The Complete Guide to Revenue Cycle Management – A New Comprehensive Course from Manage My Practice

You spoke and we listened – you asked for a comprehensive course on Revenue Cycle Management and we brought it to you!

This series is for **anyone** who wants to understand the medical practice revenue cycle from the very beginning to the very end: physicians, physician assistants, nurse practitioners, advanced practice registered nurses, practice administrators, office managers, consultants, vendors, students, coders, billers and those who want a RCM foundation to enter the healthcare field. Anyone who wants to know more about how reimbursement in healthcare works in the medical practice will find this comprehensive series **indispensable.**

You won't find this comprehensive course anywhere else except at Manage My Practice. Webinar leader Mary Pat Whaley, FACMPE, CPC has developed this program from 25+ years of experience in medical practice management and from requests she gets weekly for education on the revenue cycle management process.

The Complete Guide to Revenue Cycle Management – a Five Module Comprehensive Curriculum

Module I. The Foundation

- Payer Contracting
- Credentialing
- Payer Matrix

- Setting a Fee Schedule
- Understanding Medicare Part B

Module II. The Data Build

- Practice Management System Set-up
- Allowables
- Patient Demographics & Insurance Information
- Eligibility & Benefits
- CPTs, HCPCS, ICD-9

Module III. The Pre-Claim Process

- Collecting at TOS
- Documentation: Paper vs Electronic Medical Records (EMR)
- Physician Coding vs. Abstraction Coding
- The Superbill vs. Using the EMR to Bill
- Claim Scrubbing: The Three Gates

Module IV. The Post-Claim Process

- Write-offs, Denials and Appeals
- Daily Reconciliation Process
- Patient Collections and Payment Plans
- Refunds
- Recoupments

Module V. Monitoring

- Monthly Reports
- The Practice Dashboard/Snapshot Report
- Strategies for Improving Revenue
- Benchmarks for Staffing
- Revenue Cycle Compliance and Auditing

Also Included! Action Pack – Handouts in Word/Excel

1. Contract Reference Matrix
2. Contract Review Template
3. Fee Schedule Worksheet

4. Medicare Resources
5. Allowable Cheat Sheet
6. Write-off Approval Form
7. Daily Reconciliation Form
8. Refund Request
9. Monthly Report List
10. Sample Snapshot Report
11. Sample Revenue Cycle Compliance Plan

Here's what one attendee wrote about a recent Manage My Practice Webinar "Information was right on! Great examples and real life experiences."

5-Week Course for $799.00 (Two Options)

Option One : Every Tuesday for Five Weeks – March 12, 19, 26, April 2, and April 9

Click Here To Register!

Module I: Tuesday, March 12 @7pm ET for 90 minutes

Module II: Tuesday, March 19 @7pm ET for 90 minutes

Module III: Tuesday, March 26 @7pm ET for 90 minutes

Module IV: Tuesday, April 2 @7pm ET for 90 minutes

Module V: Tuesday, April 9 @7pm ET for 90 minutes

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Option Two: Every Thursday for Five Weeks – March 14, 21, 28, April 4 and April 11

Click Here To Register!

Module I: Thursday, March 14 @1pm ET for 90 minutes

Module II: Thursday, March 21 @1pm ET for 90 minutes

Module III: Thursday, March 28 @1pm ET for 90 minutes

Module IV: Thursday, April 4 @1pm ET for 90 minutes

Module V: Thursday, April 11 @1pm ET for 90 minutes

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Mary Pat Whaley, FACMPE, CPC has 25+ years managing physician practices of all sizes and specialties in the private and public sectors. She is Certified Professional Coder, is Board Certified in Medical Practice Management and is a Fellow in the American College of Medical Practice Executives. Mary Pat has been providing free information and resources to physicians, care providers and medical practice executives since 2008. For questions about "The Complete Guide to Revenue Cycle Management" webinar, contact Mary Pat at (919) 370-0504.

