Best Practices

A guide for improving the efficiency and quality of your practice

CMA FOUNDATION

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California Medical Association

Contents

I Introduction

Solo and small-group practices are the mainstay of the American health care system. Even in California, the birthplace of health maintenance organizations and home to some of the largest medical groups in the country, most of the state's residents receive their medical care from physician offices with only one or two practicing doctors. Solo and small-group practices also play a crucial role in America's health care safety net. And in California, solo and small-group practitioners make up the lion's share of the safety net—without them, entire California counties would not have access to a physician and many of the state's already overwhelmed emergency rooms and trauma centers would be forced to close. For these and myriad other reasons, it is worth paying close attention to the plight of solo and small-group practitioners. The health of their practices is essential to the good health of Californians.

This toolkit offers a series of proven steps that solo and small-group practices can take to improve many facets of their practice, including the delivery of better-quality medical care. It is based on an important premise: that in order to provide quality medical care, a physician practice must be efficient and well run. There are a number of reasons we've taken this view. The first and most obvious is that a practice cannot provide quality medical care unless it can keep its doors open, and even the most magnanimous physician can't support an unprofitable practice forever. More to the point, though, is that physicians who work in well-run practices can spend less time worrying about making ends meet, which, in turn, affords them more time for patient care. Efficient, well-run practices are also safer practices; an office with modern and efficient record-keeping habits, for example, is less likely to commit medical errors.

Many of the recent innovations that make practices more efficient also make for better medicine. By way of illustration, consider the impact that electronic health records have had on both the physician's bottom line and patient health. Several studies have shown that using electronic health records brings sizable financial benefits for physicians—one recent study reported that physicians who make the switch increase their income by an average of $33,000 per year. The studies report that the savings come from several sources, chief among them a decrease in personnel costs[1]. Such studies are not without their detractors; anecdotal reports from the solo and small-group practices we work with in California suggest that electronic health record systems sometimes take years to pay for themselves and can actually cost some practices money in the short and long term. But we know that going forward, picking the right electronic health record system is going to be essential to the success of a practice, especially as private payors and programs such as Medicare will base payments on whether or not a practice has such capabilities.

Some of the qualities of electronic health records that save money are also the same ones that make them good for patient care. The paper health records they render obsolete not only are inefficient, but they also contain less information about a patient and thus tell a physician less about whom he or she is treating. Similarly, some of the labor-intensive tasks made much simpler by such as reminding patients to stay on top of chronic conditions—are both less expensive and more effective when they are done with the help of an electronic health records system.

Practice management systems likewise can improve both a practice's bottom line and quality of care. For example, since they allow a physician's office to run reports by diagnosis, they allow them to identify patients with chronic diseases and the date

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[1] Robert Miller, Christopher West, Tiffany Martin Brown, et al., The Value of Electronic Health Records in Solo or Small Group Practices, Health Affairs, September/October 2005, 24 (5): 1127-1137.

those patients were last seen. Practice management systems can then generate appointment recall and reminder letters and track missed appointments—steps that are central to good disease management.

USING THIS TOOLKIT

The advice in this toolkit is written for physicians and office managers, but it can really benefit anyone looking for help with the activities it discusses. And while it is aimed primarily at practices inside California, much of the content is applicable to practices in other states. We've noted factual content that is California-specific. We've also tried to identify areas where California differs from other states—with regard to labor law, for example—so that physicians from other states who are using the toolkit will know to check their own state statutes.

The toolkit is organized into nine chapters that can be read sequentially or on an as-needed basis. We've outlined the contents of each chapter here so users can go straight to the information they need.

THE CHAPTERS

Chapter I of this toolkit looks at the very first step a physician must take when starting a practice. Even the most talented physician cannot deliver high-quality medical care without hiring a good staff. Therefore, we offer advice on the art of finding, interviewing, hiring, training, and evaluating employees. Among other helpful pieces of information, we've included questions for both telephone and in-person staff interviews, a section on hiring and the law, hints for marrying work assignments with performance standards and practice goals, and a discussion of how well-trained receptionists can be instrumental in improving patient care.

Chapter II looks at the elements of a successful practice. Every practice is different, but each requires the same basic resources to be financially successful and to deliver high-quality medical care. Identifying the right tools helps medical practices improve the accuracy of their record-keeping, coding, and billing. It also helps practices become more efficient businesses and maintain compliance with protocols that are established by private insurers and government programs such as Medicare and Medicaid. Another tool discussed is the consultant. Outside consultants offer a variety of services and can be helpful with everything from regulatory compliance to choosing and implementing practice management and electronic health record systems. We look at when and how a consultant can be helpful and offer suggestions for finding the right one.

With Medicare reimbursements projected to decrease by as much as 30 percent over the next several years, and with major health plans unwilling to negotiate contract rates that cover the cost of care, the viability of today's medical practice depends increasingly on improved efficiency.

Chapter III looks at areas such as time management and administrative streamlining, with practical advice on how to conduct a needs assessment for your practice and how to identify variances in the ways common tasks are executed. Left unaddressed, variances can cause inefficiencies and compromise the quality of medical care. We also discuss techniques for reducing patient waiting times and for maximizing the value of the time patients spend in a physician's office. Managing call volume, reducing late arrivals and no-shows, using efficiency-related technology, and making maximum use of physician time are also covered. All these changes directly impact the bottom line, improve patient experience, and can result in better care.

Chapter IV looks at improving practices from the perspective of the patient. Because both physicians and patients are such an important referral source for new patients, good customer service is a vital component of a successful practice. Improving the patient's experience starts with soliciting feedback. Here we discuss how to survey your patients and what you can do with various results. Patient surveys can best provide information about three areas: quality issues—whether the patient is satisfied with his or her medical care; access issues—whether he or she is having a hard time being seen; and interpersonal issues—whether practice staff are providing good customer service. Chapter IV also looks at the process of surveying referring physicians, a step that can reveal ways to shorten referral times and improve the patient's overall care. These types of surveys also give you a better picture of how well you are meeting the needs of referring physicians and, more important, how you can do it better.

Chapter V returns to the topic of staying financially healthy, scrutinizing how practices can better understand and improve their revenue stream. Financial crises, even short-term ones, jeopardize both the viability of a practice and quality of care. The key to preventing revenue shortfalls is actively monitoring what is coming in the door. We offer guidance on how to manage accounts receivable through proven best practices in a number of areas: measuring days in accounts receivable, or DAR, by payor, service, and provider; managing self-pay revenue stemming from co-pays, co-insurance, deductibles, and other non-covered services; benchmarking key financial indicators; and minimizing DAR.

Chapters VI and VII look at two areas that present challenges to all physicians, but particularly those in solo or small-group practices. The first is compliance with the federal Health Insurance Portability and Accountability Act, or HIPAA, for short. The second is selecting, implementing, and using electronic health-records systems. Ironically, part of the impetus behind HIPAA was the thought that it would facilitate conversion from paper-based medical records to more easily shared electronic ones. As a practical matter, HIPAA compliance has been one of the main obstacles to achieving that end.

The discussion in **Chapter VI** looks at a number of gaps that frequently cause medical practices to violate HIPAA and ways to significantly lower that risk. The chapter also looks at medical identity theft and state privacy laws that can be even stricter than HIPAA. It recommends a series of practical steps that physician practices can take to ensure compliance in those areas as well.

The discussion of electronic health records in **Chapter VII** aims to demystify what is often a very frustrating process. There is no doubt as to the great potential of electronic health records. Properly used, they can reduce medical errors and improve patient care. Using electronic health records can also save a practice a lot of money in the long term. But making EHR work for solo and small-group practices can be tricky. In this chapter we tell you exactly how to do it. We start with advice for conducting an EHR needs assessment, discuss the issues of readiness and timing, and offer advice for selecting the right system for your practice and making sure it will meet your HIPAA compliance needs.

Chapter VIII looks at yet another key to practice viability—developing a defensible fee schedule. The fee schedule is the single most important financial tool within a medical practice. Yet most practices develop their fee schedules with very little, if any, understanding of the methodology for doing so. Understanding this methodology is not easy, but the physician who puts the time into learning it will benefit greatly. The chapter looks at the basic perspectives underlying sound fee scheduling and walks physicians though the task of creating their own.

Chapter IX offers a model that one physician believes can improve both quality of patient care and the quality of life for a physician. Dr. Dan Lensink is a board-certified ophthalmologist in Redding, California, whose practice focuses on plastic surgery of the eyes. As he writes, dissatisfaction with loss of control over his practice prompted a shift to his current practice status—providing his services outside most traditional commercial insurance networks. Lensink contends this change gives him, and other physicians making similar choices, more

time with his patients and a higher quality of life. Making the case for practicing out of network, he deems it one of the best ways to improve quality of care. He offers practical advice for surviving out of network, including tips on developing an out-of-network strategic plan.

CMA ON-CALL SYSTEM

This guide references many documents that explain in more detail many of the issues and laws discussed herein. These documents are known as "CMA On-Call" documents. CMA On-Call is CMA's online information-on-demand service for physicians.

CMA On-Call documents are available free to members on CMA's website, www.cmanet.org. Nonmembers can purchase On-Call documents in the CMA Bookstore, at www.cmanet.org/bookstore. More information, including step-by-step instructions on how to access the On-Call system can be found in the Appendix of this document.

THE PEOPLE WHO PUT THE TOOLKIT TOGETHER

This toolkit is the work of several individuals and was generously supported by a grant from the Physicians' Foundation. It was researched, written, and edited by Jodi Black and Frank Navarro. Black and Navarro are directors of the California Medical Association's Center for Economic Services, established in 1999 to provide educational assistance to physician members and their staff and to develop resources to improve practice performance. In addition to the direct assistance they provide through CMA's reimbursement helpline, Black and Navarro conduct educational seminars for physicians all over California and advocate on behalf of CMA's physician members with payors and regulators. Combined, they have over 45 years of practice management experience.

Some of the chapters were written collaboratively, or in some cases primarily, by outside contributors who graciously agreed to volunteer their time. These include David Ginsberg, cofounder and president of PrivaPlan Associates; Frank Cohen, senior analyst for MIT Solutions, Inc.; Mary Jean Sage, founding principal and senior consultant of the Sage Associates; Sean Weiss and Jay Lechtman from DecisionHealth Professional Services; David T. Womack, Nancy Clements, and Kathleen Riexinger, from the Practice Management Institute; Debra Phairas, president of Practice & Liability Consultants; Linda Cole, Alan Morrison, and Melissa Lukowski, from athenahealth; and Dan Lensink, M.D. Full biographies for each of the contributors are available in the Appendix.

Special thanks go to the Alameda–Contra Costa Medical Association for its invaluable support and advice on this toolkit and for arranging the participation of a number of its physician members and their staffs. We would also like to thank the physicians themselves, in particular Marie Agleham, M.D., Lisa Asta, M.D., Julian Davis, M.D., Judith Hartman, M.D., Leonard Kutnik, M.D., Lilia Lizano, M.D., and Anthony Somkin, M.D. All contributed significant amounts of their own time to the early stages of this project.

Lastly, the toolkit was edited, re-edited, and edited some more by Katherine Boroski, CMA's director of communications . The design and helpful graphics are the fine work of David Flatter, head graphic designer for CMA. Without their invaluable help, completing the toolkit would have been impossible.

LEGAL DISCLAIMER

This toolkit provides information about the law designed to help users deal with their own legal needs. The information in the toolkit, however, is not intended to provide users with specific legal advice (the application of law to an individual's specific circumstances). For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, refer to the CMA's *California Physician's Legal Handbook* (CPLH). This book contains legal information on a variety of subjects of everyday importance to practicing physicians. Written by CMA's Legal Department the book is available on a fully searchable CD-ROM, or in a seven-volume, softbound format. To order your copy, call (800) 882-1262 or visit the CMA Bookstore at www.cmanet.org. CMA members can access most of the CPLH content free via CMA On-Call, CMA's online library of medical-legal information. (See Appendix for more information.) ■

1

The Art of Finding, Training, and Evaluating Qualified Personnel for Today's Medical Practice

By David T. Womack, Nancy Clements, and Kathleen Riexinger from the Practice Management Institute

Probably the most important decision the physician or office manager will make is hiring the right individuals to represent the practice. Whether you're seeking a receptionist, biller, or office manager, assembling a well-trained, qualified staff can be a daunting task and takes careful consideration. The right individuals should not only possess the necessary skills, knowledge, and experience, but also have a positive attitude and work well with other employees and management. One encounter, face-to-face or on the phone, is all it takes for a patient or patient's family member to form an opinion. A great team that works well together can do wonders to improve your practice and its viability.

Where do you find enthusiastic, hardworking people who look forward to making the most of themselves and their positions? Where is that rare breed of person who is smart and motivated, someone who is loyal and views employment not as a job, but as a career? Do such people even exist? Of course they do. However, they are not easy to find.

This chapter tells you how to master the art of effectively hiring, training, and evaluating employees, as well as improve staff communication, motivate staff to maximize productivity, and, ideally, minimize employee turnover.

CREATING AN EFFECTIVE JOB DESCRIPTION

The cornerstone of effective personnel management is a clearly defined job description. A well-written job description provides control and structure for each employee, defining the employee's responsibilities and establishing expectations. Δ

Background Work

A well-written job description lays the foundation for improved performance management of employees. Writing a job description is a developmental process that involves shared managerial, individual, and team input. The goal is to provide a tool that clearly communicates position expectations and allows for continual employee growth and improvement. This improvement will enhance customer satisfaction and help achieve business success for the practice.

Before you begin developing this description, consider taking a few helpful preliminary steps:

- Contact other practices. Most offices will be willing to share copies of their job descriptions or lists of employee duties and responsibilities.

- Modify an existing job description.

- Ask employees to write their own job descriptions and then review them with those employees.

Δ NOTE

A job description is not the same as a recruitment ad, which will be discussed in the next section of this chapter.

The Employee's Perspective

If you're writing a job description for an existing position, get the employee's help. Have the employee make a list of all the tasks performed. Don't be surprised if these tasks differ from the original job description. This is normal. Instruct the employee to write down all known responsibilities/duties and then track and add to the list tasks that are performed over at least a one-week period. Because some tasks are only performed on a weekly, biweekly, or monthly basis, you may want to have staff track duties over a one-month period.

Organizational Charts

An organizational chart helps define authority boundaries and job relationships. An organizational chart very clearly shows "who reports to whom." Such charts do not have to be fancy to be effective. Several very inexpensive software packages (e.g., Microsoft Word) can help you create organizational charts and also have frameworks for creating job descriptions. Most can be customized for use in different employee settings.

Putting Pen to Paper

In developing job descriptions, it is a good idea to make a comprehensive list of all tasks within the practice that are to be performed by anyone other than the physician. First, group tasks by function. For example, group together all tasks involved in registering a patient or all tasks involved in handling accounts payable. Then, categorize the tasks by position. Keep in mind how each task may impact job performance.

Once all tasks are listed and defined, categorize each task. After tasks are categorized, you will then want to prioritize each one. Beyond spelling out the particulars of specific tasks, you should also include descriptors for how much education, training, or credentialing is required or whether state licensure is essential.

Job Description Basics

Every job description should define all tasks and responsibilities of the position and should follow these guidelines:

- Avoid generalizations.

- Be precise in descriptions.

- Include only pertinent information.

- Describe tools and equipment used in the job.

- Explain work relationships and authority boundaries.

- List all required skills (typing, ten key, Microsoft Word and Excel, etc.).

- If there is overlap of responsibilities or employees are required to fill in for those in other positions, this information should be included in each individual job description.

The salary or hourly rate range for the position should also be defined, with some wiggle room for the right candidate. While salary is an important consideration, keep in mind that people do not work for salary alone and good salaries do not automatically guarantee good employees. Compensation and benefit packages should be competitive to prevent frequent turnover. Ω

Ω TOOLS

A sample job description is available in the Appendix.

HIRING THE RIGHT RECEPTIONIST

The receptionist will be the first person your patients and potential patients encounter. As the face and voice of your business, this is one of the most important members of your staff. A bad hiring decision for this position can have far-reaching consequences.

To understand whether you're hiring the right person for the job, you must first examine the receptionist's core competencies. Is the applicant articulate, accurate, capable, and confident? The answer for each of these should be yes. If you identify shortcomings in an existing employee, in some cases that person may benefit from additional training. However, you may find it necessary to part ways or move the employee to another position.

Next, perform an assessment of the required tasks for the position and ask yourself whether your receptionist or potential hire is capable of doing all these things. And last but not least, determine if a candidate's personality and interpersonal qualities will mesh with your style of practice.

In most solo and small group practices the receptionist is required to wear many hats. Failure to fulfill the following key responsibilities properly can affect other aspects of the practice.

- **Present a professional demeanor.** Remember, receptionists are the first point of contact for existing and potential patients, as well as for referring physicians. They represent your company. A cranky or unprofessional receptionist can quickly drive business away.

- **Understand your office and financial policies.** Receptionists must have the ability to explain office and financial policies to patients and answer any questions. This will prevent misunderstandings and dissatisfied patients later.

- **Understand the insurance contracts your practice holds with payors.** Clearly communicating the practice's health plan participation status at the time of scheduling and again at the time of service will help prevent confusion and complaints about the patient's out-of-pocket responsibility.

- **Understand the importance of patient confidentiality.** Keep in mind that patients in the waiting room can frequently hear conversations that take place behind the registration window. Even if the discussions are not about protected health information, if the patient has been waiting for a long time there may be an impression that the staff behind the counter is contributing to the delay.

(continued...)

RECRUITMENT, APPLICANT SCREENING, INTERVIEW, AND SELECTION

Recruitment

Once a job description is created and employment needs are identified, the search for a qualified candidate is narrowed down and made easier. Less time will be spent looking since "qualified" has been defined. It is better to consider three people who could perform the job well than to struggle through 30 candidates who cannot perform.

The Search

Now that all the preparatory work has been done, it is time to begin the search for qualified employees. Here are some suggested resources:

- Local newspaper
- Employment agencies
- Internet job listings (such as Monster, CareerBuilder, craigslist)
- Technical schools
- State and local medical societies
- Junior colleges
- Private contacts
- Patients
- Friends
- Hospitals
- Other providers

Placing an Ad

Your objective should be to solicit an adequate number of applications and résumés of potential employees. Ideally, you will wind up with at least two, but preferably three, qualified candidates to choose from. When you have more than one qualified candidate, it is easier to compare and measure a candidate's strengths and weaknesses, which ultimately will help you select the right person for the job.

One of the best ways to let people know of the available position is through newspaper want ads. Certain points to cover in the ad:

- The position to be filled
- Requirements for the position (degree, licenses, certifications)
- Your requirements for the applicant (appearance, demeanor)
- Salary
- Skills required
- A response e-mail, phone number, or fax number

Other information you may want to include:

- Type of practice
- Number of physicians

- General location of office
- Title of position
- Full-/part-time requirements
- Responsibilities
- Experience necessary
- Special requirements
- Education
- Benefits of position

When writing your ad, try to use headlines and language that attract readers and explain what the practice is looking for. The ad should be written so that it elicits interest.

Sample Job Posting

Medical Office Receptionist

North Side Pediatric Practice is seeking a full-time receptionist. An exciting and challenging position is available for the right person. Make appointments for the doctor, assist and direct patients. Some typing and filing. High school education required. Prior experience in a medical office a plus. Minimum typing speed 60 wpm. Must be comfortable working with sick children. Competitive salary based on experience. Excellent benefits with opportunity for advancement. Fast-paced environment. We would like you on our team! E-mail resume with salary history and references to reply@NSPP.com.

