding service, off-site storage and caterers.

Legal: Comply with all local, state and federal laws and guidelines including OSHA, ADA, EOE, FMLA, CLIA, COLA, JCAHO, FACTA, HIPAA, Stark I, II & III, fire safety, crash carts and defibrillators, disaster communication, sexual harrassment, universal precautions, MSDS hazards, confidentiality, security and privacy, and provide staff with documentation and training in same. Make sure all clinical staff are current on licenses

and CPR. Have downtime procedures for loss of computer accessibility. Make sure risk management policies are being followed. Alert malpractice carrier to any potential liability issues immediately. Make sure medical records are being stored and released appropriately.

Accounting: Pay bills, produce payroll, prepare compensation schedules for physicians, prepare and pay taxes, prepare budget and monthly variance reports, make deposits, reconcile bank statements, reconcile merchant accounts, prepare Profit & Loss statements, prepare refunds to payers and patients, and file lots and lots of paperwork.

Billing, Claims and Accounts Receivable: Perform eligibility searches on all scheduled patients. Ensure that all dictation is complete and all encounters (office, hospital, nursing home, ASC, satellite office, home visits and legal work (depositions, etc.) are charged and all payments, denials and adjustments are posted within pre-determined amount of time. Transmit electronic claims daily. Send patient statements daily or weekly. Negotiate payer contracts and ensure payers are complying with contract terms. Appeal denials. Have staff collect deductibles, co-pays and co-insurance and have financial counselors meet with patients scheduling surgery, those with an outstanding balance, or those patients with high deductibles or healthcare savings plans. Make sure scheduling staff know which payers the practice does not contract with. Liaison with billing service if billing is outsourced. Credential care providers with all payers. Perform internal compliance audits. Load new RBRVS values, new CPTs and new ICD-9s annually. Run monthly reports for physician production, aged accounts receivable, net collection percentage and cost and collections per RVU. Attach appropriate codes to claims for e-prescribing and PQRI. Have plan in place for receipt of Recovery Audit Contractor (RAC) letters. Make friends and meet regularly with the provider reps for your largest payers.

Marketing: Introduce new physicians, new locations and new services to the community. Recommend sponsorship of appropriate charities, sports and events in the community. Recommend sponsorship of patient support groups and keep physicians giving talks and appearing at events. Thank patients for referring other patients. Track referral sources. Recommend use of Yellow Pages, billboards, radio, television, newspaper, magazine, direct mail, newsletters, email, website, blog, and other social media. Prepare press releases on practice events and physicians awards and activities. Recommend practice physicians for television health spots.

Strategic Planning: Prepare ROIs (Return on Investment) and pro formas for new physicians, new services, and new locations. Forecast potential effect of Medicare cuts, contracts in negotiation or over-dependence on one payer. Discuss 5-year plans for capital expenditures such as EMR, ancillary services, physician recruitment, and replacement equipment. Explore outsourcing office functions or having staff telecommute. Always look for technology that can make the practice more efficient or productive.

Day-to-day Operations: Make the rounds of the practice at least twice a day to observe and be available for questions. Arrange for temporary staff or rearrange staff schedules for shortages, meet or speak with patients with complaints, and meet with vendors, physicians and staff. Open mail and recycle most of it. Unplug toilet(s).

Stay Current in Healthcare: Attend continuing education sessions via face-to-face conferences, webinars, podcasts and online classes. Maintain membership in professional organizations. Pursue certification in medical practice management. Network with community and same specialty colleagues. Participate in listservs, LinkedIn and Twitter.

What did I leave out? Take a lunch?

Read my post on “How Much Do Medical Practice Managers Make?” **here.**