Mary Pat and Dr. Peter Polack Discuss (Approximately) 101 Ideas to Increase Revenue and Decrease Costs in a Two Part Podcast

Mary Pat recently sat down with Peter Polack, MD of **Medical Practice Trends** for another podcast to talk about one of the most important parts of any practice: The Bottom Line. In this two-part podcast series, Dr. Polack and MP discuss ideas for cutting costs and raising revenue to strengthen any group's financial position.

Click here to listen to part 1

Click here to listen to part 2

A Manage My Practice Classic: 101 Ideas for Increasing Revenue and Decreasing Expenses in Your Medical

Practice

Mary Pat's Note: This post has always been popular because it answers one of the most burning questions in Healthcare: "How can I improve my bottom line?" If you have used any of these ideas in your practice- or have some of your own to share- let us know in the comments below!

BUILD ON WHAT YOU'RE CURRENTLY DOING:

1. **Add physician hours** – add evening or weekend hours; start your office hours earlier and end hours later.

2. **Reduce physician time off** – decrease vacation or change weekly days off to 1/2 days off.

3. Set a minimum number of providers to be in the office **seeing patients at all times** the office is open.

4. Have each provider add **one new patient visit** to his/her schedule weekly.

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6. Report **PQRI** measures to recoup additional Medicare revenue.

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you will get from the government.)

9. If you are in an underserved or rural area, check to see if there might be **grants or funds available** locally, in the state or federally, for adding a service to your practice.

10. If your practice does **Independent Medical Exams (IMEs), reviews records or depositions**, make sure that your fee schedule for such services is current and that the fees are collected before the physician provides the service.

ADD TO YOUR CURRENT SERVICES:

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12. Dispensing pharmaceuticals

13. Dispensing nutriceuticals

14. Dispensing Durable Medical Equipment

15. Group patient visits

16. Coumadin Clinic

17. Heart Failure Clinic

18. Diabetes Education Classes

19. Add primary care to specialty care practices

20. Add specialty care to primary care practices

21. Research

22. Joint Ventures with other practices or hospital

23. Lease space to other entities

24. eVisits (virtual visits or email visits)

25. Elective procedures or services

26. Mid-level providers

27. Walk-in clinic

28. Occupational medicine: drug screens, employment physicals, etc.

29. Hospitalists

30. Medical Director of local nursing homes

31. Complementary & alternative medicine (CAM)

32. Aging in Place services

33. Social worker

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52. Do you **correct claims daily when they are rejected at the claim level** and are not paid for for reasons that can be corrected?

53. Do you have your **contract allowables** in your PM system so you know when you are not being paid correctly by contract?

54. Do you **appeal unpaid or underpaid claims**?

55. Do you **check recoupments** or requests for refunds from payers and make sure they truly should be refunded?

56. Do you send insurance and patient payments to a **lockbox** to be scanned and stored digitally for your staff to post from?

57. Do you make **payment arrangements** in the office for balances after insurance has paid, or payment plans by drafting credit or debit cards?

58. Do you have a **policy of not sending statements**?

59. Do you **collect the patient's portion** of the service at the time of service?

60. Do you **collect fees for elective services** prior to providing these services?

61. Can your patients **make payments online** through your website?

62. Do you file a **claim with a patient's estate** if they have died?

63. Do you accept **cash only from patients who have passed bad checks**?

64. Do you accept **cash only from patients who have filed bankruptcy** with your practice?

65. Do you inadvertently **see patients who have been dismissed from your practice**?

66. When adding a physician to the practice, do you **timeline the credentialing** appropriately so the physician can see patients with insurance as well as those without?

67. If your new physician is only partially credentialed with payers, do you have him/her see the patients with payers they are credentialed with and **add payers to their schedule load as the credentialing comes through**?

68. Do you **meet with representatives from your largest payers monthly** to establish relationships and bring problems to their attention? (the squeeky wheel theory of payer relations)

69. Are you **pre-certing** everything that needs pre-certification or pre-authorization or pre-notification to be sure the service will be paid?

70. Are you receiving payments via **electronic funds transfer** (EFT)?

71. Are you receiving **explanation of benefits (EOBs) or remittance advice (RA) electronically?**

72. Are you **posting your RA electronically**?

73. Are you **protecting your practice from embezzlement?** (**see my post on this here**.)

74. Is someone in the practice responsible for staying current on **changing coding requirements** for Medicare, Medicaid, Tricare and commercial payers?