Applicant Screening

Choosing the right candidate will take into account experience, salary expectation, skills, and perhaps most important, the proper "chemistry" required to work well with the team. The initial selection process, however, will be one of elimination. The more responses, the more selective the decision can be.

The first elimination is rejection of résumés that are sloppy, are incomplete, have spelling mistakes, or are improperly written. Next, screen for content, measuring the skills and experiences of each candidate. Look for experience factors that indicate a proven track record for similar tasks. Grade each respondent's résumé, cover letter, work experience, and education and general characteristics with an "A," "B," or "C." This will prevent your having to reread résumés unnecessarily.

Job turnover can be a red flag. Review the résumé for employment longevity and gaps in employment. Ideally you want an employee who is committed and wants to grow with your practice, not one who changes jobs every six to 12 months. There are valid reasons for gaps in employment, such as the decision to stay home to raise a family or care for a loved one. Don't automatically discount a résumé that includes employment gaps, but it is very important to ask the potential employee about gaps.

If you feel you've only attracted one qualified candidate, you may want to consider expanding your advertising to other publications or reviewing the job description to ensure your ad was written in a way that generated enough interest from qualified candidates.

- **Determine why the patient needs to be seen.** Receptionists must triage the patient and determine the appropriate amount of time to schedule. Failure to accurately determine the amount of time required for the physician to accurately assess the patient can cause a backlog for the physician and for patients.

- **Ensure patient demographics are accurate.** Collection of accurate demographics plays an important role in patient care and appropriate reimbursement. Without accurate contact information, the physician may be unable to get in touch with the patient with news about test results and the like. Additionally, a failure to obtain accurate insurance information (e.g., a copy of the front and back of the patient's insurance card) at the time of service can result in reimbursement difficulties and/or delays.

- **Verify benefits and collect co-pays/deductibles.** It is best practice to verify eligibility, benefits, and co-pay/deductibles at the time of or immediately after scheduling of an appointment. This enables the practice to identify coverage issues and discuss them with the patient before the appointment. It is important for the receptionist to collect any money due at the time of service.

- **Know whether the procedure requires an authorization.** Depending on the nature of the patient's condition, it can take up to five business days to obtain an authorization from a payor. So in scheduling the patient for a procedure, it is important that the receptionist allows enough time to obtain that authorization, to avoid having to reschedule or cancel appointments. Equally as important, failure to obtain an authorization can result in delayed or no payment.

- **Mesh with your practice personality and philosophy.** If you have a curmudgeon at the window, chances are by the time patients get to see you they'll be equally sour. Tolerating temperamental behavior is not worth the risk of chasing patients away.

These real-world examples demonstrate why core competencies (articulate, accurate, capable, and confident) are so critical to the practice. They also highlight the importance of thorough training and of maintaining a sufficiently expanded knowledge base. To be truly effective, a receptionist must receive the appropriate training and have access to necessary resources.

The Telephone Interview

Once you have successfully pared down the résumés to a workable number, schedule a telephone interview to find out more about each applicant. This step is particularly helpful in hiring a receptionist because it's an opportunity to evaluate how candidates comport themselves over the phone.

Sample Interview Script

When conducting a telephone interview, take time to describe the position and consider asking the following questions:

Hello! I'm _____ from Dr._____'s office. We received your résumé in response to our ad. Do you have time now to talk for a few minutes or would it be possible to schedule some time later this week to briefly discuss your qualifications? (A few interchanges to describe the job and the practice, followed by some basic questions:)

What is it about this job that interests you?

What type of work are you doing now?

Why are you considering leaving?

What do you feel you would bring to this job?

Tell me about your training.

Tell me about your previous work experiences.

How do you feel about working with people who are ill?

When could you be available?

Name _____ Rating _____

Interviewing Possible Candidates

Everyone you invite for a face-to face interview should be asked to complete a job application, regardless of whether the person also brings in a résumé. The application lets you assess penmanship and gather information not typically included in a résumé. While all applicants will probably send résumés, these may differ from each other in structure or format and hence make comparisons difficult.

Evaluating the Application

In evaluation of the application, certain criteria should be examined:

- Is the application complete?
- Is the application legible?
- Were directions followed correctly?
- Is the spelling correct?
- Does the candidate have the basic qualifications?
- Is there a good work history?
- Were acceptable references provided?
- Do the information and dates provided match the information on the résumé? Ω

Preparing for the Interview

The purpose of the face-to-face interview is to evaluate factors not present on the application; to inform the applicant about the responsibilities of the position; and to clear up any questions concerning the applicant's qualifications. An in-person interview is an important opportunity to observe a candidate's composure, appearance, and temperament to determine whether that person can work well with the rest of the team. The method of interviewing must be appropriate and consistent in order to permit fair comparisons between applicants.

For conducting a personal interview, we recommend the following steps:

- Review the current job description and provide a copy to the candidate.
- Review application/résumé prior to interview.
- Familiarize yourself with the job details (pay, hours, benefits, etc.).
- Outline desirable traits to explore.
- Write up a standard list of questions to ask all candidates.
- Ask candidates to arrive 15 minutes early to fill out the job application.
- Conduct the interview in private without disruptions.
- Make the applicant feel comfortable.
- Reserve enough time to get to know the applicant.
- Make sure you have answered any questions from the candidate about the organization and position.
- Make notes during and immediately after the interview.
- Complete all interviews before making a final decision.

Remember that an employment interview should be a structured conversation with a specific goal. The goal is to determine if the candidate has the education, experience, interests, and temperament to fill the specific job available.

Testing Candidates

Incompetence takes a costly toll on a practice. A problem employee can increase your stress, your workload, your legal liability, and your expenses. The best way to have the best staff is to hire the best people in the first place. One way to ensure you are hiring the right person for the right job is to test applicants' skills. Objective tests can provide valuable information about the degree of competence in a particular area.

Fine-Tuning the Interview

To efficiently and wisely interview, develop a standardized list of questions in advance and follow a conversational structure that will provide the needed information. Only ask job-related questions.

Here are the two most common errors managers make in the hiring process:

1. Not taking or allowing enough time for the interview

2. Talking too much about themselves instead of using the interview to learn as much as possible about the candidate

Try not to use closed-ended questions. A closed-ended question requires only a yes or no answer. An open-ended question requires explanations and encourages the candidate to expand on the response. Examples of some effective open-ended questions:

- Tell me about yourself.

- What are your long- and short-term career goals?

- What did you like best about your last position and why?

- What did you like least and why?

- If you could design the perfect job, what would it look like?

- What are your strengths/weaknesses?

- What three words would your current supervisor use to describe you? Your coworkers?

- What do you think you can contribute to this practice? To the patients?

- What exactly did you do in your last job? Before that?

- What is it about this job that interests you?

- How has your educational training prepared you for this job?

- In school, what were the subjects you enjoyed and found easy to master?

- What circumstances have prompted you to change or consider changing jobs?

- At times we have all had to work with difficult individuals; tell me about the most difficult person with whom you've had to work.

- How did you like working for your last employer? May we call him/her for a reference?

- What other experiences have prepared you for this job?

- Are you willing to be bonded?

- What has contributed to your success in previous jobs?

- What circumstances have contributed to problems in past jobs?

- If you were in my position and involved in hiring, what qualities about yourself would you consider appealing?

- What additional information about yourself do you want me to know?

- Do you have any questions about the position or the company that I can answer?

Tell the applicant about the organization and the position for which he or she is being considered. Make appropriate comments regarding that person's background and experience. Explain that there are other candidates being interviewed and give some idea of when you will be notifying applicants of your decision.

Keeping the Interview Legal

Improper interviewing techniques can expose physician practices, hiring managers, and their employees to potential lawsuits from individuals or investigation by government agencies. Most such violations are committed by mistake and out of ignorance. Unfortunately, ignorance of the law is no excuse. A variety of topics and issues must be dealt with delicately and in some cases avoided altogether. Because laws change and vary by state, you must obtain the appropriate information from your state's department of labor to make sure the questions you are asking and methods you employ are within the parameters of the law. An employer should never ask a potential employee questions related to any of the following:

- Race, creed, or color

- National origin

- Gender

- Age

- Sexual orientation

- Marital status

- Children

- Religion

- Residency or citizenship (this information will be required at the time of employment)

- Physical or mental condition or disabilities

- Foreign languages spoken at home

- Arrest record (you can ask for additional information relating to criminal convictions that the applicant lists on the employment application, but the application must include a statement that a conviction will not necessarily disqualify an applicant for employment)

- Credit rating

- Home ownership

- Education (based on responses provided on an application, you can ask confirming questions about academic degrees or schools attended, but you should never ask the date someone received a degree or diploma, as that can lead to charges of age discrimination. Such information can be confirmed through a background screening)

- Social security number (this will be required at the time of employment)

- Receipt of unemployment benefits

- Physical condition (unless related to requirements for performing job duties)

- Any question related to pregnancy or applicant's medical history or condition

- Questions regarding workers' compensation claims

- Mode of transportation ✡ Ω

Next Steps

If further interested in a candidate, follow these guidelines:

- Set up a second interview. Candidates tend to be more relaxed the second time and you can get more information and confirm your earlier assessments or impressions.

- Provide more information about the position and the practice.

- Conduct a brief tour of your facility.

- Introduce the applicant to other staff members.

- Encourage questions about the job and practice.

- Thank the applicant for his or her time.

- Make final notes on the initial interview form.

- Consider having someone else interview the candidate, for another opinion.

- Ask the applicant whether you can contact current and/or former employers for a reference.

- Ask the candidate for a list of other references you can contact.

- Allow enough time to reach your decision.

Checking References

It is important to check references on candidates being considered for hire.

Performing a reference check allows you to confirm employment history and may also provide information on the strengths and weaknesses of a candidate. Additionally, speaking with a direct supervisor can help you determine how the candidate performed on a day-to-day basis. In general, reference checking can be helpful if you have doubts about the candidate and can alert you to dishonesty or other serious problems.

While there are certainly benefits to checking references, be sure to avoid some of the pitfalls:

• Employers may be sued for defamation of character if found giving inaccurate or false information. For this reason, many employers will now only verify basic information, such as title held and dates of employment.

• References are often opinions and sometimes nothing more than gossip.

• A favorable reply could mean the applicant is a good candidate or it could mean the previous employer is just happy not to have to pay for unemployment benefits.

• Information given in a reference tends to be general and not particularly helpful.

• There is no guarantee the person on the telephone is truly the person being called.

• You could end up screening out an excellent candidate because of personality conflicts or disagreements with the previous employer. Ω

Other Considerations

Added factors to remember in using references to evaluate candidates:

• Nobody ever provides a reference list of employers likely to give a bad report.

• Most large organizations have a personnel department that provides only a confirmation of employment because of the potential for lawsuits.

• Many candidates leave an organization because the management has problems—which have no bearing on an individual's qualifications or ability to do an excellent job for you.

• Many applicants are hired because of good references but, in the end, are unable to perform to standard or work well with the team. References should be used only as an additional tool in the larger context of deciding on a particular hire.

• Many businesses and practices are screening applicants by testing the candidate's skills instead of relying on subjective evaluations and job history alone.

• If possible, speak only to the direct supervisor who observed the person in action, not to a coworker. The supervisor can tell you how a person performed on a day-to-day basis. Get signed permission to check references. Unfortunately, as stated above, many employers require that all references be handled through their human resources department.

Providing References for Past Employees

Wrongful dismissal and libel suits are costly, both in dollars and in emotional pain. If not careful, your medical office could find itself caught in a wrongful dismissal suit or contending with myriad investigative agencies because of an unhappy former employee. It is best to take control of your reference-providing process now and avoid future problems. Of course, you should consult with your attorney on this and all other matters that require legal advice.

It is critical that you designate one individual, whether it is the office manager or a physician or some other employee, to be the point person to field all reference requests. Be sure everyone in your office, including any physician who might be approached for a reference, contacts the designated point person about all references. The worst-case scenario for a wrongful dismissal case is when the office manager has moved an employee through appropriate disciplinary stages and dismisses that employee, and then someone else within the organization provides a written or verbal reference.

What information should your practice disclose about a previous employee? In addition to consulting with your personal attorney about what to say, another important safeguard against lawsuits is to avoid issuing written letters of reference. Once such a letter is in the hands of a departing employee, it could be used against you.

Your practice can avoid these types of problems by providing only the date of employment and the title of the worker's position at the time of departure. If someone requests salary information, you can direct the inquirer to W-2 forms and pay stubs, which should be in the possession of the employee. The former employee should also be able to provide a prospective employer with copies of any performance reviews you provided during that person's employment. It is wise to refuse to provide such information over the phone to a potential employer. Instead, demand a written information release form signed by the employee. Some firms will ask whether or not an employee is "eligible for rehire." By asking this question, they're essentially asking if the former employee left on good terms. Staff who leave in good standing (because of resignation, layoff or, in some cases, discharge) would be considered "eligible for rehire." A former employee's "rehire status" is sensitive information and you could wind up paying attorneys to defend you in a libel suit if you answer that question with a "no." Remember, for a former employer, there is no obligation to answer this question.

It is unfortunate that you are restricted by potential liability from praising good employees who have moved through your organization. If you have been providing all employees with copies of their performance reviews, however, your opinion has been recorded in a formal context available to all such employees and potential future employers.

The Commitment Interview

Once a match is found, act on it quickly. If there is procrastination, the best candidate will take another position with someone else. Set a "commitment interview" with the candidate you've selected, to review personnel and office policies and provide a general idea of the working environment. This meeting should also confirm salary and starting date. Straightforward communication at the outset of employment will reduce misunderstandings and conflict later. The candidate should agree to the salary provisions and read and understand the written office policies and fringe benefits. The candidate should be given the opportunity to ask any questions. It is also a good idea to put your offer in writing for the potential employee to read, sign, and return to you.

Contingency

Keep the paperwork on your second-choice candidate for a period of time. If for some reason the first applicant does not work out, you may need to fall back on your second choice.

TRAINING AND STAFF MOTIVATION

Training new employees is absolutely essential, no matter how much experience they bring with them to the practice. Every practice does things differently, and if you want a new employee to succeed in your practice, you must provide training. Part of that training includes the following:

- Ensure that the new employee clearly understands the responsibilities of the job based on the written job description.

- Review the office policies and procedures manual with the new hire, and get the employee's signature confirming he or she has received and read the manual. Place the original of this signed document in the employee's personnel file.

- Ensure that all necessary paperwork is completed in a time frame within the scope of the law.

- Set a predetermined introductory time frame, such as 90 days, and evaluate the employee at the end of that period. Allow for interim evaluations before the end of the introductory period to resolve any problems that arise. Questions can be addressed and clarification provided along the way.

- Ensure that the new employee is at the minimum performance standard level at the end of the introductory period.

- Ensure that every step or aspect of training for each task is covered. If a task is long or difficult, break it into subunits for training purposes.

- Be patient. Not everyone learns at the same rate. Some employees are slower to learn certain aspects of a job, but if properly trained will become star performers.

- Encourage employees to take notes they can refer to later when questions or points of confusion arise.

- Set completion dates for each portion of the training, and monitor progress.

- Document all training and evaluations and keep this information in the employee's personnel file.

Methods of Training

There are several methods of training employees. Here is a brief list of training methods used by most medical practices:

- On-the-job training is conducted periodically by the office manager or, in some cases, by staff members. If staff members are conducting the training, it is imperative that they are qualified and can be relied upon to explain how things are done. Employees are set up for failure if an inexperienced, poor-performing staff member is put in charge of their training.

- Formal training is conducted classroom style, either by qualified trainers who are part of the organization or by outside experts.

- Group seminars to cross-train and enhance existing personnel are conducted either by formal trainers who are part of the organization or by outside experts.

- Employees enroll in traditional college, university, trade school, or correspondence courses.

Cross Training

Cross-training—educating individuals in multiple job functions or duties—is a valuable tool for a practice. Frequent turnover, the demand for qualified and committed workers, and the need to cover for sickness, vacations, and leaves of absence make it essential for a well-run and profitable office.

Staff Motivation

Finding good employees is difficult enough; once you do, it is important to keep them. Salaries clearly matter; still, while money can be a dis-satisfier, it is rarely the key motivator for a good employee. One of the toughest roles in managing employees is to keep them happy and dedicated. Praise, acknowledgment of a job well done, and public appreciation will generally keep a good employee from looking for another job.

Some basic ways to demonstrate appreciation:

- Recognize exceptional performance at the time it occurs rather than weeks or months later.

- Praise employees periodically and immediately, not just at the annual review.

- Encourage employees to become confident in their actions and abilities.

- Say hello and good-bye to employees when entering and leaving the office.

- Give credit where credit is due; recognition inspires more loyalty and good work.

- Ask how your employee's vacation went or how the sick family member is doing. The personal touch is usually appreciated.

POLICIES AND PROCEDURES MANUAL

Any practice, no matter how many employees, should have a policies and procedures manual. A number of companies and attorneys offer guidance to physicians and medical groups putting together such manuals. The cost of obtaining such assistance should be viewed as money well spent if your practice does not have a manual or there is any question the existing manual is complete and up-to-date.

- Show excitement about the work; enthusiasm is contagious.

- Don't punish employees for understandably being less invested in the practice's success than an owner/manager would be.

- Keep employees informed about what is happening with the practice; don't expect them to perform in a vacuum.

- Fairness and consistency in style are fundamental in cultivating respect.

- Employees will make mistakes. Use those mistakes as growth and learning tools and indicators of areas where there is room for improvement.

- Treat employees the same way you wish to be treated and employees will take pride in the practice.

- Support employees when they are enforcing office policy. Otherwise they may feel their responsibility to do so is being undermined.

- Redesign jobs when necessary to keep employees from getting bored and losing interest. No one likes to perform the exact same tasks daily over long periods of time.

- Lead by example.

- Show a willingness to change when necessary.

- Consider an employee profit-sharing plan so workers will be encouraged to behave like owners. Amounts might be based on achieving certain goals during a quarter, such as improving the bottom line by $10,000.

- Bonuses are also valuable as motivators. A bonus need not be big to communicate appreciation of an employee's contribution or a job well done. Ensure that goals are attainable and clearly communicated.

Praise Will Create Champions

People at work need many things, but among the most crucial is encouragement and recognition. In all cases seek reasons and opportunities to compliment your employees. To motivate, employers must build confidence. With confidence, employees have the pride in themselves needed to take knowledge they obtain and turn it into performance. As an employer you can successfully motivate others by adhering to these guidelines:

- Communicate standards, and be consistent.

- Be aware of your own biases and prejudices.

- Let people know where they stand.

- Give praise when it is appropriate.

- Keep your staff informed of changes that may affect them.

- Care about your staff.

- Do not behave as though you perceive people as a means to an end.

- Go out of your way to help others.

- Take responsibility for the learners on your staff.

- Build independence.

- Exhibit personal diligence.

- Be tactful with learners and fellow staff members.

- Be willing to learn from others.

- Demonstrate confidence.

- Allow freedom of expression.

- Delegate, delegate, delegate.

- Encourage ingenuity.

- Praise and encourage every improvement.

- Let the other person save face.

- Let the other person do most of the talking.

- Let the other person think most of the ideas are theirs.

- Try to see the other person's point of view.

- Provide others with a challenge.

EMPLOYEE PERFORMANCE EVALUATIONS

Performance standards are the expectations for staff performance of duties and conduct in the medical practice. These standards should be outlined so every staff member knows what is expected in everyday operations and in case of unexpected events.

Developing a Fair and Consistent Performance Appraisal System

Managers should be trained to use the appraisal system. Subjective measurements must be applied as uniformly as possible to avoid charges of disparate treatment, especially in promotion. A well-defined job description and clearly communicated job standards and expectations help establish a baseline of fairness for each employee. Follow specified, written procedures for conducting appraisals and, to the greatest extent possible, use objective rather than subjective measurements. It also helps to be factual and specific about shortcomings and to cite specific instances of behavior in all cases. Give the employee specific time frames to correct faulty behavior and consider retraining the employee, if necessary. Ω

Establishing Performance Standards

To effectively evaluate an employee's performance, you must first establish performance standards. Job performance standards should outline the quality of the work to be performed; conduct standards must establish rules of behavior and a scope of infractions. Also important are appearance standards to define the office dress code and etiquette standards for employee interaction and behavior. Additionally, it is critical to establish patient relations standards that spell out the employee's role in patient contact and explain what is expected in conduct and demeanor.

Practice Goals

All performance standards should reflect expectations that employees uphold and promote the practice goals of the office as a whole. These goals should be stated at the beginning of the personnel manual, possibly in the format of a mission statement. Some examples:

- To provide the best possible medical care to our patients

- To treat every patient with dignity, respect, understanding, kindness, and courtesy

- To serve our community

- To maintain a fully functional practice where staff and physicians work together in a spirit of cooperation

- To create an efficient pace without hurry or confusion

- To employ highly qualified and motivated personnel

Evaluation Factors

In an employee evaluation, a manager will want to evaluate both quality and quantity of work. Determine which job functions are essential for successful completion of tasks and assess whether the employee performs these well. It is also important to assess whether employees are dependable and whether they take initiative in their work. Ability to work well with others and decision-making skills are also critical factors. If the employees being evaluated are in a management role, you will also want to assess supervisory abilities.

Of course, it is always important to gauge whether an employee has achieved the goals previously established. However, employees feel a sense of ownership and are more likely to achieve their goals when they have had the opportunity to provide input. So, when establishing goals for the next evaluation period, it's smart to do it in collaboration with the employee.

Sample Performance Standard

Name:	*Mary Doe*
Position:	*Accounts Receivable/Insurance Processing*
Responsibility:	*Minimum Standards*
Insurance:	*80 percent of claims to carrier in 3 days, 80 percent paid in 45 days*
Collections:	*85 percent of office visits under $100 at time of service. Maintain 80 percent collections in 120 days.*

THE POWER OF FEEDBACK

Feedback provided about a person's (or team's) performance or behavior is essential for reinforcing or changing the performance or behavior. By openly and constructively giving and receiving feedback we can create motivation and energy in others. Employees receive an answer to the question "How am I doing?" which usually removes stress and increases job satisfaction. Feedback provides direction and helps employees stay or get back on course. It can also confirm whether employees are performing as required and when they are attaining goals. By providing positive feedback, you also strengthen relationships and promote high self-esteem.

COMMON EVALUATION MISTAKES

To avoid common performance evaluation mistakes, managers should always follow set procedures. These include making sure that the review accurately measures the skills required for the job and covers the entire time period. The review should also expressly address conflicts and problems.

Ω TOOLS

A sample "Staff Performance Appraisal" form is included in the Appendix.

Attitude:	Courteous with patients 100 percent of time. Cordial to coworkers and pleasant attitude.
Appearance:	Within standards for administrative staff members

Additional Information:

_____

Preparing for and Conducting the Review

Several steps can help a manager properly prepare for a review. First, it is important to ask the employee to complete a self-evaluation. The self-assessment should follow the same format the manager will use. Compare the self-assessment to the manager's assessment prior to the review meeting to identify similarities and differences. Any similarities or differences should be openly discussed during the review session.

A good manager will also examine the current job description to be sure the job is clearly defined before sitting down with the employee. Does the employee meet the minimum standards or go well beyond the established standards? This is also an excellent opportunity to review and/or update the job description, as the job may have evolved since the description was written. It is unfair to hold an employee accountable for duties not listed in the description.

During the evaluation, it is important to communicate effectively. Evaluations should allow for a two-way dialogue. You should be prepared to give feedback on actual measurable performance throughout the documented review. A performance review should not give rise to debates. If a problem area is defined, discuss the problem with the employee, outline the solution, provide for training if necessary, and set a specific goal and time frame for improvement. Although two-way communication should be encouraged, arguing should not.

When discussing areas for improvement, try to first use praise, then outline the problem, and then offer solutions—an approach known as the "sandwich" technique. (The critical feedback is sandwiched between positive comments.) That makes talk of improvement easier for the employee to accept. Always keep personal feelings out of the conversation and speak solely about observable behavior. Goals should be measurable and set with specific time periods for achievement.

Common Rating Errors

Mistakes happen during evaluations. Here are common but avoidable errors:

- It is hard to rate employees if you don't know them well. Make a point of getting to know your employees.

- Don't succumb to the "halo" effect—giving a high overall rating because of one task performed well. Each area of the person's performance should be evaluated separately.

- Don't be so lenient that you overrate performance. It is misleading and unfair to employees and keeps them from being able to view themselves realistically.

- Don't go to the other, severe extreme and rate the employee too low. "Power trips" are inappropriate and never well received. Don't assume an employee cannot achieve a "10" status.

- Don't rate people based on who their friends are, what social groups they circulate in, their religion, or a manager's own personal dislike. Everyone has prejudice and biases, but keep it out of the review. Employees should be rated unemotionally on observable, measurable behavior.

- Do not overemphasize isolated matters. People have a tendency to dwell on the negative, but the evaluation should be based on the total person. Maintain records of both the good and the less-than-good behavior over time to keep the big picture in view.

Employee Performance

Everyone needs praise, including your staff. Expressed appreciation of work is the number one criteria for job satisfaction, ranking far above money. Praise should be more than casual, although frequent reinforcement is a positive force. With a structure for positive feedback, there's a built-in channel for meaningful two-way communication.

Of course, there is always room for improvement. No one is perfect. Performance reviews can be a vital tool for positive reinforcement, correcting deficiencies, examining problems, saying thank you, and providing stimulation and motivation for better performance.

Follow a Process

Managers who follow a standard process when discussing employee performance present a more organized, structured, and clear review. The following steps help ensure a smooth discussion:

- Put the employee at ease

- Open two-way dialogue

- General overview

- Review of tasks

- Praise and/or counsel

- The problems, with specific examples

- The solutions, with specific examples

- Retraining

- Cross-training

- Resources

- Employee input

- Areas handled well

- Goals

Counseling

Most employees want to do a good job; however, there may come a time in which you will need to discipline employees for not doing their job effectively.

Counseling and/or disciplining an employee is usually something a manager prefers to avoid, but it is essential to use progressive disciplinary procedures to resolve problems that arise. Failure to correct an employee's performance or work habit problems can have far-reaching negative effects. The other employees will see inaction as unfair, especially if they end up picking up the slack, or they may lapse into similar misbehavior. In either instance, morale and performance suffers.

Discipline should not be approached as negative or as punishment. Having a well-disciplined team means working together with precision and skill. Discipline is a means to an end—hopefully not termination, but an end to the problem. During a disciplinary discussion, you should emphasize problem solving, not punishment.

In preparing for such a discussion, be sure to do your homework by reviewing any previous discussions and all available documentation on the subject, examining company policy guidelines, and gathering any other relevant information. By obtaining all the necessary information and being prepared, you will be able to focus on the facts rather than the employee, which is what you want to correct—the behavior, not the person. Any manager-employee counseling must be conducted in private to prevent embarrassment or violation of privacy laws.

Three key tactics to use in any discussion of a performance or work habit problem with employees:

- Maintain or enhance self-esteem.

- Listen and respond with empathy.

- Ask for their help in solving the problem(s).

If you adhere to those principles, the employee should not feel threatened or become emotional during the discussion and should feel motivated to change the unproductive behavior.

Grievance Procedures

Fair employee treatment must include a structured grievance system for resolving problems and dealing with employee complaints. The system need not be elaborate; in some medical practices a simple suggestion box will suffice. But the most effective system has a formal written component. Ω

Ω **TOOLS**

A sample grievance form is available in the Appendix.

TIPS ON PROPER DOCUMENTATION

Only job-related information should be documented.

Do not document any off-duty activity or any personal situations that do not interfere with the employee effectively fulfilling job responsibilities.

Documentation must be consistent and impartial.

Be sure to be fair. If you are going to write up someone for being late, then you need to do that for everyone else who shows up late as well.

Be specific.

Do not write generalities. Provide documentation that gives specific dates, times, and incidents for the employee's infraction or misconduct. Do not just state, for example, "You are late all the time."

Documentation must be substantiated.

All information written down must be true. Accusations, false testimony, or rumors should not be recorded in writing.

Documentation should be timely.

Make a record of an incident of misconduct as soon as possible. Documenting it later on or terminating the employee long after the incident will be of little value in defending your management actions.

Ω TOOLS

A sample corrective action plan form is available in the Appendix.

When developing a grievance system for your practice, clearly communicate the steps of the formal filing process and guidelines for airing grievances, as well as steps on how to appeal a decision.

Misconduct

Misconduct is defined as a violation of policy or published rules. Common examples include theft, insubordination, use of drugs or alcohol, or excessive absenteeism.

Refer to your policies and procedures manual when addressing a misconduct incident with an employee. Disciplinary action for misconduct commonly takes the form of oral warnings, written warnings, suspensions without pay, and ultimately, if necessary, discharge.

If the warning is oral, record the date of the warning and a brief description of the infraction in the employee's personnel record. For example:

June 25, 2006
Maryann was warned about her absenteeism today as she was out again yesterday. Maryann has missed a total of x hours in the year.
(Signature)

The disciplinary process should be described in the office policies and procedures manual and the guidelines followed exactly for every case of poor performance or misconduct.

Other corrective action tips:

- Investigate the incident.

- Verify facts, check records, get statements from "witnesses."

- Speak with the employee in private.

- Specify the nature of the misconduct and why it is undesirable or inappropriate.

- Specify what corrective action must be taken.

- Specify what happens if the misconduct continues (for instance, suspension or termination).

The most important step in dealing with disciplinary problems is to document incidents, making sure the documentation is factually accurate and complete. Ω

The Importance of Progressive Disciplinary Action

The California Supreme Court has made it clear in recent years that an employer has the right to terminate an employee without cause provided the employee, at the time of hire, is put on sufficient notice that the employment being offered is "at will." However, there are exceptions to the "at will" doctrine that prohibit termination for any reasons involving retaliation or discrimination against a protected group.

Contracts, including "at will" employment contracts, are likely to be viewed by courts as imposing a duty of good faith and fair dealing upon the employer. For that reason, it is commonly recommended that office policies and procedures manuals specify that employee job performance be formally assessed at certain intervals, possibly

as infrequently as once a year for established employees but typically more frequently for new employees.

Equally important is making sure the evaluations are conducted, documented in writing, and kept in the employee's personnel file. The personnel file should include written documentation of any instances in which the employee has 1) violated any of the practice's policies and procedures or 2) failed to adequately perform job duties. Such documentation represents what is commonly referred to as progressive disciplinary action, in which employers let employees know certain behavior will not be tolerated, and that an employee's failure to remedy the situation may lead the employer to take further action, "up to and possibly including termination."

It is essential that employers meet with employees and document misconduct or poor job performance that warrants progressive disciplinary action. Specifically, you must provide written evidence (in the personnel file) that the poor conduct or job performance has been brought to the employee's attention and the employee has been warned that further action "up to and including termination" may result if the situation is not immediately resolved. With this documentation and an appropriate policies and procedures manual as outlined above, an employer is in a markedly better position to successfully defend itself against a wrongful termination action.

Progressive Disciplinary Action Is Not Always Appropriate

The employment termination protocols suggested above assume the presence of and adherence to a policies and procedures manual. While it is strongly recommended that all practices implement and follow such a manual, it should also be noted that circumstances may arise that make it appropriate and advisable to terminate an employee immediately, without any "progressive disciplinary action," and regardless of whether the practice has a policies and procedures manual. Examples of these circumstances include situations where an employee has engaged in violent behavior or is caught stealing. Such conduct requires a commonsense judgment call as to whether the particular facts—and they should be facts, not speculation—warrant immediate termination. In such circumstances it is important to consult your personal attorney.

Is Termination Appropriate?

A number of issues should be considered before you terminate an employee. Apart from legal matters, more practical considerations may include whether there is any realistic prospect the employee might be rehabilitated through additional training or whether there might be another position in the practice to which the employee might be better suited.

The Actual Termination Process

Terminating employment of a member of the office staff is a task that creates considerable uneasiness in many physicians and practice administrators. Such uneasiness is not altogether unwarranted in today's climate of wrongful termination lawsuits.

As emphasized throughout this chapter, one of the most important keys to a smooth and legally defensible employment termination is the presence of, and adherence to, an appropriate policies and procedures manual. Assuming you have such a manual, here are some general suggestions on how to advise an employee that his or her employment is being terminated. These are merely guidelines; consultation with an experienced employment law attorney is strongly suggested if there is any question as to the employer's right to terminate the employee or if the employee may be a member of a legally protected class based on considerations such as age, disability, gender, or race.

Preparing for the Termination

Privacy

Conduct the discussion in private, for example in the manager's office.

Witnesses

It is often advisable to conduct employment termination meetings in the presence of more than one person from the employer's side. In a medical practice, that might mean the practice administrator and a physician meeting jointly with the employee. Having a witness can help protect the practice against any subsequent allegations by the employee of misconduct occurring or promises made during the meeting.

Timing

Plan the timing of actual termination for when you are mentally prepared. You may decide to meet with the employee at the beginning or near the end of the day and schedule the session for payday or the last day of the workweek.

What to Say to the Employee

There is no easy way to tell someone he or she is being fired. Most experts agree the actual termination meeting should be kept fairly brief and that employees should be given a short overview of the reason they are being let go. Once again, if the basis for termination is poor job performance or violations of a company policy, the employee should, in most cases, have previously been apprised of the problem.
Do not get into an argument with the employee over the merits of the decision to terminate, and try to use words that are compassionate yet firm. Once termination has been decided, do not allow the employee to change your mind. Speak of the termination in the past tense. "It has been done. You have

already been terminated." If an employee reacts in a violent or threatening manner or if there is any question of potential for workplace violence, the police should be alerted immediately.

Items to Be Delivered to the Employee

Under California law, during a meeting when an employee is informed of termination, the employee must be given a final paycheck, including payment for any accrued unused vacation time. If the business employs 20 or more employees (full or part time), you must make a point of notifying a departing employee of his or her rights regarding continuation of health insurance under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Items to Be Retrieved From the Employee

At the termination meeting, be sure to collect all items previously entrusted to the employee that are used or owned by the practice, such as office keys, laptop computers, files, records, or the like. Also make sure you have barred the employee's access to the practice's electronic systems and changed or deleted any relevant building entry codes. Delaying such access denial can lead to serious problems that could easily have been prevented. ☀

Employee Termination Checklist

☐ Resignation letter

☐ Copies of disciplinary reports

☐ Office keys, if applicable

☐ Locks changed, if applicable

☐ Security notified

☐ Computer access deleted

☐ Pager collected, if applicable

☐ Parking card collected

☐ Other office property collected

☐ Long-distance phone cards/access

☐ Forwarding address and phone number

☐ COBRA information provided

☐ Retirement plan payout information provided

☐ Final paycheck issued

☐ Personnel file examined for completeness

☐ Personal belongings collected

☐ Employee escorted from property

☐ Exit interview performed ■

2

Tools and Resources for Practice Success

By Sean Weiss and Jay Lechtman, DecisionHealth Professional Services

Every practice is different, but each requires the same basic resources in order to be successful. Access to the right tools helps ensure your practice submits complete and accurate claims to insurance carriers the first time, which decreases days in accounts receivable (AR) and can increase practice viability. In an industry overloaded with coding, compliance, and practice management how-to resources, how do you know which resources make sense for you?

Practices should take advantage of the wide array of commercial publications and other practice management products on the market today. While many of the resources we will discuss in this chapter are available free of charge, these can be cumbersome to use. Purchasing a superior product will improve accuracy and productivity; because these resources are often easier to use and understand, they can be more valuable to the practice. It is important to consider the cost of these products and include them in your annual budget.

Consider three things before you purchase a resource:

1. Will it help improve accuracy?

2. Will it help you become more efficient as a business?

3. Will it help you minimize compliance risks while improving your bottom line?

CRITICAL CODING AND BILLING RESOURCES

Every practice must have the most up-to-date coding and billing tools to make sure it collects every dollar owed without claiming non-billable services. These five core content sets are considered critical to coding and billing success.

The typical practice purchases at least the three code books—CPT, ICD-9-CM, and HCPCS—and very often CCI and RBRVS guides as well.

Physicians' Current Procedural Terminology (CPT)

CPT codes are developed and maintained by the American Medical Association (AMA). They are, in AMA's own words, "a listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians and other health care providers, patients, and third parties" (www.ama-assn.org/ama/pub/category/3882.html). And as you know, CPT codes are used to report professional services to payors.

AMA updates CPT codes annually and it is critical that practices have access to the most current year CPT for reporting medical services. Each year codes are added and deleted, and it is imperative that your practice is referencing the CPT book that corresponds with the date of service. Additionally, it is helpful to retain past versions of CPT in the event you need to appeal a claim from prior years.

International Classification of Disease, 9th Revision (ICD-9)

ICD-9-CM (International Classification of Disease, 9th Revision -Clinical Modification) provides insurance carriers with the medical reason a patient visited a physician or other qualified non-physician practitioner. This manual is used to help providers establish medical necessity for billed services. The manual also allows providers to tell an insurance carrier about both past personal and family experiences with diseases and/or how a patient was injured.

As with CPT, AMA updates ICD-9 codes annually, so it is critical that you are using the most current version for reporting medical services. Practices that do not stay on top of ICD-9 changes frequently receive unnecessary denials or requests for medical records due to inaccurate or incomplete diagnosis coding. For example, failure to code to the maximum specificity will most certainly generate a denial from the payor.

Healthcare Common Procedure Coding System (HCPCS)

Healthcare Common Procedure Coding System is Medicare's system of National Level II codes and includes a listing of products, supplies, and services not included in the CPT manual. HCPCS also "crosswalks" from CPT procedure codes to codes recognized for payment by Medicare and Medicaid (G-Codes and Q-Codes).

The Correct Coding Initiative (CCI)

Correct Coding Initiative edits, developed by and for Medicare, are also used, in some form, by many insurance carriers. CCI edits identify which physician services are not appropriately billed together—called mutually exclusive procedures—and which should be bundled or included in a more comprehensive service. Claims that run afoul of CCI edits are automatically denied by Medicare, unless the edit can be overridden with a modifier or proper documentation to support the exception. CCI edits are updated quarterly.

CCI edits can be located on the CMS website free of charge. There are also simplified user-friendly versions available for purchase from for-profit entities.

The Resource-Based Relative Value Scales (RBRVS)

Resource-Based Relative Value Scales is Medicare's physician fee schedule. Many private payors use some form of RBRVS to set their own fees as well. For example, some payors may contract with physicians based on a percentage of Medicare's RBRVS fee schedule. Medicare also provides guidance on how to correctly apply certain modifiers to services and indicates when an additional supply can be billed with a service.

Medicare sets national fees for each service, and that amount is adjusted based on the Geographic Practice Cost Index (GPCI) for each locality. In other words, Medicare payment is adjusted based on your practice's geographic location. This GPCI-adjusted fee is the amount that a physician will be paid by Medicare for an approved and correctly billed service. Simply put, a physician who performs a service in Manhattan, Kansas, will be paid less than a physician who performs the same service in Manhattan, New York, because of differences in the cost of practicing in each location.