DECREASE EXPENSES:

75. Eliminate **overtime**. Evaluate the need for additional staff (part-time?) vs. overtime.

76. **Send some staff home** (sometimes called “low census”) when

there are no patients to be seen.

77. Use **volunteers.** Tap into the local hospital volunteers, or recruit and train your own.

78. Hire an after-school **student** employee to do routine jobs.

79. **Discontinue paying staff for inclement weather closings** when the practice is not open.

80. **Shop everything.** Negotiate existing service contracts. Do not assume anything is non-negotiable. Negotiate the rent.

81. **Get rid of yellow pages advertising.** It rarely brings you new patients and is primarily a place to look up phone numbers. You will still get your white pages listing free with your phone service.

82. Utilize **pre-employment testing** to make sure job applicants have the skills you need.

83. Shop postage machines or look into **stamps.com.**

84. Join a **group purchasing entity** (hospital, professional association, etc.)

85. Improve your **accounting cycle.** Invoices and statements are matched up with packing slips and negotiated prices. Use purchase order numbers.

86. Get the **payment discount** by paying on time or early – ask vendors for an on-time or early payment discount.

87. Make sure **office supplies** are not going home with the employees. Make sure office supplies that are ordered are "really need" and not "sure would be nice."

88. Remind patients of their appointments to **decrease no-shows**. Call patients who no-show and attempt to reschedule (unless they feel better!) Track no-shows and evaluate the reasons for them.

89. Consider **charging for no-shows** or dismissing patients for no-shows.

90. Have a good **recall system** in place. If patients leave without scheduling a needed follow-up, make sure that they are called if they have not scheduled within a certain amount of time. Keep track of annual wellness visits and remind patients to schedule them.

91. Take advantage of any **discounts offered by your malpractice carrier** by completing risk management surveys and having speakers give annual updates on decreasing malpractice claims. Some carriers give discounts for managers who are members of **MGMA** or Fellows in the **ACMPE.**

92. Evaluate any **discounts on services or products offered by your physicians' professional associations** and societies.

93. **Evaluate your leases** – are those big old copiers and faxes worth paying for a service contract?

94. Consider **speech recognition/voice recognition** and eliminate transcription.

95. Review your **computer maintenance contracts.** Are you paying for maintenance on equipment or software that is no longer being used?

96. Take advantage of **online CME** for physicians, midlevel providers, clinical staff and managers.

97. Make plans to attend face-to-face seminars well in advance to take advantage of **early enrollment discounts and good flight deals.**

98. **Evaluate outsourcing.** Think about outsourcing transcription, coding, billing, pre-authorizations, credentialing, switchboard, payroll, accounting and medical records copying.

99. Replace your **answering service** with an answering machine educating patients on the limited reasons for calling after hours and giving the number of the physician on call.

100. **Destroy archived financial and medical records** that you are paying to store, once you have ascertained that they exceed the required time limit.

101. Hold a **brainstorming session with the staff** and ask for their ideas for increasing revenue and reducing expenses. The people on the front lines will have excellent ideas. In return, do not nickle and dime the staff to death by charging for coffee, reducing parking stipends or eliminating uniform allowances. Keep in mind that for your rank and file staff, having to pay for their own uniforms or paying more for parking might be a deal-breaker that causes them to search for work elsewhere. Try to focus on the bigger items for savings and make sure the staff know you are trying to keep their small benefits in place in appreciation for their work.

The Right Way to Do Write-offs

A write-off is an amount that a practice deducts from a charge and does not expect to collect, thereby “writing it off” the accounts receivable or list of monies owed them by payers or patients.

There are lots of reasons why write-offs are taken, and it is common practice to divide write-offs into two major categories.

Necessary or Approved Write-offs

These are write-offs that you have agreed to, either in the context of a contract, or in terms of your practice philosophy.

Contractual write-offs are the difference between the practice fee schedule and the allowable fee schedule you've agreed to accept.