The Medicare fee schedule is typically updated annually but can change at midyear, or even quarterly. Updated information is always available via the Centers for Medicare & Medicaid Services' or fiscal intermediaries' websites.

ADDITIONAL RESOURCES

Practice Management

A physician practice, like any business, may benefit from outside managerial advice. Numerous resources are available to help your practice run more efficiently. Some can help you create more effective forms and other practice documents; some offer guidance on strategic and business plan development; some help you successfully negotiate managed care or private payor contracts; others can help you develop effective policies and procedures.

Compliance

Every practice should have a compliance program to satisfy state requirements and federal regulatory requirements of the Office of Inspector General (OIG). Compliance in this case refers to coding and billing, documentation standards, anti-kickback, antitrust and self-referral laws, and a few other areas.

If you're not prepared, compliance problems can be costly, and a small investment in good compliance resources up front can save you from financial and legal woes in the future. There are many off-the-shelf solutions for creating compliance programs and corrective action plans. Practices that need more complex plans or want plans tailored to their unique needs often hire a consultant to help them develop a plan.

Adopting an OIG compliance plan is voluntary, but it shows a good faith effort to comply with standards set by public and private payors. An OIG fraud and abuse compliance plan has six elements:

1. Standards of Conduct

2. Training and Education

3. Appointment of a Compliance Officer

4. Open Lines of Communication

5. Monitoring

6. Enforcement

Other compliance areas to consider:

• OSHA (Occupational Safety and Health Administration) sets and enforces standards for employee and patient safety.

• HIPAA (Health Insurance Portability and Accountability Act) sets standards for transactions between providers and payors, patient privacy, and security for electronic data.

Resources to help develop and maintain effective compliance programs are only part of the solution. Staying up-to-date on changes in laws and regulations is equally important. Print and electronic news sources can be helpful, alerting you to new rules and areas of enforcement. They also often contain compliance case studies, so you can learn from the mistakes of others.

Part B News provides weekly news, analysis, and guidance on critical Medicare physician payment issues, making it indispensible to practices that care about both reimbursement and compliance. This publication can be purchased at www.decisionhealth.com/store.

Staff Development and Certification

When it comes to maintaining reimbursement as well as compliance, your greatest resource is your staff. Professional certifications and credentials and the education and training that come with them can help ensure that your staff is competent, productive, and up-to-date on the complex rules and regulations regarding reimbursement and compliance for your practice.

To ensure accurate payment and minimize your exposure to compliance risks, staff should be encouraged to take the necessary courses to become certified medical coders or certified in specialty-specific coding. Many physicians are now listing coding certification as a minimum requirement for new employees.

Several organizations offer certification programs for practice staff for a fee:

• The Medical Group Management Association (www.mgma.com) offers certification for physician office managers through its American College of Medical Practice Executives (ACMPE).

• Practice Management Institute (www.pmimd.com) is another organization that offers certification for medical office managers, medical coders, and medical insurance specialists.

• DecisionHealth offers certification and education for specialty practice coders through its Board of Medical Specialty Coding (www.medicalspecialtycoding.com).

• The American Academy of Procedural Coders (www.aapc.com) also offers a variety of medical coding certification exams for physician practices and the outpatient facility environment, as well as specialty certification.

State and Local Medical Association Membership

It is vitally important for you to be a member of your state and local medical associations. Together, they make sure physicians' voices are heard by state and federal lawmakers, the for-profit health industry, government regulators, and others trying to interfere with your ability to care for your patients. Your state and local medical associations will always take a stand on issues that impact the practice of medicine. They are partners working every day to develop and maintain a physician-led, patient-centered health system. Association membership often provides valuable discounts on many of the resources mentioned in this chapter.

Office Policies and Procedures Manual

Every size business should have an office policies and procedures manual. The high staff turnover in medical practices today makes it more critical than ever to have these how-to resources at your fingertips. It ensures that institutional memory stays with the practice even if your office manager or other staff chooses to leave. Policies and procedures manuals are useful for training new staff or for cross-training purposes. Below is a partial list of items that should be included in such a manual.

- Job descriptions (see Chapter I for more on job descriptions)
- Employee evaluation forms
- Financial policies
- Appointment scheduling policies
- Triage policies

High-Speed Internet Access

Major payors now post payment rules and eligibility and medical policies online and also allow claims submission and appeals via their websites, which is a huge time-saver. Physicians may be required to register before gaining access to the information.

Copies of All Third-Party Contracts

Practices frequently lose money because they do not understand the specifics of payor contract language. To be successful in billing and collections, you need access to current information about each payor's contract requirements, including fee schedule by contracted product line, payment rules, authorization requirements, time frames for claims submission, and billing procedures for physician services.

Form Letters

Because medical practices are often required to repeatedly address the same issues, form letters minimize redundancy, save time, and promote consistency. CMA and county medical societies can provide many such formats to members for free. Δ

Other Publications

- Medical dictionary
- Specialty related publications

KEY CONTACTS

Some of your most important resources can be those you develop in house, such as a list of key contacts for each payor. Compiling a helpful network of contacts requires effort. As you identify these individuals, a list should be created and made available for office use. Listings for each payor should include these contacts:

- Account-Specific Payor Representative
- Customer Service Manager
- Provider Relations Manager
- Contracts Manager
- Claims Manager/Supervisor
- Medical Director
- Chief Medical Officer

When starting to develop your contacts list:
- Review the list of contacts provided by the payor.
- Make a note of a payor representative who is effective in helping you get a claim paid and try to use the same person for claims in the future.
- Ask if there is a specific payor representative assigned to handle account issues for your practice and if so, whether that representative has authority to resolve issues.
- To help develop your payor contact list, refer to the Payor Profiles on the CMA website. (www.cmanet.org/member, under "reimbursement advocacy")

Δ NOTE

Form letters are not an effective means of addressing medical necessity appeals.

CONSULTANTS: A CURE FOR PRACTICE ILLS?

When books, newsletters, conferences, and other resources aren't specific enough to address an individual practice's issues, physicians often turn to consultants for help.

A consultant can serve as the physician's physician—diagnosing and curing practice ailments. Consultants are individuals with expertise in certain areas who can identify problems and propose solutions. A good consultant will fix the immediate problems identified. A great consultant will identify process improvements and training opportunities to make sure the problems are solved for good.

The best consultants have practical experience. They've "been there and done that." Knowledge of theory is important, but in order to properly guide a client, the consultant really needs to have walked in your shoes.

Consultative services aren't cheap, but they can be extremely beneficial to a struggling practice and should be considered an investment in the future of the business. As with any investment, however, the practice should have a good understanding of its expectations and long-term goals before committing precious time and resources.

You don't need to be a rocket scientist to know when there are problems within your practice. Completing your own practice assessment before hiring an outside consultant is important. Some problems will be very apparent—for example, decreased cash flow, work flow bottlenecks, overcrowded schedules and/or long patient wait times leading to dissatisfied customers and ultimately loss of revenue. If you have identified serious issues within your practice and believe you need outside help, we encourage you to first educate yourself. Before you hire a consultant:

• Seek assistance from your state, county, and specialty societies. Frequently these organizations have developed practice management toolkits, compliance guides, and other valuable publications designed to educate physicians on medical office best practices and improving the bottom line. Note: These resources are generally made available to members at no cost, while nonmembers should expect to pay.

• Encourage your office manager or administrator to join state or local office manager groups or associations. Participation in these groups is a relatively inexpensive way to keep current on issues and can provide opportunities to share and learn how other practices are addressing challenges similar to your own.

• Organize physician-to-physician meetings. Practices will also benefit from physicians meeting with and talking with their peers about practice management issues.

If you have done your research and believe your practice is ready for a consultant, we recommend first conducting your own practice assessment. Identifying those areas that need improvement can save you money by prioritizing what you want and expect from a consultant. Note: For more information on how to conduct a practice assessment, see Chapter III.

Why Consider a Consultant?

A consultant brings an outside perspective to the day-to-day operations of your practice in critical areas of opportunity and risk:

• Revenue Cycle Management

• Regulatory Compliance

• Operational Efficiency

Specifically in these areas, a practice consultant can provide objective analysis, guidance, and education on everything from coding and billing to medical/legal issues to how to effectively respond to an audit. Customized training for your specialty, chart audits, practice management analyses, practice start-ups, mergers and acquisitions, exit strategies for physicians, benefit packages for staff and tax, and financial and strategic planning are just a few of the areas where a practice consultant may benefit your organization.

How Do You Select a Consultant?

Referrals are the best way to narrow down the choice of consultants. Check with your state, county, or specialty society or other professional organization. Often these organizations will have vetted referral sources for you and you may be entitled to discounted rates. Interview the consultant directly about the following:

• Inquire about the particular area(s) of expertise, style, personality, experience, fees, and availability to ensure this consultant can meet your needs and will mesh well with your practice.

• Ask whether the consultant has worked with practices of your specialty, your size, your structure. What works for family practice may not work for oncology. Similarly, what works for an oncology practice may not work for a primary care practice.

• Ask the consultant for references who can provide information relevant to the issues your practice is facing. Make sure you contact each of the references. You can assume you'll be calling a happy client, but that doesn't mean you can't ask about negative factors as well as positive. You could glean useful and telling information by taking this extra step.

Many consultants promote themselves based on their own professional accomplishments. But the best base their success on the accomplishments of their clients. If they excel at what they do, they can represent the practice during an audit, identify administrative inefficiencies, and ultimately turn failing practices into positive-cash-flow businesses.

Below are common services a comprehensive practice consultant can offer:

- Strategic planning and budgeting to help maintain viability of the practice

- Training and education (coding, compliance, and practice management for staff and providers)

- Recommendation and implementation of compliance initiatives (OIG, HIPAA, OSHA, employment law)

- Charting reviews (finding lost revenue and identifying potential overpayments and liabilities)

- Improving operational efficiency (including front office proficiency and staff morale)

- Representing a practice during an audit (private and governmental payors)

- Guiding a practice through mergers and acquisitions (expansion and adding ancillary services to a practice)

- Addressing revenue cycle concerns (stopping leaks in accounts receivable)

- Serving as interim manager/administrator/COO/CEO

- Guiding medical practice start-ups (providers going out on their own after years in a group practice or new physicians setting up a practice right out of school)

- EHR implementation (selecting a system that is right for your practice and negotiating the best price)

- Negotiating managed care and private payor contracts

- Structuring joint ventures (hospital and physician relationships)

- Regulatory guidance (Stark, Anti-Kickback, False Claims Act)

- Exit planning (helping physicians prepare to retire or leave a practice)

Beware of Unscrupulous Consultants

In June of 2001, the Office of Inspector General (OIG) issued a special advisory bulletin about the practices of business consultants[3]. The bulletin pointed out that most consultants are honest, but physicians should be on the alert against some questionable business practices:

- Illegal or misleading representations that the consultant is somehow affiliated with, or certified or recommended by, the Centers for Medicare & Medicaid Services, or that he or she has "inside" information

- Promises or guarantees of specific results that are improbable or unreasonable to expect

- Encouraging abusive billing practices

- Discouraging compliance efforts

CHOOSING A CONSULTANT

Sample questions you may want to ask:

- Were there any problems with the consultant's work, and, if so, what did the consultant do to correct it?

- What do you think the consultant could have done better or differently for your practice?

- What do you think are areas of weakness for the consultant?

- How long did it take for the consultant to schedule the engagement, to complete it, and to deliver the findings? Was this within your expected or promised time frame?

- Did the consultant respond to voice mail or e-mail in a timely fashion?

- Can you point to specific, measurable benefits from the consultant's work?

The decision to hire a consultant is an important one that requires research, thought, and scrutiny. If you've decided your practice can benefit from consulting services, get referrals from other practices, perform a thorough interview, and conduct a complete reference check. Failure to do this legwork can result in wasted staff time and money.

In general, be cautious of advice that seems too good to be true. Physicians must also remember that hiring a consultant does not relieve a practice of its responsibility to comply with federal and state laws. Ultimately, the physician is responsible for all coding and billing in the practice.

Also, while consultants can offer a great deal of valuable advice, if the practice is not committed to following through on such recommended changes, you're not apt to see many positive results.

The tools discussed here are just a few of the important basics every practice needs to promote success—helpful resources you and your staff can take out of the toolbox again and again. Other tools are available for more specific tasks. We encourage you to investigate and explore to make sure that you have the tool you need for every job, that it is the right tool for you, and that it is a quality tool that will last and serve you well. ■

3

Time Management and Administrative Simplification: Running Your Practice Efficiently and Effectively!

By Mary Jean Sage, Sage & Associates

Medical practices are struggling to survive in an industry beset by constant change and declining operating margins. With Medicare physician reimbursement projected to decrease 30 percent over the next several years and major health plans unwilling to negotiate contract rates that cover the cost of care, every practice must be performing both efficiently and effectively to ensure financial viability and quality care for patients. Efficiency—accomplishing goals without waste or loss—lowers costs and increases your return per unit. Effectiveness—producing desired results—increases quality outcomes and patient satisfaction. When a practice is running efficiently and effectively, the physician is free to focus on seeing patients rather than dealing with administrative hassles.

According to Owen Dahl, author of *Think Business! Medical Practice Quality, Efficiency, Profits*, efficiency for a medical practice hinges on the goal of providing value to a patient in every single encounter—be it face-to-face time with the physician or a phone call to schedule an appointment, get a prescription refill, or ask about lab results.

In today's environment, it is critical to control your costs. In reviewing each service your practice provides, you must consider these questions: Does the service bring value to my practice? Are my customers pleased with this service? How much does this service cost? How can this service be provided more efficiently to reduce costs and increase quality of care?

The practice must provide this value in a cost-effective way or you will not be able to stay in business. Therefore, it's crucial to review how day-to-day work is performed and figure out how to optimize results. Generally, completing in-house tasks can involve multiple staff members and myriad steps, so you'll need to look at each process from start to finish. Ask questions. Often, certain steps have been integrated into a process and passed along as gospel with no one having any idea why. When asked, a worker may say, "We've always done it that way." Make sure staff knows and understands why each component of a task is necessary. This is also the perfect time to write down the particulars of each process and create or update a procedures manual.

In this chapter, we will focus on identifying errors, delays, bottlenecks, and inefficiencies through practice assessment. We will discuss how these errors and inefficiencies contribute to reimbursement problems and loss of productivity and give pointers and tools for standardizing processes and improving customer satisfaction and office flow.

LOOKING AT YOUR PRACTICE

The first step in improving efficiency and effectiveness is identifying where your practice is succeeding and where there is room for improvement. There is no better way to determine that than to perform a self-assessment of the practice. During your assessment, you will want to cover the following:

- Defining roles

- Front-end processing

  - Accuracy of information collected

  - Appointment scheduling

  - Check-in

  - Failure to collect

  - Patient wait times

  - Check-out

- Late arrivals and no-shows

- Managing call volume

- Operational and patient flow

  - Utilizing the Internet

  - Clinical services/procedures

  - Billing systems

  - Other systems as appropriate

- Patient satisfaction (for more on patient satisfaction, please see Chapter IV)

  - Surveys

  - Results

  - Goals

- Avoiding common traps and pitfalls

THE ASSESSMENT

Conducting an assessment of your practice does not have to be complicated. Focus on one process at a time (including interrelated work) and assess each aspect from start to finish. Generally this entails these basic steps:

1. Collect all existing written documentation about the process.

2. Inform staff of your goals and conduct an interview with each staff person directly involved in the process.

3. Observe processes as they are performed in real time.

4. Participate in or perform the task yourself.

5. Develop recommendations.

Below we've provided a sample road map for conducting an assessment of two essential procedures: patient registration and check-in. While it could be followed just as written by most practices you will gain far more knowledge and understanding of your office workings by creating your own guidelines, using the five steps outlined above.

Part of this assessment will require you to pretend you are a patient undergoing registration and check-in. This is an important opportunity for you to experience what it is like to be a patient in your practice. Viewing things from a different perspective can be very useful as you work to improve the efficiency of your practice.

Before you begin, inform staff about your goal and instruct them to act in the normal fashion. Make sure they understand you are assessing processes and not anyone's individual performance. Write down each of the steps so you have a road map to follow after the assessment is complete.

Step I–Locate Documentation

Find and review any documentation you have for check-in and registration procedures. Make a list of all forms and paperwork and keep it all in a file for easy access. Your list should include:

- Job descriptions

- Registration forms

- Payment rules

- Pre-authorization requirements

- Authorization process

- Other clinic rules

Step II–Interview Staff

After you have reviewed the above documentation, you can begin interviewing each staff member directly involved in patient registration and check-in. Ask staff to walk you through each phase of the process. Details are important! After you have completed the interviews, give employees the opportunity to comment or suggest improvements.

Take detailed notes. Information and feedback from these interviews serves several important purposes:

- Testing staff job knowledge

- Identifying bottlenecks and other inefficiencies

- Creating new or updated job descriptions

- Creating a new or updated procedures manual

- Creating new or updated education and training tools

- Creating or updating patient survey questions

- Encouraging staff comment and recommendations

Step III–Observation

Next, watch staff as they conduct patient registration and check-in. Observe these processes twice a week for several weeks during peak clinic hours. While this process is normally the purview of the office manager or administrator, the physician can and should be involved in how it is performed.

Listen, watch carefully, and document any bottlenecks, inconsistencies, or other issues. Remember, you need to pay attention to the time each task takes to complete. Try not to distract or disrupt what would be the normal routine. Ask questions when necessary or to clarify something you may have missed. This is not the time to make suggestions or change current processes; wait until it is time for your final assessment in Step V.

Step IV–Participation

It is important that you are able to perform the tasks associated with registration and check-in by following the documentation you have on hand.

You should also take part in the process as if you are a new patient. Your employees should experience the process from that vantage point too. Have different staff members engage in this role-play during peak business hours several times over the course of one month. Each staffer should sit in the waiting room and complete all the forms patients are required to complete. Take note of any questions on the forms that are not necessary.

• Honestly assess your waiting room for the following:

  - Comfort

  - Cleanliness

  - Reading materials

  - Seating

  - Water

  - Restroom availability

  - Lighting

  - Medical/educational literature/pamphlets

• Observe other people in the waiting room and note any relevant remarks overheard.

• Complete the forms as any new patient would.

  - Note the time it takes from the moment you arrive at the receptionist window until you sit down to begin completing forms.

  - Complete the forms as though you are at your own physician's office.

  - Document the total time it takes you to complete the forms.

  - Once you've returned the forms to the receptionist, note the amount of time it takes the receptionist to enter the information from the forms into the practice management system and ready your chart for rooming.

  - Now, note the amount of time it takes for to be escorted to an exam room.

Step V–Create Recommendations and Implement Change

Once you've completed the previous steps, deficiencies will have become very apparent. Now it is time to do something with the results. Make sure each task or service you've observed is necessary, brings value to your practice, and is performed well in a cost effective manner. As a final step, to complete your assessment:

• Analyze background gathered.

• Review notes taken during the interview, observation, and participation phases.

• Outline your recommendations.

• Determine the cost of any changes. Will it be cost-effective and add value to make the recommended changes?

• Meet with staff to discuss and fine-tune recommendations.

• Formalize and implement recommendations.

• Monitor progress.

• Create goal-oriented incentives. For example, if you are having problems with your scheduling (schedules aren't full, you are frequently double booked, etc.), offering an incentive to correct these issues can be much more motivating than corrective action.

Acknowledge areas where the practice is performing well. There is no surer way to motivate your staff than to praise them when a job is well done.