Charity write-offs are the difference between the practice fee schedule and anything collected. Charity write-offs may be in accordance with a community indigent care effort, a policy adhered to in a faith-led healthcare system, or a financial assistance program.

Small balance write-offs are amounts left on the patient's account that may not warrant the cost of sending a bill, which has been estimated to cost about $12.00 each, taking into account the statement process, as well as the cost to receive the check, post it, and deposit it. Many practices write off the small balance (usually $15 or less) and collect it when the patient returns. Others run a special small balance statement run once a quarter.

Prompt payment discounts and **self-pay (no insurance) discounts** are write-offs for patients paying in full at time of service, and/or patients who receive a discount off the retail price because they do not have insurance coverage.

Unnecessary Write-offs

These are write-offs that you have not agreed to and you reluctantly reduce the charge based on billing mistakes or situations that you should have been able to control, but were

not.

Timely filing write-offs are caused by filing the claim past the date required by the payer. Medicare requires that claims be filed no later than 12 months after the date of service to be paid. Medicaid varies from state-to-state. Commercial payers usually have very tight timely filing limits and most average three months. (Make sure you know your timely filing limits for each payer.)

Uncredentialed provider write-offs are those caused by filing a claim for a provider before they are credentialed with the payer.

Administrative write-offs are those approved by the manager based on service issues. For instance, if the practice assures the patient that they are participating with the patient's insurance, then it turns out that the practice is not in-network, the manager may approve a write-off based on the practice's error. If the patient has a very bad experience in the practice, the manager may want to discount the service or to write-off the charge completely. If you do discount the service, remember to submit the claim for the altered fee, as you cannot discount the fee to patient and charge the payer the full fee.

Bad debt write-offs are balances that you have decided to write-off and not pursue further. These are balances that for whatever reason, you are forgiving forever.

Collection agency write-offs are those that are written off the main A/R (accounts receivable) and transferred to a third-party collection agency to collect on your behalf. These balances are not forgiven. Some PM (practice management) systems maintain a separate collection bucket or A/R and others do not maintain collection accounts in the system. Most practices do not schedule appointments with patients that have a collection balance until that balance is satisfied or the

patient is committed to a reasonable payment plan.

Some guidelines for managing write-offs

1. Start with the basic write-offs but add write-off categories as the need arises.
2. Decide which write-offs require managerial approval. Do not make staff get approval for routine write-offs, but do not completely relinquish approval for all write-offs as this is one place where staff could abuse their authority. Make sure write-offs are addressed in your compliance plan so staff understand their responsibilities.
3. Review all write-off categories monthly and pay attention to unusual spikes as well as creeping trends. Keep in mind that if you raise your fees and don’t renegotiate your contracts, your contractual write-offs are going to escalate, and you’ll need to account for that difference in your evaluation.
4. Audit write-offs periodically to make sure that they are being done correctly. Staff will know that their work is being checked and you can be sure the numbers you are making business decisions on are sound.
5. Best practices for unnecessary write-offs are no more than 5% of your total expected collections. The formula for expected collections is gross charges minus necessary/approved write-offs.

Kris Jones of Healthcare Management Services: Baby Stepping Your Way to EHR

Some of worst horror stories in healthcare operations right now have to do with the failure of Electronic Health Record, (or EHR) installations. The high rate of EHR failures is being compounded by the pressure to attest in 2011 and start recouping some money against the EHR purchase and implementation.

To help organizations adopt EHRs smoothly and successfully, billing and management specialist Kris Jones, owner of Healthcare Management Services, is providing her clients with an innovative EHR program that she calls “Crawl. Walk. Run. Fly.” Kris told me “I found my clients so resistant to EHR, so paralyzed by the horror stories of money spent and productivity lost that I couldn’t help them move forward like we both knew they should.”

So Kris created the program that she thinks of as “Baby Steps” to make the process much more manageable and less intimidating. She brings the practice team on board a step at a time, removing the fear of the unknown and the greatest fear of all – change! Because Kris supplies the practice management software as well as the EMR, it is feasible for for her to let the practice take as much time as it needs to move through each stage.

Step 1. Crawl

The practice uses the EHR as a repository for medical record images. Staff makes first contact with the software.

Step 2. Walk

The practice adds e-prescribing and the staff enters data into the EHR for the problem list, the medication list and vitals. The software begins a functional role in patient interactions.

Step 3. Run

The physicians start with partial, then move to a full progress note. Physicians make first contact with the software.

Step 4. Fly

The practice achieves Meaningful Use with full implementation of the EHR.

What Kris has developed for her clients is the antithesis of the experience most practices have with the purchase of an EHR. It gives her clients the continual support and incremental change they need to preserve their workflow while slowly integrating the new software. This “slow and steady” approach has allowed her clients to be able to get their feet wet in the Electronic Health Record before being assured that the water’s fine and taking a full dip.

Click here to see the special free offer Kris and her team have put together for Manage My Practice readers.

Kris Jones-Bartley founded Healthcare Management Systems in 1985. Over the last 25 years, Kris built HCMS in to a multi-faceted practice management company with clients nationwide. Kris has personally managed every phase of a medical practice, from start-up to retirement, and including the recovery of

practices "on the brink" of insolvency. Critical thinking, candor and eye-for-detail, make Kris a valuable partner in the business of medicine. HCMS is focused on specialty Revenue Cycle Management deployed in conjunction with E.H.R. capability.

HealthCareManagementSystems – Experience. Expertise. Integrity. Determination. Results. Value.

What is Revenue Cycle Management?

Revenue cycle management (RCM) is a critical function in any healthcare entity. Managers do not have to know every detail about RCM, but if the RCM is on-site, they must understand:

- RCM reports and how to spot and be proactive about down-trends;
- performance measures for RCM staff and how to coach staff to improved performance; and
- the billing system and relationship with electronic claims, payments and remittance advice.

If the RCM department is outsourced, managers must be able to:

- generate ad hoc reports to assess billing company performance;
- hold the billing company to its performance guarantees; and
- stay abreast of changes in payer regulations and legislation and not rely solely on the billing company's advice.

No matter what else a manager accomplishes or does well, if

the RCM isn’t tight and right, nothing else will count.

What exactly is RCM?

Revenue Cycle Management encompasses all facets of the process of contracting for, accounting for and collecting the practice’s revenue. It includes:

1. Setting fees.
2. Contracting with payers.
3. Identifying patients’ correct payer sources (eligibility) and plans (benefits).
4. Counseling of patients prior to a high-cost procedure or surgery or needing financial assistance.
5. Documenting the services provided and producing charges for the services.
6. Collecting from outpatients at time of service.
7. Entering the services and patient payments into the computer system.
8. Filing primary and secondary payer claims.
9. Posting payments and contractual adjustments from payers.
10. Researching and appealing payer denials and underpayments.
11. Writing off small balance accounts and bad debts.

You notice that I didn’t mention sending statements.

The Benefits and Drawbacks of Managing a Private Practice

vs. Managing a Hospital-Owned Practice

Image via Wikipedia

Ownership

Private practices are organized in a corporate model where the physicians are shareholders, or where one or more physicians own the practice and employ other physicians or providers. Private practices are almost exclusively for-profit. Physician practices are organized into corporations for the tax benefits as well as protecting the owners from liability judgments.

Hospitals can be for-profit, not-for-profit or government-owned. For-profit hospitals make up less than 20% of the total hospitals in the United States.

Financial Models

Private practice owners take a salary draw, split any receipts after all expenses are paid, and generally distribute receipts monthly or quarterly. This leaves very little at year end to be taxed through the corporation.

Hospitals that employ physicians typically guarantee a salary and offer an incentive plan where the physicians earn more for seeing more patients and/or being more productive based on

work Relative Value Units (wRVUs). Hospitals may or may not use a practice expense and revenue model to measure the margin.