On the flip side, also point up areas where there is room for improvement and processes that need to be reorganized or restructured. You will need to develop plans to bring these areas into compliance with your goals for the practice, its operation, its quality, and its profitability. Your goal should be to look at the entire practice within a six-month period.

Some practices, rather than conduct this assessment all by themselves, will ask a medical practice management consultant to perform it or offer guidance. Your state medical association, local medical association, or professional society may be able to refer you to practice consultants in your area (see Chapter II). The Medical Group Management Association (MGMA, www.mgma.org) and National Society

of Certified Healthcare Business Consultants (NSCHBC, www.smdmc.org) can also direct you to such advice.

As you formulate recommendations for change, remember that while you can cut costs by reducing employee time, it's not time to start handing out pink slips. Being overstaffed is obviously a financial drain, but before making changes you need to make sure all employee departments are functioning as they should. While you may be overstaffed in one area, you may be understaffed in others; for example, you may find that one of your front office workers has time on her hands, but your billing and collection staff is clearly shorthanded, judging from the volume of accounts over 90 days. In this instance you may want to consider shifting some of your resources from the front office to the back.

IDENTIFYING AND ELIMINATING VARIANCES

Variance in the way tasks are performed can contribute significantly to breakdowns in processes, which can create practice inefficiencies. The rest of this chapter focuses on recommendations that will help eliminate these variances, increase practice productivity, and reduce rework.

Defining Roles

Many problems in physician practices can be traced back to a lack of written job descriptions, policies, and procedures. Compounding these problems are high staff turnover, inadequate training, and lack of communication. Failure to maintain employee job descriptions and policies and procedures manuals severely limits a business's ability to achieve optimal efficiency.

Successful businesses maintain manuals that clearly define employee roles and provide step-by-step instructions on how to complete tasks. Such manuals and instructions will allow you to quickly identify system breakdowns, measure quality of work and productivity, evaluate staffing levels, hold employees accountable, and prevent unnecessary work and other redundancies that increase the cost of doing business. Well-thought-out, documented processes contribute significantly to a smooth operation. For more information on the importance of a policies and procedures manual, please see Chapter I. Ω

Ω TOOLS

A sample job description is available in the Appendix.

Front-End Processing

Accuracy of information

Errors and omissions in data fields on the claim form—such as incorrect patient dates of birth, insurance addresses, insurance identification numbers, and patient addresses—frequently generate denials or requests for additional information. Both create duplicative work and delay reimbursement.

To reduce inaccurate claims, patient insurance information should be verified at the time of scheduling and re-verified at check-in. The receptionist or scheduler should always obtain a copy of the front and back of the patient's insurance card, which lets your office verify eligibility and benefits before the visit and recheck it before the patient is seen and the claim submitted. It's also useful to print out the patient's demographic and insurance information at check-in, have the patient confirm the information with his or her initials, and file that document with the chart.
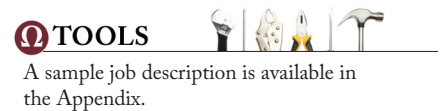
Some practice management systems will flag diagnosis codes not coded to the maximum specificity and modifier issues. If your system does not include this functionality, have staff spot-check claims for accuracy before they go out the door. While this is an additional step, the goal is to touch a claim once. When inaccurate information is submitted, it costs the practice money: Typically you receive either a denial or request for more information, which requires at least three times the staff time as it will to spot-check the claim in the first place. Beyond staff time, there's the cost of materials used to resend or appeal a claim, and of course, delays in payment itself are costly. According to the Advisory Board Company, a Washington-based research organization, an estimated 90 percent of claim denials are preventable and 67 percent of denials are recoverable. All additional staff time required to address these issues takes away from patient care.

Appointment Scheduling and Check-In

Everyone feels the impact of an improperly managed appointment schedule—physicians, staff, and patients. If employees scheduling appointments are not properly trained in how to triage patients and allot the appropriate amount of time, either your schedule will have gaps or, more often, the physician will run behind, which frustrates patients. Before tackling a scheduling problem, take the time to look back at past schedules to recognize what isn't working and consider what might be a better approach. Then make a commitment to institute changes.

Begin by looking at a few weeks of your schedule to assess trends. Look for:

• Production

  - Number of patients seen each day

  - Average number of patients seen each day

  - New patients

  - Returning/established patients

• Number of double-booked appointments

• Number of patients "squeezed in"

• Number of no-shows

• Number of rescheduled appointments

Next, spend a few days gathering data on the amount of time spent with each patient. This is best done with a time flow study.

Ω TOOLS

A sample time study assessment form is available in the Appendix.

At the end of each day, staff should calculate the wait time between each step in the process. After completion of the time study assessment, determine the average wait time for each step. You may also want to consider asking your patients to complete similar time studies Ω

The next step is to analyze the data and organize it into a report that identifies areas where your practice is doing well and areas where your practice needs improvement. For example, you may find that your physician is often running behind because the scheduler is routinely double booking, squeezing patients in, or not scheduling the appropriate amount of time for visits. In these cases, your practice should consider written protocols for your scheduler that clearly define conditions that require

immediate attention and should be fit into the schedule versus those that can be seen within a few days. Exceptions should only be made by the physician.

Another possibility is that your practice constantly runs behind because the physician is spending more time with patients than is actually scheduled. Practices can avoid this type of problem by creating written protocols that clarify how to triage a patient, including what types of questions to ask, as well as the appropriate amount of time to be scheduled depending on the patient's condition or reason for being seen. For example, pre- and post-op appointments may only require 10 or 15 minutes with the physician, whereas annual physical exams may require 60 minutes and new patient visits may require 30 minutes. If the scheduler is not asking the right questions to determine the appropriate amount of time to allot, the physician will be unable to stay on schedule.

Creating the right schedule for each practice requires an understanding of why it hasn't been achieved previously, predicting scheduling needs, and understanding how the physician works and what actions will promote a more efficient workday.

Failure to collect

Collecting co-pays, coinsurance, deductibles, and past due balances from the patient at the time of service is often one of the most overlooked tasks in a physician practice. Because the majority of payments come from managed care plans, it's easy to forget that charges paid directly by patients are an important source of revenue, and not collecting these up front can have significant impact. In fact, co-pays can represent as much as 20 percent of a physician's income.

Beyond impacts on the immediate revenue stream, billing after the fact runs up expenses as well. Studies have shown it can cost a practice at least $5 to $7 to generate a statement. So if a practice fails to collect a co-pay and later bills for it, the $20 due turns into only $13 to $15. Multiply that by the number of patients you see in a day and it quickly adds up. And according to a U.S. Department of Commerce study, ability to collect drops to 74 percent at 90 days and to 30 percent at 180 days for payments not collected at the time of service.

Accordingly, consider implementing an office policy requiring that co-pays, coinsurance, deductibles, and unpaid balances be paid at the time of service. Clearly communicate this rule to patients before their visit and in your financial policy documents, which patients should sign annually. Inevitably, a handful of patients will show up without the cash, checkbook, or credit card to make the co-pay. Be prepared by locating the nearest ATM, and either direct the patient there or offer to reschedule the visit for a day when the patient can arrive with the proper payment. If you remain firm on this policy, it is unlikely that patients will forget the next time around. Δ

Check-Out

After examination, physicians frequently request that patients schedule follow-up, pre-op, or post-op visits for later dates. Failure to schedule these appointments at check-out can impact patient care and create additional work down the road in the form of scheduling-related phone calls.

Depending on the patient's type of insurance, coverage, and services performed, additional money may be due at check-out.

BALANCE BILLING

California physicians should be aware that on January 8, 2009, the California Supreme Court put an end to the controversy surrounding "balance billing" of HMO enrollees in the emergency care context -the practice by out-of-network providers to bill patients the balance of an emergency care bill that the patients' Knox-Keene plan refused to pay. *The Court in Prospect Medical Group v. Northridge Emergency Medical Group*, __ Cal.Rptr.3d __, 2009 WL 36855 (2009) (Prospect), ruled that the Knox-Keene Act prohibits this practice of balance billing. The court clarified that providers may only seek recourse against the payors, not patients, for underpayments. The Department of Managed Health Care too has taken action to prohibit noncontracted providers from balance billing for emergency care services, promulgating a regulation, 28 C.C.R. sec. 1300.71.39, that defines such practices to be an "unfair billing pattern." The *Prospect* decision and the DMHC's regulation make it clear that balance billing for emergency care services is no longer permitted if the patient is covered by a Knox Keene-regulated plan (HMOs, certain PPOs, and any delegated medical groups or risk bearing organizations). For more information about the Prospect decision and its implications, see CMA's Balance Billing Toolkit at www.cmanet.org.

⚠ NOTE

Practices should exercise caution when it comes to turning patients away for failure to pay balances due at the time of service. Patients whose condition is urgent should be seen regardless.

To avoid these time-consuming and costly pitfalls, it is best practice to have a staff member available upon patient check-out to confirm with the patient whether any additional appointments need to be scheduled and to collect any additional payment due before the patient leaves the office.

Late Arrivals and No-Shows

Late arrivals create a backlog for the receptionist and delay the physician, which causes longer waits for other patients. No -shows can leave gaps in the schedule, reduce practice revenue, and contribute to timely access issues for patients.

To avoid these disruptions in your schedule and revenue flow and provide better access for your patients, it is a good idea to set some staff time aside each day to call patients to remind them of their appointments. Alternatively, an automated appointment confirmation and reminder service can help reduce missed appointments or late arrivals and relieve staff of the task of manually calling patients. Of course, automated services cost money, so run a cost-benefit analysis to see which option is right for your practice.

During the manual or automated confirmation call, patients should be reminded to bring their insurance card, patient history, and any other needed information for the visit. If your practice requires that a co-pay or deductible be paid at time of service, include that reminder as well. Clearly stating your practice's policies on late arrivals or no-shows is a good idea, too. For example, your office may require patients more than ten minutes late to reschedule, or specify that the physician may discharge a patient from the practice if he or she is a frequent no-show .

Before discharging a patient, be aware of state and federal laws regarding patient abandonment. ✿

Managing call volume

For many medical offices, the volume of phone calls received daily is overwhelming. Often the front desk is swamped with incoming calls, causing frustration and patient dissatisfaction. When call volume is heavy, inadequate phone systems may result in dropped calls or patients may hang up due to long waits. During peak periods patient calls may not be returned promptly and patients arriving for appointments may have to wait to check in because front desk staff are stuck on the phone. Some practices have responded by investing in expensive phone tree solutions, but frequently these only annoy patients rather than solve the volume issue.

Phones that ring off of the hook cause disruptions and contribute to staff errors. However, phone lines are still the most common form of communication in a practice, so understanding what makes your phone ring is extremely important to your practice's success.

Our physician practice volunteers decided to examine what made their phones ring. For two weeks they collected information about the nature of incoming calls (see sample tracking sheet in Appendix). Calls to schedule appointments comprised less than half the load; other calls were appointment cancellations, rescheduling, inquiries about lab results, requests for prescription refills, calls from pharmacies with formulary conflicts, requests for directions, questions about office policies, and insurance questions. Some were from repeat callers who were simply frustrated that they had not yet heard back from the physician or from the staff regarding the status of their prescription, authorization, or referral.

One practice determined it was spending more than $20,000 per physician per year trying to manage calls that could have been avoided. Instituting better processes and minimizing the need for patients to call improved patient satisfaction and reduced costs.

To reduce unnecessary call volume, you will need to systematically evaluate the reason for the calls and create a plan for change. Below is a list of call types and recommendations that can help you manage the call volume in your practice:

Call Type	Recommendation
Canceling or rescheduling an appointment	• Implement an appointment reminder system (manual or automated) to contact patients 1 to 2 days prior to scheduled visit. Necessary rescheduling can be handled at the same time. • Have patients fill out an appointment reminder card at check-out and mail it to them 1 week in advance. • Develop a firm policy on no-shows and clearly communicate it to your patients.
Directions to the office	• If making manual appointment reminder calls, confirm the patient knows where you are located. If not, provide general directions. • If using an automated appointment reminder service, the message to patients should include the general location of your office, including cross streets. • Post this information on your website (if applicable). • Include general directions in your new patient orientation package and send to patients before their scheduled visits.
Office policies	• Mail new patients a full orientation package ahead of their scheduled visits. Include information on your office policies.
Clinical questions	• Establish clear boundaries around clinical questions, such as when it is appropriate for office staff vs. a physician to answer a patient query. - Calls requiring physician attention should be routed directly to physician along with the patient's chart, which is placed in a pre-designated spot. • Establish callback hours, publish them in new-patient information materials, and remind patients of these when they call. • Follow through on a commitment made to contact a patient, even if you don't have the needed information or test results yet. • Consider implementing a secure system via your practice's website that allows patients to send messages to their physician and to request appointments, referrals, and prescriptions. This is a flexibility way for patients to relay a medical question at 10 p.m. and for physicians to respond when suitable or convenient.

Call Type	Recommendation

Inquiries about lab/test results	• Develop an internal process for handling lab/test results and a policy on how results are communicated to the patient:
	
	• **Internal process:**
	  - Results that come in via mail or fax are placed in folder.
	  - Charts are pulled, results are attached, and chart is placed in a designated spot for physician or practitioner review.
	  - Reviewer signs off on the result and indicates the appropriate action (physician call, MA call, practitioner call, e-mail to patient, schedule an appointment, etc.) .
	
	• **Make sure patients are aware:**
	  - How long it will generally take to receive results
	  - How they will be notified
	  - Who will notify them
	  - When they should check back with the practice (if they haven't heard after x number of days, have additional complications, have questions, etc.)
	  - Note: It is important to follow through on a commitment made to contact a patient, even if you don't have the needed information or test results yet.

Requests for prescription refills	• **Calls from patients:**
	If your practice uses an automated phone system, consider including a message that encourages patients to contact their pharmacy for prescription refill requests.
	
	• **Calls from pharmacies:**
	  - Set aside a certain time of day to review routine refill requests received by fax or phone (e.g., during lunch hour and/or after 5 p.m.). Urgent requests should be handled based on patient needs.
	  - Chart should be located, message or fax attached, and the chart placed in designated spot for physician review.
	  - Pharmacy is contacted via phone/fax.
	  - Patient should be contacted via phone/e-mail to advise them of the status of their prescription.
	
	• Provide information about the prescription refill process via your website (if applicable).
	• Include this information in the orientation packages mailed to new patients.
	• Post this information in your waiting room.

Authorizations and referrals	• Explain the process for obtaining an authorization or referral to the patient:
	  - How long will it take
	  - How and when will the patient be notified
	  - When the patient should check back and with which practice (if they haven't heard after x number of days, etc.).
	  - Note: It is important to follow through on a commitment made to contact a patient, even if you haven't yet obtained the authorization/referral.

Formulary conflicts/pharmacy questions	• Physicians and their office staff have access to formulary reference software, such as Epocrates Rx (www.epocrates.com), free of charge. These types of products provide physicians with access to the formularies of most major payors. Verifying whether the medication your practice is about to prescribe is in the patient's formulary or requires an authorization can drastically decrease pharmacy callbacks. • Consider a dedicated fax line to receive all pharmacy inquiries/requests.
Repeat callers	• Clearly communicating when calls will be returned can decrease the number of repeat callers—for example, "calls will be returned within one business day." Handle urgent requests as needed.

Now it is time to identify what makes your practice's phone ring. We recommend using the call volume tracking sheet for one to two weeks. Any staff member responsible for answering the phone should use this form to track calls by frequency, time of day, and issue.. Note any additional issues in the space provided on your worksheet. Use one sheet per staff person per day. Total up the number of calls per day for a one-week period. At the end of the week, chart out the call volume for each topic. Identify the top five issues and determine if issues differ based on day of the week. Ω

You may also want to consider soliciting feedback from your patients regarding their satisfaction with your phone system. While in the waiting room, you can ask patients to complete a brief survey about their experience when contacting your office. Ω

Once you've reviewed and addressed the volume of calls, assess whether your practice has sufficient phone line capacity to handle it. Contact your phone company to request a report on busy signals, abandoned calls, and peak call volume. Typically there is a fee for this type of information, but it is an inexpensive way to help your practice assess whether you need to add lines or make changes that will improve customer satisfaction and access.

Avoiding Common Inefficiencies

The Physician's Time
A practice's biggest expense is the physician. The goal is to be efficient and productive and to make sure the physician is using his time and other resources wisely.

Schedule
Your major source of revenue is your patients. Regardless of your financial mode of practice (capitation, contracted fee for service, non-contracted self-pay), your goal should be to have a full schedule of patients each day and handle that schedule effectively.

Delegate
Many physicians complain that they have too many meetings to attend, too much business correspondence to read and review, and too much paperwork to complete. Delegate these administrative tasks. Let your office manager start doing some real management. If that employee doesn't have the necessary management education, investing in such education will ultimately save you time and money.

Organize and Prioritize
Use a task organizer, such as a Day Runner, Microsoft Outlook task list, or a simple handwritten to-do list, to plan, organize, and prioritize your non-patient appointment tasks. By prioritizing your non-patient tasks, you can expect to save 30 minutes a day and use the rest of your time more productively. For example, if you have prioritized your tasks and there is a no-show, you can use that time to accomplish one of the tasks on your list rather than wasting time.

Perform a self-inventory to determine how well you manage this list. Over a period of a week or 10 days, look at how many of those tasks in your organizer are actually being accomplished, how many are being dismissed or forgotten, and how many are being bumped into another day. If you are accomplishing less than 90 percent of

Ω TOOLS
A sample call volume tracking sheet is available in the Appendix.

Ω TOOLS
A sample patient satisfaction survey is available in the Appendix.

what you set out to do, something is wrong. It could be overly ambitious plans (being unrealistic) or it could be events, people, or habits that get in your way. Identify the problem and find a solution so you can make the most of each day without working longer hours.

Start on Time

Start both the morning and afternoon on time. Sage & Associates, a California practice management consulting firm, estimates that late starts cost a practice roughly $2 per minute. This expense comes straight out of profits, since expenses have already been incurred. Your staff, especially the schedulers, can help the physician stay on track, but the physician must be committed to starting on time.

Practice Preventive Administration

Every physician should devote, on average, an hour a day to administrative work. This is true even if you are in a group practice and you are not the managing partner. By making this a priority, you are much less likely to fall behind on or miss important deadlines that could have far-reaching consequences. For example, failing to review and respond to a contract change (such as a fee schedule change) within the required time frames could lock you into those rates for another year.

While doing this, make every attempt to process all correspondence, chart notes, lab work, refill requests, and the like within 24 hours. Delays can lead to unnecessary work: For example, staff's inability to locate a medical record can hold up the process of rooming the patient and consequently put the physician behind for the rest of the day.

OFFICE COMMUNICATIONS

Keeping communication healthy and open is certainly important, but you must also determine the best forum to communicate various types of information, be it sensitive, generic, or positive. Your goal should be timely, thoughtful, healthy communication that makes the best use of everyone's time.

Manage Staff Meetings to Make Them Meaningful Communication within the practice is a key component of success. In addition to promoting teamwork and providing an opportunity for staff to work collaboratively, office meetings are a great way to ensure open communication between staff members.

Start by making a commitment to keep the meeting meaningful. Give everyone enough notice so they can attend prepared and the meeting can be well planned. Structure the meeting by defining its purpose and setting an agenda that addresses that purpose. The agenda needs to be managed, with a specified amount of time for each item. Manage the meeting to assure it

is an informational exchange and does not become monopolized by one or two people or degenerate into a gripe session.

Even an informal five-minute huddle every morning to review the day's schedule and plan ahead provides an opportunity to explore potential problems or conflicts and identify actions to resolve them.