Benefits of Managing a Private Practice

1. You get to do everything, so if you like or want to learn about HR, marketing, finance, IT, contract negotiation, revenue cycle management, facility management, and lots of other stuff, you'll get to do it in a private practice.
2. You are the top position in the practice, so you get to put your imprint on the practice. You can often be more creative.
3. Physicians can be very laid-back and practices can maintain a more relaxed, family-like atmosphere.
4. Decision-making can be straightforward and swift, so you can help your practice to be nimble in response to news events, trends and new ideas. If your practice decides to become a concierge practice or stop or start taking a particular payer, so be it!
5. You may find it easier to get a foot in the door and start your management career in a private practice as physicians don't always hire managers using traditional means. A recommendation from another manager, a consultant or a physician may be enough to get you started.

Drawbacks of Managing a Private Practice

1. You report to the physicians who may not have business expertise and may fight you on your well-founded recommendations.
2. There is no internal career path – you're at the top in the practice.
3. Physicians will make less money every time a new non-revenue generating position is added or any time

equipment needs to be replaced – expect them to be generally slow to respond to capital expenditure needs, especially if they cannot see that any new revenue will come from the expense.
4. When physicians “eat what they kill”, taking home the dollars they personally earn less their expenses, they can be pitted against each other and have conflicting priorities.
5. Your practice could be purchased by a hospital and you could find yourself out of a job, or your job radically changed.

Benefits of Managing a Hospital-Owned Practice

1. You report to a management professional who should understand the business and be supportive of your well-founded recommendations.
2. You will receive support from other hospital departments: the Human Resources department will screen, orient and provide benefit support to your staff; the Information Systems department will provide and maintain your practice management system, EMR system and other hardware and software; and the Accounting department will pay the bills and write the payroll.
3. You may be able to climb the career ladder and manage multiple practices, or become the Vice President of Physician Practices, or the COO, CFO or CEO of the hospital.
4. You will get to interact with managers of other departments and broaden your hospital knowledge and understanding of the care continuum.
5. You can learn a lot from the process of preparing for and living through a JCAHO (a.k.a. “The Joint Commission”) visit.

Drawbacks of Managing a Hospital-Owned Practice

1. Hospitals use different terminology for charges, adjustments and receipts and work on the accrual system instead of the cash system, which most private practices use. It takes time to understand and distinguishes the terminology and process differences.
2. The entire system will be in a tizzy on a regular basis getting ready for a JCAHO (a.k.a. “The Joint Commission”) visit.
3. You can expect to have much less autonomy in a hospital system and there may be more red tape involved in getting even simple requests filled.
4. Hospital administration may find it difficult to relate to the perspective of the hourly staff and it could be frustrating to balance the needs of the staff and the needs of the organization.
5. Because the hospital is the big-dollar earner, the needs of the clinics may be second, third or fourth down the line in importance.

What do you see as the benefits or drawbacks of your private practice or hospital practice job?

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51. Do you **correct claims daily** when they are rejected at the practice management, claims clearinghouse or payer level?

52. Do you **correct claims daily when they are rejected at the claim level** and are not paid for for reasons that can be corrected?

53. Do you have your **contract allowables** in your PM system so you know when you are not being paid correctly by contract?

54. Do you **appeal unpaid or underpaid claims**?

55. Do you **check recoupments** or requests for refunds from payers and make sure they truly should be refunded?

56. Do you send insurance and patient payments to a **lockbox** to be scanned and stored digitally for your staff to post from?

57. Do you make **payment arrangements** in the office for balances after insurance has paid, or payment plans by drafting credit or debit cards?

58. Do you have a **policy of not sending statements**?

59. Do you **collect the patient's portion** of the service at the time of service?

60. Do you **collect fees for elective services** prior to providing these services?

61. Can your patients **make payments online** through your website?

62. Do you file a **claim with a patient's estate** if they have died?

63. Do you accept **cash only from patients who have passed bad checks**?

64. Do you accept **cash only from patients who have filed bankruptcy** with your practice?

65. Do you inadvertently **see patients who have been dismissed from your practice**?

66. When adding a physician to the practice, do you **timeline the credentialing** appropriately so the physician can see patients with insurance as well as those without?

67. If your new physician is only partially credentialed with payers, do you have him/her see the patients with payers they are credentialed with and **add payers to their schedule load as**

the credentialing comes through?

68. Do you **meet with representatives from your largest payers monthly** to establish relationships and bring problems to their attention? (the squeeky wheel theory of payer relations)

69. Are you **pre-certing** everything that needs pre-certification or pre-authorization or pre-notification to be sure the service will be paid?

70. Are you receiving payments via **electronic funds transfer** (EFT)?

71. Are you receiving **explanation of benefits (EOBs) or remittance advice (RA) electronically?**

72. Are you **posting your RA electronically**?

73. Are you **protecting your practice from embezzlement?** (**see my post on this here**.)

74. Is someone in the practice responsible for staying current on **changing coding requirements** for Medicare, Medicaid, Tricare and commercial payers?

DECREASE EXPENSES:

75. Eliminate **overtime**. Evaluate the need for additional staff (part-time?) vs. overtime.

76. **Send some staff home** (sometimes called “low census”) when there are no patients to be seen.

77. Use **volunteers.** Tap into the local hospital volunteers, or recruit and train your own.

78. Hire an after-school **student** employee to do routine jobs.

79. **Discontinue paying staff for inclement weather closings**

when the practice is not open.

80. **Shop everything.** Negotiate existing service contracts. Do not assume anything is non-negotiable. Negotiate the rent.

81. **Get rid of yellow pages advertising.** It rarely brings you new patients and is primarily a place to look up phone numbers. You will still get your white pages listing free with your phone service.

82. Utilize **pre-employment testing** to make sure job applicants have the skills you need.

83. Shop postage machines or look into **stamps.com.**

84. Join a **group purchasing entity** (hospital, professional association, etc.)

85. Improve your **accounting cycle.** Invoices and statements are matched up with packing slips and negotiated prices. Use purchase order numbers.

86. Get the **payment discount** by paying on time or early – ask vendors for an on-time or early payment discount.

87. Make sure **office supplies** are not going home with the employees. Make sure office supplies that are ordered are "really need" and not "sure would be nice."

88. Remind patients of their appointments to **decrease no-shows**. Call patients who no-show and attempt to reschedule (unless they feel better!) Track no-shows and evaluate the reasons for them.

89. Consider **charging for no-shows** or dismissing patients for no-shows.

90. Have a good **recall system** in place. If patients leave without scheduling a needed follow-up, make sure that they are called if they have not scheduled within a certain amount of

time. Keep track of annual wellness visits and remind patients to schedule them.

91. Take advantage of any **discounts offered by your malpractice carrier** by completing risk management surveys and having speakers give annual updates on decreasing malpractice claims. Some carriers give discounts for managers who are members of **MGMA** or Fellows in the **ACMPE.**

92. Evaluate any **discounts on services or products offered by your physicians' professional associations** and societies.

93. **Evaluate your leases** – are those big old copiers and faxes worth paying for a service contract?

94. Consider **speech recognition/voice recognition** and eliminate transcription.

95. Review your **computer maintenance contracts.** Are you paying for maintenance on equipment or software that is no longer being used?

96. Take advantage of **online CME** for physicians, midlevel providers, clinical staff and managers.

97. Make plans to attend face-to-face seminars well in advance to take advantage of **early enrollment discounts and good flight deals.**

98. **Evaluate outsourcing.** Think about outsourcing transcription, coding, billing, pre-authorizations, credentialing, switchboard, payroll, accounting and medical records copying.

99. Replace your **answering service** with an answering machine educating patients on the limited reasons for calling after hours and giving the number of the physician on call.

100. **Destroy archived financial and medical records** that you are paying to store, once you have ascertained that they

exceed the required time limit.

101. Hold a **brainstorming session with the staff** and ask for their ideas for increasing revenue and reducing expenses. The people on the front lines will have excellent ideas. In return, do not nickle and dime the staff to death by charging for coffee, reducing parking stipends or eliminating uniform allowances. Keep in mind that for your rank and file staff, having to pay for their own uniforms or paying more for parking might be a deal-breaker that causes them to search for work elsewhere. Try to focus on the bigger items for savings and make sure the staff know you are trying to keep their small benefits in place in appreciation for their work.