MAKE THE MOST OF THE VISIT

When seeing patients in the office, make the most of that visit by handling whatever tasks you can at that time. For example:

- Review prescriptions and issue appropriate refills, to prevent the need for a call from the patient or pharmacy 30 days down the road.

- Convey the findings of any consultation or diagnostic reports.

- Have the patient schedule as many follow-up appointments as possible before leaving (i.e., a series of prenatal visits, post-op visits, wellness exams).

- Remind patients to schedule return appointments for such things as annual pap smears, mammograms, flu shots, or repeat studies, to prevent unnecessary mailing costs.

USE YOUR ONLINE RESOURCES

Get your staff off the phone and onto the Internet. Online is a far better way for your staff to communicate with referring practices, verify insurance eligibility and benefits, obtain authorizations, and check on claims status. As seen in Figure 2, a 2006 Milliman study found that a solo physician can save more than $42,000 per year by increasing electronic transactions such as claims submission, eligibility verification, referral certification, pre-authorizations, claims status, and payment posting[4].

[4] Phelan, John and Naugle, Andrew, Electronic Transaction Savings Opportunities For Physician Practices, Milliman Technology and Operations Solutions, Revised 2006.

Figure 2 - Milliman Technology and Operations Solutions: Electronic Transaction Savings Opportunities for Physician Practices - Revised January 2006
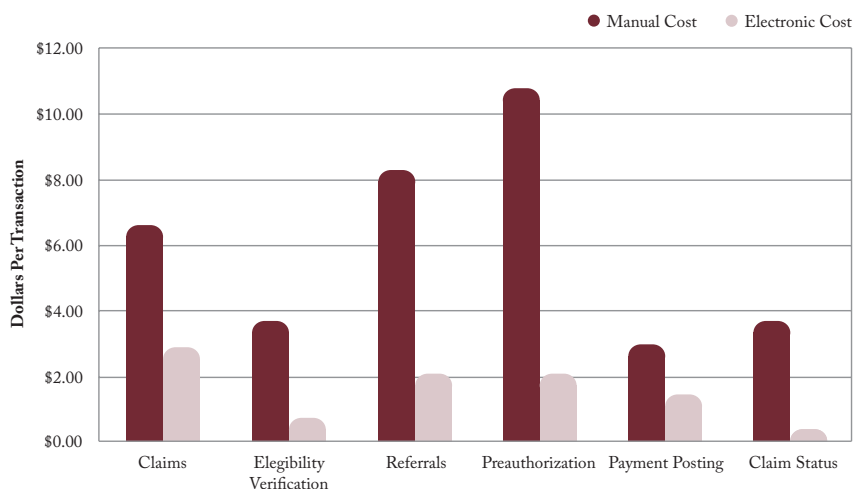
Utilizing Automation and Information Technology (IT)

As mentioned above, solo physician practices can save more than $42,000 per year by utilizing technology. Automation can save staff time, increase patient satisfaction, and decrease your bottom line all at the same time. Here are some suggestions on how your practice can become more effective by implementing technology solutions:

Instant Messaging

Electronic communication saves an unbelievable amount of time and makes intra-office communication more efficient. Intra-office e-mail and instant messaging are great ways to transmit information in real time, with minimal steps. Here are two easy ways to use electronic messaging within the practice:

• The billing office can send a message to the receptionist when a slow-paying patient is spotted on the appointment schedule. The receptionist can then direct these slow-paying patients to the billing department before they leave the office. The schedule should be routinely examined ahead of time by the billing office, not "if there's time."

• When Mrs. Brown arrives for her appointment she tells the receptionist she also needs to pick up a new prescription for her husband. The receptionist can send an instant message notifying the nurse that Mrs. Brown will be asking for this prescription. The nurse can access Mr. Brown's record and can have the prescription ready by the time Mrs. Brown sees the physician.

Both of these are steps staff members can take at their desks, saving time.

On-Hold Messaging

On-hold messaging is an inexpensive and efficient way to provide general information to your patients. It beats subjecting the patient to silence (and wondering if they've been disconnected) or music they don't care for. Use this messaging for patient reminders (time for flu shots) and as a means of marketing any new services being offered by the practice. It is also a good opportunity to introduce any new providers or staff members of the practice. Make sure you are able to change the messages frequently and with ease.

E-Prescribing

E-prescribing can reduce the steps required of a manual prescribing system. It can also decrease the volume of calls from the pharmacy regarding illegible scrips. A number of health plans, including Medicare, are planning to offer bonus incentives to physician practices that use e-prescribing. Medicare's program will be implemented in 2009.

EMR/EHR

Electronic Medical Records (EMR) or Electronic Health Records (EHR) certainly require a financial investment from the practice, as well as a large investment in time for training and implementation. However, having access to data from anywhere, reducing costs involved with paper charts (such as paper, transcription, and record storage), and improving practice productivity should be enticing incentives to consider the move toward EMR/EHR.

If it appears financially prohibitive to implement an EMR/EHR in your practice right now, consider using a hosting company to provide the service. The system itself resides at the hosting company and the practice accesses all functions and features via the Internet. The hosting company is responsible for maintaining and upgrading the system and keeping all records HIPAA compliant. This has proven to be a much more cost-effective way for solo and small group practices to advance into the age of the electronic health record. For a more comprehensive discussion on EHR selection and implementation, please see Chapter VII.

Benchmark Your Practice

Use your practice management system and scheduling system to provide the benchmarking data so you can track and assess practice performance. Typical benchmarking includes productivity, income, operating expense, and financial management. Chapter V provides an in-depth discussion on benchmarking and how your practice should use such performance measures for a "snapshot" of how the practice is doing.

Use Your Practice Management System Effectively

It is estimated that most medical practices only use about half the functionality in their practice management systems. Talk with your vendor to learn more about the standard reports your system creates as well as how to create custom reports. System reports are critical to measure a practice's progress toward goals and identify areas of opportunity.

STRATEGIES FOR EFFICIENCY AND EFFECTIVENESS IN YOUR PRACTICE

Become Proficient at Managing Your Practice

Continuing education in practice management is important to physicians, their office managers, and their staff. It is strongly recommended that you include the cost of these courses in your budget.

Invest in Good Staff

As discussed in Chapter I, one of your practice's most important assets is your personnel. To attract and retain good staff, you have to compensate them well. We have all known that one staff person who was able to do twice the work of everyone else. That's who you want on your team. Below-average workers are costly. Pay extra for good workers and you'll need fewer of them. Investing in and retaining qualified, dedicated staff can make or break your practice. This is a critical area where it just doesn't make sense to cut corners. By some estimates, the cost of turnover could be as much as a third of an employee's annual salary[5], so finding and retaining the right employees in your practice is critical.

Eliminate Frequent Overtime

If overtime is frequent or excessive, evaluate whether your practice should consider hiring additional staff to get the work done. First, overtime should be authorized either by the physician or office manager. This will ensure the overtime hours are really necessary. Second, there should be a clear understanding between office manager and employee of what is to be accomplished during the overtime that is authorized. Once the overtime has been used, the physician or office manager should confirm that the agreed-on goals were met.

Overtime pay costs the practice 150 percent of the employee's hourly rate, so it is important to evaluate how much overtime you are paying on average each month. If that amount is equal to or greater than the cost of a part-time or full-time employee at the hourly rate, it is time to consider hiring additional staff. It will prevent burnout and errors that occur when staff is overworked.

Use Bonus Systems

Consider rewarding staff for meeting production- and collection-related goals and for controlling overhead costs. If you offer incentives for achieving predefined goals, staff are more likely to become invested in the outcome of their work, meaning a more effective, efficient, and profitable practice.

[5] Business and Legal Reports, What is the Cost of Employee Turnover in Your Company?, http://www.blr.com/landingPR/index.aspx?landingPRID=1

Closely Review Your Overhead

Left unmonitored, overhead can quickly get out of control and eat into profit. The keys to controlling it are creativity and striving to improve operations. In physician practices, overhead primarily consists of labor, rent, insurance, and purchased services. While those areas can have a big impact on net income, don't overlook the smaller expenses that can all add up.

For the new or inexperienced manager:

• Review your bills. Closely examine invoices for unusual charges.

• Competitively bid your purchases. Compare prices on products or services with little differentiation, such as general liability insurance, employee benefits, and services.

• Renegotiate deals. Don't wait for the renewal period to renegotiate terms, especially if you are important to the vendor.

• Weigh leasing vs. buying. Leasing can help you conserve capital, but it is important to determine whether the total cost is lower in a lease or a loan.

Stick to Your Budget

Of course, you first need to develop a budget and stick to it. On a monthly basis, you should review actual costs vs. budgeted costs to determine the variance. This will help you plan for changes, identify areas that need attention, and stay within budget.

All of the tips and advice in this chapter may seem overwhelming, particularly for a busy medical practice, but a little time and effort up front will save you a lot of time and money in the long run. More important, these tips will help keep the practice's doors open and allow the physician to focus on providing high-quality care to patients. ■

4

Assessing Customer Expectations and Improving the Patient Experience

By Debra Phairas, president of Practice and Liability Consultants, and Mary Jean Sage, Sage & Associates

It is important that physicians, administrators, and staff do not become complacent about customer service. Merely assuming that your practice provides excellent customer service is not enough. Moreover, just because you've always done things a certain way doesn't necessarily mean there isn't room for improvement. In this chapter, we will discuss continuous assessment and quality improvement measures you can take to ensure high satisfaction for both patients and referring physicians who are vital to your practice.

In today's market, especially with the move toward consumer-directed health care, it has become essential for a physician practice to be customer service oriented. This means recognizing that patients and referring physicians are customers and then continually reinforcing that philosophy. In the past, patients tolerated 30-minute wait times. But recent studies show that tolerance threshold has dropped to 13 to 15 minutes past the scheduled appointment time.

SOLICITING FEEDBACK

Ideally, a practice should continuously solicit feedback from its patients. One way to obtain feedback is through your receptionist. The receptionist has more face-to-face time with the patient than any of your other staff, and those encounters can yield invaluable information about the patient experience. The receptionist should keep a log of observations from those interactions and share the information during the regular office meetings. In addition, have a process in place for more serious issues to be brought to the physician's or office manager's attention.

Another excellent way to get feedback is to survey your patients. A permanent, locked box on the premises where patients can deposit their completed survey forms is an excellent tool to collect ongoing feedback and also immediately address issues as they develop.

At a minimum, we recommend practices conduct patient satisfaction surveys at least twice a year. Discuss with staff the intent, benefits, and importance of these surveys. You may also want to consider offering incentives to your staff for encouraging patients to participate, for a higher response rate.

You can also promote responses by placing surveys in multiple locations on site, for example, on the clipboard with other forms patients need to fill out, displayed in the waiting room. and in easily accessible plastic wall holders in the exam rooms. Patients are less likely to participate in surveys that require them to mail back responses; response will be much greater if they can confidentially drop the form into a secured box at the beginning or end of the visit.

If you have computer-savvy patients, you may want to take advantage of electronic surveys available online. Several vendors offer online survey tools that can be customized to meet your individual needs and will automatically tabulate confidential responses. You can place a computer in the reception room so patients can complete the survey as they wait to be seen. Provide a URL so they can complete the survey at

home or work if they prefer. These online survey tools also let you survey your own staff for their perceptions of the practice, benefits, office manager, morale, physician management abilities, and other important factors that may be impacting your bottom line.

Results should be tabulated either by the physician or the office manager and then presented to the managing partner or owner. If your practice has performed patient satisfaction surveys in the past, it is helpful to compare these so you can track progress. After presenting results to the physician(s), discuss results with employees individually in order to give praise or provide coaching for future improvement.

The results of any survey can be very informative. For example, they may show that the receptionist is sullen, is frequently occupied with personal phone calls, or ignores patients. Conversely, you may find that patients view the receptionist as very friendly, efficient, and personable. In any case, it is important to be transparent with employees about what you learn. For this reason, we recommend that all job descriptions include a performance metric based on patient satisfaction survey results. Achievement of that goal should be considered during yearly performance reviews for possible salary increase. Also document and discuss deficiencies and develop a corrective action plan.

It is also important to evaluate feedback on physician-patient communication. It can be enlightening for physicians to see how their bedside manner and communication skills are viewed by patients. Patient satisfaction surveys also give managing physician partners the opportunity to share constructive feedback with physician employees.

Patients may also indicate that they think the office should be redecorated or updated, that the janitorial effort needs improvement, or that communication of tests results could use improvement. One physician we worked with was surprised to find out that when he was concentrating on listening to the patient, he was frowning and patients perceived his look as "mean." In fact, he had a very warm, friendly smile and this survey feedback reminded him to smile when he was listening. The results of these surveys will give you a true picture of how patients perceive your practice and are useful tools for providing better customer service. Ω

UNDERESTIMATING THE VALUE OF PATIENT SATISFACTION

Some practices believe patient satisfaction surveys are not worth doing—that the data is unreliable or they can't justify the cost. The truth is that they can help you identify ways of improving your practice, which will translate into better care and happier patients.

It's essential for the success of any practice to satisfy patients and thoroughly understand their needs. Addressing patient needs also is the basis of all quality management programs. A patient satisfaction survey shows your staff and the community that you're interested in quality and that you are looking for ways to improve.

Another good reason for doing a patient satisfaction survey is simply to remain competitive. The environment physicians work in today demands that data on patient satisfaction be used to empower consumers. If physicians don't get on board, make the data as good as possible, and earn as high a score as possible, they are going to be hurt in the marketplace.

Ω TOOLS

A sample patient satisfaction survey is included in the Appendix.

Remember, these are the steps to follow in conducting patient satisfaction surveys:

• Do it.

• Use it.

• Track it.

• Repeat it (often).

Many practices do a satisfaction survey and then do nothing with the results. It can't be emphasized strongly enough that if you are going to conduct a survey you must plan to analyze the results and then use them! If you are not going to do the analysis or use the results to improve the practice, then there is no use wasting the time or money to do the survey.

Most practice surveys (when done once a year or even semiannually) ask about office visits that happened a long time ago, and the patient may only have a vague recollection of that visit. A more effective way to ascertain their satisfaction is to ask patients to check off a few boxes in a survey at the time of the visit or via a postcard mailed to them within a day of the visit. Keep the survey simple with just a few questions that address any practice's three general goals when interacting with patients:

• Quality issues -is the patient satisfied with his or her medical care?

• Access issues -is it easy to make an appointment or get a referral?

• Interpersonal issues -are the physicians and staff caring and compassionate?

You may think that quality is more important than access, but patients think differently. Data from the National Committee for Quality Assurance (NCQA) has shown that patients place access at the top of their list of what makes them satisfied.

High patient satisfaction levels, documented by ongoing surveys, can be very effective in helping a practice gain access to a new health plan or insurer or convincing a payor not to drop you from a plan in which you are already participating. Survey data documenting the value-added services you have provided to enrollees can also sometimes be a deciding factor in securing higher payments for your services since the carrier will not want to lose you.

PHYSICIAN REFERRAL SATISFACTION SURVEYS

For specialists, customers are both patients and referring physicians. In addition to patient satisfaction surveys, it is helpful to perform referral satisfaction surveys on an annual basis. You may discover a perception that your office is not handling referrals or authorizations efficiently or that patients are not scheduled in a timely fashion.

One physician we worked with learned that his blunt manner about communicating the need for weight reduction with female patients was disconcerting to the point that patients began complaining to their primary care physicians, who then stopped referring patients to him.

While many physicians have a set process for communicating patient status with referring physicians, you may also want to consider customizing your approach. For example, one physician specialist reports that he keeps a three-column list by his dictation station indicating which physicians prefer to be telephoned, faxed, or sent consult letters as follow-up on their patients.

Implementing Referring Physician Satisfaction Surveys

The survey for referring physicians should be quick and easy to complete. Respondents should be able to provide anonymous and confidential feedback. Survey response rates are generally higher when participants can answer questions freely without fear of being identified.

Make a list of your potential referring physicians (you can get addresses from either the local medical society or hospital). Send the survey with a cover letter thanking physicians for referrals and expressing your desire to better serve them and their patients. You can assure them of anonymity by mentioning that you are sending this survey to, say, over 50 physicians.

If you work with a consultant, consider having the consulting office mail out the survey on your behalf. Responses can go directly to the consultant to analyze in writing, further reassuring respondents that their identity will not be known.

Also promote anonymity by providing self-addressed stamped envelopes that list your address in both the addressee and addressor spots, to ease concerns about being identified by return address or office letterhead. If you have computer-savvy referring doctors and their e-mail addresses, another option is to design a custom online survey using an anonymous survey tool.

For physicians in groups, it is helpful to analyze the feedback by individual practitioner so results may be discussed one-on-one and you can develop an appropriate action plan. Ω ■

Ω **TOOLS**

A sample referring physician survey and sample cover letter are available in the Appendix.

5

Understanding Your Revenue Stream

By Linda Cole, Alan Morrison, and Melissa Lukowski, athenahealth, and Debra Phairas, Practice and Liability Consultants

In today's environment of decreasing reimbursement, consumer-directed health care, and increasing complexity around payor-specific payment rules and medical policies, it is imperative for solo and small group practices to understand and manage their revenue streams. Failure to do so can significantly impact a practice's viability, which directly impacts access to care. Operating inefficiently and ineffectively can also have a significant effect on delivery of quality care. Given the tremendous demands on already very busy office staff, how can a practice know that it may be facing tough times ahead and avoid financial crisis?

The key to preventing revenue shortfalls is to proactively monitor what is coming in the door. While it may seem unthinkable to add one more task to your already overwhelming list of things to do, proactive revenue monitoring helps you understand what you can depend on a few weeks down the road. More important, it helps you identify what may not be there so you can plan accordingly. This chapter presents simple techniques and tips for managing your accounts receivable (AR) through proven best practices in:

• Measuring days in accounts receivable (DAR) by payor, service, and provider

• Managing self-pay revenue stemming from co-pays, coinsurance, deductibles, and other "non-covered" services

• Benchmarking key financial indicators

• Understanding how to minimize DAR

These techniques are key to staying in the black and allowing physicians to shift their focus from financial concerns and administrative hassles to providing quality care.

MEASURING DAR

The first step in understanding your revenue stream is to look at how long it takes for you to receive payment for services you perform. Being aware of the time frames required to realize revenue is critical to knowing what you need to do to stay in the black. For example, California's prompt pay laws require payment of all preferred provider organization (PPO) claims within 30 working days of receipt. If your practice has not received payment on a PPO claim after 30 working days, the staff should be checking in with the payor to find out why. Δ

In fact, you may be due interest for late payment.

DAR is an industry term that measures the amount of time it takes for your practice to receive payment in full for services provided by the practice. DAR is calculated by dividing the total outstanding AR by the average daily charge. While this equation may not make a lot of sense at first glance, the components are actually quite straightforward once examined in further detail.

There are different ways of calculating your average outstanding AR and average daily charge. While some suggested methods use averages based on 365 days, others

Δ NOTE

Remember, in California, the timely payment clock doesn't start ticking until the payor receives a clean claim. A clean claim is one with no errors, omissions, deficiencies, missing documentation, etc.

calculate averages based on a seven-day period, typically the final week of the month. There is no right or wrong way, but one of the advantages of using seven-day averages is that these numbers tend to more readily reflect billing behavior changes, which provides early warning indicators for the practice. For our example, we will base our calculation on seven-day averages.

To arrive at your total outstanding AR, you will want to average the outstanding AR over a one-week period (seven days), typically the last seven days of the month.

For example, if we are calculating the outstanding AR on January 1 12/25, 12/26, 12/27, 12/28, 12/29, 12/30 ,and 12/31 and then divide by 7 to get the average outstanding AR.

For example:

Date	Outstanding A/R
12/25	$115,000.00
12/26	$120,000.00
12/27	$105,000.00
12/28	$108,500.00
12/29	$102,500.00
12/30	$107,000.00
12/31	$109,000.00
Total	$767,000.00

Once you have your total outstanding AR for the seven- day period, divide the total by 7 to get the average outstanding AR. In this example we would do the following:

$767,000 / 7 days = Average outstanding AR of $109,571.43

Now that you've calculated your practice's average outstanding AR, you will want to calculate the average daily charge. The average daily charge in this example is also based on a seven-day average of 60 days' worth of averages, which admittedly sounds a bit confusing. Note: The average daily charge data should be based on the date billed rather than the date of service (DOS) to accurately calculate the DAR. You don't want to include the lag time between DOS and date billed in your DAR calculation, as it is not part of the measurement of how long it takes a payor to pay your claim.

Using the same date range in the example above to calculate the average daily charge on 12/25, you would add up 60 days' worth of your billed charges, or 10/25 through 12/25, and divide by 60 to get the average daily charge for 12/25. For 12/26, you will add up the billed charges from 10/26 through 12/26 and divide by 60 to get the average daily charge for 12/26, and so on through 12/31.

Example:

Date	Average Daily Charge (based on 60 days of billed charges)
12/25	$ 2,850.00
12/26	$ 3,175.00
12/27	$ 2,450.00
12/28	$ 2,240.00
12/29	$ 3,570.00
12/30	$ 3,400.00
12/31	$ 2,450.00
Total	$ 20,135.00
Average	$ 2,876.43

Now that you have calculated both your average outstanding AR and your average daily charge for the period of 12/25 through 12/31, you are ready to calculate your DAR.

Example

Average Outstanding AR = $109, 571.43
Average Daily Charge = $2876.43
$109,571.43 / $2875 = 38.09 DAR

This calculation is also helpful in determining your DAR by payor. For example, let's say that in any given month, you run your average outstanding AR for Aetna, and it is $10,000. Let's also assume that your average daily charge with Aetna is $400. Calculating DAR by the equation outlined above, you would have a DAR of 25 days with Aetna ($10,000/$400 = 25 days). What this means is that, on average, Aetna pays you within 25 days from the date that you enter the claim into your practice management system.

As opposed to looking at straight cycle time categories (i.e., 30, 60, 90, and 120 days), which only factors in processing time, DAR considers how long it takes for a practice to receive payment based on the dollar amount of the service. The theory is that higher-dollar services for which payment remain outstanding longer have more of an impact on a practice's bottom line.

With operating costs on the rise, revenue becomes less valuable the longer it remains unbilled or in the hands of others. For the vast majority of practices, the largest percentage of revenue continues to come from third-party payors. Over the past several years, however, insurers have progressively increased the patient's share of cost by increasing co-payments, deductibles, non-covered services, and other out-of-pocket expenses. It is imperative for the practice to know, understand, and be kept up-to-date on each payor's rules for claim submission. Failure to understand a payor's unique payment rules and

medical policies will increase the cost of providing medical care and lower profit margins. All too often, practices do not become aware of these requirements until their claims are denied or rejected by the payor, requiring additional staff time and potentially physician time for medical necessity appeals, and increasing DAR. Δ

It is equally important that the practice have policies in place to collect the coinsurance and overdue balance amounts due from the patient at the time of service. If trends continue, more of the cost of health care will continue to shift to the patient. Therefore, the practice must have a defined process for understanding what the patient owes at the time of service and protocols for how to collect before the patient leaves the office. Δ

REVENUE BY PAYOR

The simple steps to analyze payor DAR are as follows:

Paint the Picture

To understand where outstanding revenue sits by payor, run a standard AR aging report that categorizes your outstanding AR by increments of time (e.g., less than 30 days, 31 to 60 days, 61 to 90 days, etc.). This report will give you a snapshot of your AR by payor and an indication of how long it takes each payor to correctly pay a claim. Most practice management systems have standard AR reports that can be run by payor. Check with your vendor about a system's reporting capabilities.

Ensure that the Outstanding AR is in Line with the Total Payor Volume

Run the aging report to show outstanding AR by payor. If the total dollar amount in the over-60-days category does not reflect the same percentage as your overall charge volume with that payor, it is important to examine that payor more closely. For example, if Cigna represents 5 percent of your total charge volume on average, yet the outstanding AR over 60 days for this payor is 15 percent of your total outstanding AR, this should be a red flag that you need to investigate further.

Drill into the Specifics

Assuming you have done the above and know which payors you should examine further, it is important to dig into the details to see if you can identify any important patterns or trends. Refine your report criteria to look at the following:

- Report by service/CPT code: Tells you how long it takes for you to receive payment for each service you perform. If you discover that a particular CPT code has an abnormally high amount of total outstanding AR, it could indicate a change in payor policy or even credentialing requirements for certain procedures. The key here is to identify trends that are negatively impacting your AR and act quickly.

- Report by rendering provider: Will help you identify providers that have a higher outstanding AR amount relative to their peers with a given payor. If this scenario exists, it could indicate a potential credentialing problem or that a provider or employee is not submitting charges promptly. It could also indicate that a provider's coding needs to be reviewed. Perhaps the physician is coding for a procedure that is not payable per the payor's medical or payment policies. Regardless of the root cause, proactively running and monitoring this report will help you frame the appropriate questions for the parties of interest.

Δ NOTE

A few states have laws in place that prohibit the collection of unpaid or underpaid claim balances directly from the patient. Consult the laws in your state to confirm.

Once you have determined which payors are taking longer to pay and, as a result, adding to your practice costs, you can develop a set of steps to pursue the issue with the payor.

While terminating a contract with a payor may not be an option, this data may be useful in renegotiating your agreements or, at a minimum, in helping you target your efforts to improve payment times. There are many sources of information on payor benchmarks that will allow you to compare your DAR with that reported by other practices. One excellent source is compiled by athenahealth, Inc., and is available at no charge on its Payer View website at www.athenapayerview.com. You may also want to check with your state medical and specialty societies or Medical Group Managers Association (MGMA) for information on DAR benchmarks.

MANAGING SELF-PAY REVENUE

As you did in your analysis of outstanding AR by payor, it is important to analyze the amount represented by self-pay. As the cost of co-pays, coinsurance, deductibles, and out-of-pocket expenses shouldered by patients continues to rise, so does the difficulty of collecting this revenue. Practices are assuming an increasingly complex collections burden that is driving operational costs up and lowering margins. In reviewing your self-pay AR, you will want to:

Determine Which Payors Contribute Most to Your Self-Pay Business

Which payors have policies with higher deductibles, co-pays, or coinsurance for which the patient is responsible? Which tools (e.g., real-time claim adjudication, deductible tracker information via eligibility verification) do these payors make available to assist you in determining the patient responsibility at the time of service? It's also important to have a clear understanding of the services that will be performed. For example, what care is the patient going to receive? What is the patient's coverage for that care? What is the remaining deductible?

Unfortunately, many payors do not provide up-to-date information on remaining deductibles for individual patients. You will have to do some proactive research on which tools payors are making available to help you determine patient responsibility. Those that do provide deductible information typically do so via their web portal. Other major national payors (such as Cigna) offer online tools to help you estimate the patient responsibility. If the payor in question doesn't have any such tools, we recommend that you develop a policy whereby you will collect a certain percentage at the time of service. Many practices find it easier to issue patient refunds than to chase the dollars.

Establish a Clear Financial Policy

One of the most effective tools for managing any practice's self-pay accounts receivable is a well-documented office policy. The practice must set expectations with both staff and patients, and then effectively communicate those expectations. Coordination between the front desk staff and the billing department is essential to the successful management of self-pay accounts receivable. Make sure that staff understand and can explain your financial policies and can answer any patient questions. It is strongly recommended that staff also explain your payment policies to new patients calling to make appointments. Patients should be required to read and sign your financial policy before being seen for the first time and again annually. The internal policy should detail procedures for the following situations:

BALANCE BILLING

California physicians should be aware that on January 8, 2009, the California Supreme Court put an end to the controversy surrounding "balance billing" of HMO enrollees in the emergency care context -the practice by out-of-network providers to bill patients the balance of an emergency care bill that the patients' Knox-Keene plan refused to pay. The Court in *Prospect Medical Group v. Northridge Emergency Medical Group*, __ Cal.Rptr.3d __, 2009 WL 36855 (2009) (*Prospect*), ruled that the Knox-Keene Act prohibits this practice of balance billing. The court clarified that providers may only seek recourse against the payors, not patients, for underpayments. The Department of Managed Health Care too has taken action to prohibit noncontracted providers from balance billing for emergency care services, promulgating a regulation, 28 C.C.R. sec. 1300.71.39, that defines such practices to be an "unfair billing pattern." The *Prospect* decision and the DMHC's regulation make it clear that balance billing for emergency care services is no longer permitted if the patient is covered by a Knox Keene-regulated plan (HMOs, certain PPOs, and any delegated medical groups or risk bearing organizations). For more information about the *Prospect* decision and its implications, see CMA's Balance Billing Toolkit at www.cmanet.org.

- Co-payments: Payment is expected at time of service (TOS).

- Out-of-network visits: Full (best practice) or partial payment is expected at TOS.

- Co-insurance/deductible: Best practice should be to require payment of this amount in full at the time of service.

- Outstanding balances: Payment in full is expected at time of service. Ideally, the account will be automatically flagged in your practice management system when there are balances due. Absent this functionality in your billing system, it is strongly recommended you have a process in place to flag the chart or encounter form so that the receptionist can collect, if possible, any outstanding monies due at patient check-in. Physicians should exercise caution in this area to ensure they do not turn away patients for failure to pay a bill and then be charged with patient abandonment.

- Payment plans: If your practice chooses to offer payment plans, you may wish, depending on the circumstances, to require at least partial payment before the new services are provided. Establish consistent criteria for developing payment plans and make sure billing staff is prepared to answer patient questions about outstanding or past due accounts. Ω

Verify Coverage Each Time a Patient Is Seen

Most payor websites will provide you with quick access to patient eligibility and benefits information. If the patient is showing as ineligible, ask that person whether he or she has changed insurance since the last visit. If the benefits information displayed on the payor website indicates the service will not be covered, it is best to advise the patient in advance.

Define Your Collections Policy

The longer it takes to collect, the less you will collect. At 90 days, accounts reach a critical depreciation period of .5 percent per day. According to a U.S. Department of Commerce study of depreciation of accounts held in house, at 120 days, your ability to collect has dropped significantly and the accounts are much more difficult to work. By 180 days, your ability to collect drops to less than 30 percent.

Seriously consider referring accounts over 120 days past due to a reputable collection agency. You can contact your state and local county medical associations for collection agencies in your area. You may also want to ask another practice if it is happy with the agency it is using.

A good collection agency will report to the credit bureaus, provide you with collection and aging reports similar to those your practice management system generates, and meet with you regularly.

REGULARLY MONITOR FINANCIAL BENCHMARKS

Benchmarking is the practice of comparing industry best practices against your own to identify areas that need improvement. The financial benchmarks and ratio analyses we will discuss in this section are not absolutes that your practice must achieve. Instead, they are tools for examining and analyzing your business and can help you identify and address inefficiencies that impact your practice overhead, staffing productivity, and ultimately, your income. Your office manager or billing service

Ω TOOLS

Sample financial policy forms and notices are available in the Appendix.

PHYSICIAN COMPENSATION AND COST SURVEY

One benchmarking resource that provides a wealth of specialty-specific information is the Medical Group Managers Association (MGMA)'s yearly Physician Compensation and Cost Survey. Your specialty society may also conduct such studies.

should prepare this information for you on a monthly basis and should also provide year-to-date information. It is important to analyze this data over six to 12 months for highs and lows.

Ideally, your office manager will have a strong background in the business of medicine and can assist you by analyzing and reporting on the key benchmarks. The manager should be encouraged to stay current with industry benchmarks.

The following ratios and information should be presented and discussed with the physician within seven days after the close of every month to ensure you are reviewing the most current data.

Gross Collection Percentage

Gross Collection Percentage = Collections / Charges

The gross collection percentage measures the percent of gross collections to billed charges. If you have not updated your fee schedule for several years, if your production has remained the same, and if this ratio decreases, it indicates you have agreed to accept deeper discounts in your contracts. This would be a sign that you need to update your usual and customary rates and/or to renegotiate your contracts. Adjusted or Net Collection Percentage

Adjusted Net Collection Percentage = Net Collections / (Billed Charges –Adjustments)

The adjusted net collection percentage can directly measure the ability of the staff to collect money due the practice after discounts and contractual adjustments. In addition, this information can provide insight into substandard contracts or payor nonperformance. This ratio should be over 95 percent. Ratios above 100 percent can indicate that production/volume or billed charges have decreased during this period or that additional adjustments are being taken that are above the norm. An audit of explanation of benefits (EOBs) matched with claims and charts should be performed monthly to make sure staff is correctly appealing underpaid claims and not making inappropriate adjustments.

It's also critical that the physician and office manager know and understand the terms of the contracts signed, including the reimbursement rates agreed to, payment rules, and medical policies. Many practice management software systems let you enter reimbursement rates and will immediately flag accounts when the payment amount does not match the contracted rate. Check with your software vendor about whether your system has this functionality.

Aging Spread Comparison

This ratio is specialty specific. Your percentage in these categories should be compared to your specialty norms.

Days in AR	0-30	31-60	61-90	91-120	120+	Total AR Balance (should equal 100%)
Total $ amount in each AR category	$72,000	$14,400	$9,600	$8,400	$15,600	$120,000
% in each category (divide total AR balance by amount in each category)	60%	12%	8%	7%	13%	100%

The goal for most specialties is to have less than 15 percent of their claims in the 120-days-and-over category. The older the account, the less likely the practice is to collect on the amount.

HOW CAN A PRACTICE IMPROVE ITS DAR?

Once you have examined the steps you can take to review revenue and identify areas of concern, it is time to look at how you can proactively improve your DAR.

Here are best practices that will help you improve DAR:

TOS Charge Entry

Employ time-of-service (TOS) charge entry as a guiding principal. TOS charge entry helps you decrease DAR by decreasing the time it takes for the payor to receive your claim and for you to receive payment.

Understand Payor Requirements

One way to decrease DAR is to understand how much of your outstanding AR is due to payor denials that remain unresolved. Do your part by understanding the payor's medical and payment policies so that you are submitting a clean claim and avoiding appeals on the back end. Every time you touch a claim, it costs your practice money and reduces profit.

Use Electronic Transactions

The key to streamlining your transactions with all parties is to complete transactions electronically whenever possible. While electronic claim submission is more expected today than in the past, make a point of billing electronically whenever possible, at least for your major payors. Additional information on HIPAA compliance can be found in Chapter VI. ☼

Verify Eligibility and Benefits Information

Many denials stem from patient eligibility issues. Prevent these by verifying eligibility and benefits each time a patient is seen in your practice.

Sign up for Electronic Remittance and EFT

Electing to receive your EOBs electronically (referred to as electronic remittance advice or ERA) and payments (referred to as electronic funds transfer or EFT) can shave as much as five to eight days from the standard time frame for payment, by eliminating the wait for USPS to deliver paper EOBs and checks. And having funds transferred electronically eliminates the need to physically deposit a paper check. Together ERA and EFT can mean a great deal of savings in processing time. For an in-depth discussion on EFT, see CMA ON CALL Document#1609, "Electronic Funds Transfer."

BEYOND AR BENCHMARKING

In addition to monitoring your AR closely and benchmarking against specialty norms, it is equally important to keep an eye on other benchmarks that affect your practice's viability.

Key financial indicators that every physician needs to know about and monitor on a monthly and yearly basis:

1. Physician Productivity
2. Revenue and Net Income
3. Overhead Ratios
4. Staffing Ratios

Physician Productivity

Understand what level of productivity is needed to achieve financial goals. Learn about benchmark norms for your specialty regarding number of yearly/monthly/daily office visits, hospital visits, surgeries, and procedures.

The MGMA Physician Compensation Report profiles the number of office visits, hospital visits, and surgery or procedures by mean, median, 25th,, 75th, and 90th percentile. Work relative value units are also profiled. Physician net income is one factor of physician productivity. If you are at the 25th percentile of productivity, you may also find that you are in the 25th percentile of net income. In higher rent or staff cost areas, often it is necessary to perform at the 60th percentile to achieve median net incomes.

Revenue and Net Income

Prepare profit and loss reports monthly and understand revenue and net income norms for your specialty. Your profit and loss report is a financial management tool, not just an accounting tool. It is important to know what the typical physician in your specialty collects in actual revenue and what the net income norms are for the specialty. In addition to productivity standards, the MGMA Physician Compensation Report provides data on charges, collections, and physician compensation and net income by specialty.

Overhead Ratio by Expense Category

Prepare profit and loss reports with item expense ratios for your specialty. A neurosurgeon, for example, will have a lower overhead ratio than a family practice physician. Most physicians know their total overhead ratio, but do not know how the individual line item expenses compare with those of others in their specialty. In physician practice management, we translate each line item expense into a percentage of net collections. For example, you want to convert rent costs into a ratio to collections or actual revenue received, not billed charges.

Example Overhead Ratio

Rent costs = $48,000

Net collections = $500,000

Divide 48,000 / $500,000 = 9.6% of net collections goes toward rent

Using a program like Quickbooks or Microsoft Excel to track this information can make it easier to quickly access the data. Alternately, encourage your CPA to add a column on your profit and loss report that divides each category of expense into collections to demonstrate the ratio you are spending for this type of expense.

Create separate line item categories for revenue-producing supplies like immunizations. These categories should not be included in the medical supply costs for items like cotton balls and the like.

For benchmarking purposes, separate out physician owner compensation from mid-level employees (physician assistant /nurse practitioner) and other staff, including physician employees. If the practice is a corporation, the owner physician's compensation is often included in the overall expenses. Organize the corporation profit and loss report so that physician compensation and expenses appear at the bottom after practice expenses, to show the true operating cost expenses for benchmarking purposes.

Compare your total overhead and line item ratios with benchmarks to determine if you are over or under the norm. Staff and rent are the two biggest expense categories for physicians and should be carefully monitored and considered, for example, when taking on new rent space. If the rent norms for your specialty are 7 percent and the new space is projected to cost 12 percent, your net income will decrease unless revenue increases or you are able to cut costs in other areas. Project the cost and overhead ratio for the new space to your collections to see if you can afford that space. Perhaps you will be hiring another provider to assist with your practice, increasing the capacity for patient visit, which should increase gross revenue.

Sample Profit and Loss Report

Revenue

Revenue	
Patient Fees	$530,000
Refunds	-$15,000
Total Net Revenue	$515,000

Overhead Expenses	Actual Expense	% of Net Revenue
Accounting and Legal	$5,150	1.00%
Bank Charges	$250	0.05%
Dues and Subscriptions	$3,500	0.68%
Insurance		
General	$1,800	0.35%
Malpractice	$9,000	1.75%
Health, Dental Staff	$15,400	2.99%
Workers' Comp	$2,926	0.57%

Medical Supplies

Medical Supplies		
Immunizations	$20,600	4.00%
Regular Medical Supplies	$5,150	1.00%

Office

Office		
Office Expense Other	$2,000	0.39%
Office Supplies	$10,300	2.00%
Postage	$900	0.17%
Rent	$36,050	7.00%

Staff Wages	Actual Expense	% of Net Revenue
Manager	$45,000	8.7%
Billing	$38,000	7.4%
Front Office	$32,000	6.2%
Medical Assistant	$34,000	6.6%
Medical Records	$5,000	1.0%
TOTAL STAFF WAGES	$154,000	29.90%
Taxes Payroll	$11,781	2.29%
Telephone	$5,000	0.97%
TOTAL OVERHEAD	$283,807	55.11%
MD Net Income	$231,193	

Staffing Ratios

There are two key ratios to analyze and compare to determine if your staffing pattern is within norms—staff wages as percent of revenue and full-time-equivalent staffing ratios.

Staff Wages as Percent of Revenue

Compare average staff wages to net revenue/collections for your specialty by type of staff. It is important to separate staff by type in the profit and loss report. The following example shows the areas that are over or under the benchmarks of what other physicians are spending on the type of staff members. The ratios should be similar, even with national benchmarks, because reimbursement (e.g., Medicare) rates adjust for overhead in some areas. Very high cost areas, for example San Francisco or Los Angeles, may be 3 to 5 percent over benchmark norms for staff costs.

Revenue – $515,000

Staff Wages		Your Practice	Benchmark
Manager	$45,000	8.7%	5.50%
Billing	$38,000	7.4%	6.00%
Front Office	$32,000	6.2%	6.50%
Medical Assistant	$34,000	6.6%	5.00%
Medical Records	$5,000	1.0%	2.00%
Total Staff Wages	$154,000	29.90%	25.00%

Full-Time-Equivalent (FTE) Staffing Ratios

Staffing benchmarks should be expressed as full-time equivalents (FTE). Divide the normal hours worked per week by 40 hours (full time) to obtain the FTE for each position. Then add these up to obtain your total staff FTE ratio for the practice by physician. If you have more than one physician in the practice, you will want to determine the number of FTE physicians, then divide the FTE staff by FTE physicians to

obtain the comparison. Compare your staff FTE with benchmarks to see if you have the usual amount of staff for the various positions and where you may be under or over the norms.

Example: Based on a Solo Physician Practice

Staff	Hrs Worked Per Week	FTE	Benchmark	% Variance
Manager	24	0.60	0.30	+50.00%
Billing	32	0.80	0.75	+6.25%
Front Office	40	1.00	1.10	-10.00%
Medical Assistants	40	1.00	0.80	+20.00%
Medical Records	10	0.25	0.33	-32.00%
Total	146	3.65	3.28	+10.14%

Analysis of Staffing Ratios

It is important to look at staffing costs as a percent of practice revenue. If the practice is high performing and at the 90th percentile of revenue and physician net income as compared with benchmarks, these ratios may be higher than the norms. More staff are needed for higher-performing practices, and if the physician net income is at the 90th percentile, these staff levels are probably necessary.

If your FTEs are within the norm, but the percent of net revenue is high, your practice may have the correct amount of staff, but the wages may be at the top of the pay scales due to staff longevity. A billing, collection, or physician productivity issue could also be contributing factors for lower-than-expected net revenue. Either way, if one of the two numbers is outside of the norm, it should trigger a look at why the collections seem lower than usual or physician productivity appears below the norm.

If both indicators, staffing percent of revenue and FTEs, are below the norms, the practice may be understaffed. In the example in the chart above, both the medical records percent of revenue and FTEs were below the norm. This may be the reason why medical record filing is behind. It could be that there is not enough staff for filing/pulling charts.

Also in the above example, the medical assistant category was higher than the norm for both staffing percent to revenue and FTEs. This finding may indicate overstaffing in that area. It could mean you should consider shifting some of the medical assistant's time to help the medical records person pull and file charts.

It cannot be emphasized strongly enough how important it is for solo and small group practices to understand and manage their revenue streams. By following the advice in this chapter, you will be better poised for financial success in today's challenging health care environment and will be able to focus on providing high-quality care to your patients rather than on whether you will be able to keep your doors open. ■

6

Practical Steps Practices Can Take to Ensure HIPAA Compliance

By David Ginsberg, PrivaPlan Associates

Most medical practices feel they have done all they need to do to satisfy Health Insurance Portability and Accountability Act (HIPAA) requirements and are reluctant to dedicate precious resources to additional compliance efforts. However, a number of gaps can expose medical practices to patient identity theft and violation of state laws that may be far stricter than HIPAA requirements.

Rather than reviewing HIPAA regulations in depth, this chapter provides an overview of information that will help you remain HIPAA compliant.

HIPAA ENFORCEMENT

HIPAA enforcement is real. The latest data from the Office of Civil Rights (OCR) show that complaints and investigations are increasing. As seen in Figure 1 below, HIPAA complaints have increased since 2003 by 117%. Most complaints are initiated by disgruntled employees.

Figure 1 - Health Information Privacy Complaints Received by Calendar Year
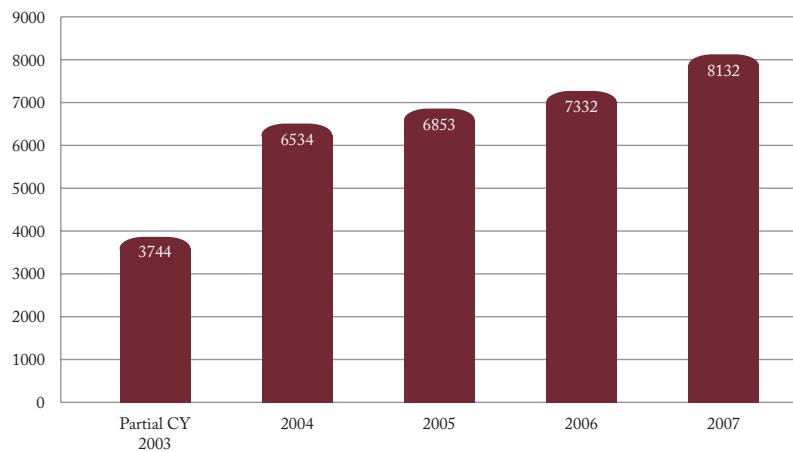
HIPAA COMPLIANCE RESOURCE

For an in-depth guide to HIPAA compliance, medical practices can purchase a complete do-it-yourself tool for HIPAA compliance developed by the California Medical Association (CMA) and its HIPAA partner, PrivaPlan Associates, at www.privaplan. com. Physicians in other areas should contact their state and local medical associations or PrivaPlan for more specific information about HIPAA compliance.

For these reasons, it is more critical than ever for physicians to review their current policies and procedures and upgrade them, if necessary.

Federal law does not create what is known as a private cause of action under HIPAA. In other words, individuals cannot sue for a privacy or security violation citing the HIPAA regulation. Only the federal government can enforce HIPAA and take covered entities to court for violations. However, some states have allowed private parties to bring actions seeking remedies for violations of HIPAA.

So, while HIPAA enforcement has been driven by complaints to either OCR or the Centers for Medicare & Medicaid Services (CMS), these cases have opened the door for successful private lawsuits against physicians when a privacy or security violation occurs.

HOW CAN YOU LOWER YOUR RISK?

The best defense against a HIPAA-related action is to not have a privacy or security violation occur. Here are the minimum steps any HIPAA-covered entity should take:

1. Periodically review your HIPAA privacy and security compliance efforts.

2. Ensure your policies and procedures are up-to-date.

3. Ensure that your policies and procedures actually "work," are understood by employees, and are implemented.

4. Ensure your training is up-to-date for all employees, board members, key contractors, etc. Employees should be required to annually review and sign a statement that they have read and understand the office's HIPAA privacy policies. (This information should be stored in personnel files.)

5. Ensure that key procedures are in place (such as the complaint procedure).

6. Ensure that your business associates have written agreements in place.

7. Ensure that you report and respond to any and all privacy and security incidents.

8. Ensure that your workforce and patients understand they will not be retaliated against if they complain about or notify you of a privacy or security breach.

MEDICAL IDENTITY THEFT

Medical identity theft is on the rise. In some cases protected health information is stolen to submit fraudulent claims; in others the information is being used to obtain health care coverage itself (i.e., the identity of an insured individual is assumed). And the risk comes not only from outside sources such as hackers. You must also ensure that sensitive patient data is available only to staff who need to access that data.

Some Practical Steps You Can Take

Establish (and Follow) Workforce Clearance Procedures

It has become increasingly important to do effective criminal background checks on employees who will have access to protected health information. Be sure to follow state and federal laws regarding how you notify a new employee of an impending background check and how you apply the findings.

Develop Effective Workforce Access and Authorization Protocols

In the "old days" it would take a large truck to steal information on even a small solo practice's patients. Today it requires a USB thumb drive and a few minutes. As more and more organizations convert to electronic health records and use portable devices, this threat becomes greater.

Are employees restricted to accessing only the information needed for their jobs? If not, most practice management systems have security features that will allow you to limit access by user. We strongly recommend contacting your vendor to find out how to use this feature.

Establish Effective Workforce Termination Procedures

Policies should be in place to terminate all access to protected health information, including systems and building access, immediately upon the termination of an

employee. Policies should be in place to discourage the sharing of system passwords. If you provide staff with keys to your office, make sure each key is clearly stamped "Do not duplicate." This will alert locksmiths not to make duplicate keys. Finally, be cautious when giving employees or others access to your Medicare and Medicaid provider transaction access numbers (PTAN). There have been many cases where these numbers have been acquired fraudulently to submit bogus claims. This also applies to other personal information that can be used to obtain Medicare and Medicaid provider numbers. If you suspect your provider number has been stolen, report it immediately. Check with your local Medicare and Medicaid fiscal intermediary about how to report fraud.

Routinely Review System Activity

It is important to routinely review system activity and conduct technical audits to monitor suspicious activity. Your practice management system should have auditing capabilities to track employee activity in patient accounts. You may not have doubts about the integrity of your staff, but even trusted staff may be inappropriately accessing/using patient information. Schedule enough time every month to go over reports with your office manager or administrator. Make sure you understand the data and ask questions if you don't.

Maintain Data and Equipment in an Encrypted Mode

All electronic devices and data should be password protected to prevent theft.

Use Security Reminders

Use periodic security reminders and alerts to keep your workforce vigilant and on the lookout for security incidents.

These steps are, of course, just part of your overall HIPAA compliance program. Make certain your organization has done everything it can to protect sensitive data.

COMPLIANCE REVIEWS AND INVESTIGATIONS

In the case of a complaint or investigation, HIPAA requires cooperation from covered entities, sometimes including allowing investigators access to facilities, records, and other information at any time, without notice. Ω

Ω TOOLS

A list of information that might be requested in a HIPAA investigation or compliance review is included in the Appendix.

NOTICE OF PRIVACY PRACTICES

All physicians covered by HIPAA are required to provide their patients with a written notice of the privacy practices (NPP) they use to protect patients' health information. Covered physicians that maintain a physical delivery site must post their privacy practices in a prominent place likely to be seen by patients.

HIPAA also requires that providers with a "direct treatment relationship" use their best effort to have the patient sign an acknowledgement of receipt.

If you at some point revise your privacy practices, you need only make the revised version available *upon request* (and of course replace your existing posted NPP as well as the one you provide to new patients). You do not need to resend the revised NPP to all existing patients.

Also remember that if you have a website, you must prominently post the NPP on your website and make it available to viewers who request a copy.

Sample NPPs in English and Spanish are available as part of PrivaPlan's HIPAA compliance toolkit.

PROTECTING INDIVIDUALS WHO COMPLAIN

Covered entities should be especially vigilant when handling complaints so there is not the impression of retaliation. Such a signal may not always be obvious to you, but to your employees or patients who complain, sometimes even subtle and unrelated actions can feel like retaliation. For example:

• Rescheduling patients who have complained or "passing them off" to other providers

• Disciplining an employee who has complained for an unrelated workplace action

Some Practical Tips

1. Be sure you have written policies and procedures and that every member of your workforce has been trained in these procedures.

2. Review your current Notice of Privacy Practices and be sure it clearly states that the individual will not be penalized or retaliated against for filing a complaint.

3. Review your complaint and whistleblower policies and procedures. The CMA/ PrivaPlan HIPAA Privacy and Security Compliance Toolkit contains appropriate language for this. The toolkit is available for purchase at www.privaplan.com.

4. Whenever a patient or member of the workforce files a complaint, immediately ensure that your key managers, owners, and other relevant supervisors understand they should be careful not to act in a way can been interpreted as retaliatory or intimidating.

5. Of course, handle complaints immediately and with full documentation.

6. If you find you have legitimately violated HIPAA, implement a corrective action plan. ■

7

Successful Preparation and Implementation of an Electronic Health Records System

By David Ginsberg, PrivaPlan Associates

Selecting, purchasing, and implementing an electronic medical records (EMR) or electronic health records (EHR) system is one of the most complex and resource-intensive activities any medical practice can undertake. Despite advances in technology, even with the best planning and preparation, problems will undoubtedly arise. Experience has shown that firm resolve and commitment is necessary to withstand these pressures. Key to maintaining this resolve is appreciation of the business case for adopting an electronic health records system.

EMR VS. EHR

Many people use the terms EMR and EHR interchangeably. So what is the difference?

In general, EMR systems replace the paper medical records or charts maintained within a physician's practice. EMR systems, which have been around for many years, can range from the scanning and digitizing of paper records and medical charts to more complex systems.

Electronic health record, or EHR, refers to systems that go beyond simply providing an electronic form of a medical record. An EHR is a comprehensive health record and includes the following:

- Interoperability: the ability to exchange information with other sources—for example, to order laboratory tests and integrate results directly into the record.

- Decision support: the ability to use information about the patient within the EHR in combination with external information (such as diabetes care guidelines) to guide the physician in patient care. Decision support can also include warnings and alerts such as a potential drug interaction during the prescription-writing process.

- Continuity of care: the ability to exchange and interface patient clinical data with other health care providers such as hospital emergency departments or specialists and provide patients with their own personal health record.

Through these features, EHRs can provide increased communication, coordination, and decision support. Additional benefits include reduced medical errors, improved quality of care, and saving of physician time[7][8]. By reducing errors, improving timely physician access to necessary patient information, reducing adverse drug events, and providing clinical decision support, EHRs can improve quality of patient care.

For these reasons, this chapter will focus on EHRs rather than EMRs. We will discuss the steps you should take to determine whether an EHR is right for your practice and if so, how you can avoid mistakes commonly made during the selection and implementation phases.

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[7] Berman, Jeff. "Safety Centers and EMRs." Health-IT World, 2004. Available at http://www.health-itworld.com/emag/050104/183.html (accessed August 11, 2004).

[8] Hier, Daniel, Adam Rothschild, Anne LeMaistre, and Joy Keeler. "Differing Faculty and House Staff Acceptance of an Electronic Health Record." International Journal of Medical Informatics 74, no. 7/8 (2005): 657-662.

WHAT IS A BUSINESS CASE?

Most medical practices don't think in terms of business strategies, return on investment, long-term cash flow analysis and projection, etc. They should, however, because implementing an EHR is one of the most important business decisions a practice can make.

A business case is a set of considerations that justify a particular business strategy, investment, or process. It is the rationale for a particular business decision. Because of the complexity and cost involved with electronic systems, it is imperative that medical practices identify the business cases for such a significant business decision. Throughout the implementation, medical practices may need to remember and rearticulate the business case in order to make necessary decisions.

Here are potential business cases for implementing an EHR in the current environment:

1. Reducing office staff time spent looking for paper charts.

2. Providing access to medical records anywhere and anytime. This can improve quality and continuity of care along with efficiency, notably, for example, for an on-call physician or a multiple-location practice.

3. Improving legibility of medical records. Illegibility of the paper record alone can cause errors. Handwritten and hard-to-read notes are replaced by computerized text.

4. Accessing drug recall or other patient alerts based on criteria such as the prescription medications the system has on file.

5. Reducing filing time by automatically loading laboratory results and other diagnostic tests.

6. Reducing filing time and paper-handling by scanning documents and appending or attaching to the medical record.

7. Reducing time spent filling out forms and tracking and managing prescriptions, laboratory results, or diagnostic test orders.

8. Reducing time spent copying records for the numerous records and access requests/transfers a practice receives.

Business cases for implementing an EHR in the future or with emerging best practices:

1. Implementing evidence-based practices using clinical guidelines and other data.

2. Improving patient safety and quality improvement.

3. Ability to review quality metrics and report data to health insurers' pay-for-performance programs.

4. Increasing the ability to share information with health information exchanges and health information networks (such as an immunization registry or a regional health information network).

5. Improving the ability to analyze patient populations and participate in clinical trials.

All of the above business cases point to the most important business case, which is the ability to improve quality of care.

A discussion about EHR preparation is not complete without reviewing how practice management (PM) software fits in. Most EHR vendors now include an integrated PM module that incorporates billing and collections or, at a minimum, can create an interface with your PM system. Without an integrated billing and collections module or interface, your practice will be forced to perform dual entry of patient demographic and billing information, which can be a significant drain on staff time.

THE EHR IMPLEMENTATION PROCESS

Many practices have staff who are already overwhelmed and find their administrative overhead steadily increasing. Commonly, offices struggle to keep up with the tremendous demands of third-party payors, referral management, scheduling, and paperwork.

It is also a challenge for many practices, especially those in rural areas, to recruit, train, and retain qualified and experienced staff. Selecting and implementing an EHR system can place additional strain on staff and resources. If practices don't plan for this change, they will likely create more work and defeat the intended purpose of increasing efficiency. Experience has shown that a multistep process is the best way to plan for change, including:

• Performing a needs assessment

• Performing a readiness assessment

• Performing a work flow analysis

• Creating your road map for selecting and implementing a system

In this chapter, we will walk you through each of these steps.

THE BEST WAY TO DO A NEEDS ASSESSMENT

Performing a needs assessment is your first step in the EHR selection and implementation process. It is a step that won't be finished until you complete two additional steps: the readiness assessment and the work flow analysis.

The needs assessment has one primary purpose: to help you clearly define what you need in an EHR. In the process, you may discover that your needs can be met without an EHR, perhaps by improving your business processes or use of forms or improving your current technology and computer systems.

The best way to complete a needs assessment is to involve all the "stakeholders" who will ultimately use the EHR. This is sometimes known as a "facilitative" process because it facilitates feedback from all involved people. It not only assures that you will have appropriate feedback and information; it also creates a sense of ownership and involvement in the process, which may improve physician and staff buy-in and use of the system later on.

Stakeholders include just about everyone in a typical physician practice:

• Office managers or administrators

• Front desk and scheduling personnel

• Billing and collections staff

• Filing staff

• Medical assistants or nurses

• Physicians, nurse practitioners, and physician assistants; as well as other health care providers, if applicable

• Your billing service, if you use one

• Your computer support staff, if applicable

Performing the needs assessment is relatively straightforward. Once your team is assembled, ask all participants to describe how they believe an EHR will improve their job and what they believe they need from a system. Some people may not have seen an EHR before and won't know how to describe potential benefits of implementing one. Some practices find it valuable to have a web-based demonstration of one system just to get an overview, or to visit a colleague who is already using an EHR.

COMPLETING A READINESS ASSESSMENT

The next phase of preparation is a readiness assessment. This is a very important step and should not be overlooked. Many practices have done a good job defining their needs and selecting an appropriate vendor, only to fail in their implementation because they were not ready. Sometimes the readiness assessment will reveal enough deficiencies in the practice to warrant either delaying or discontinuing your search for an EHR until the deficiencies are addressed and resolved.

The readiness assessment looks at both your internal and external environment. Below are some areas you should

evaluate. Use this as a guide and add any other readiness questions that may be appropriate for your practice. The answers can help you determine your EHR "road map" (described in the next section) or decide whether or not to move forward with an EHR. They can also help you figure out whether to resolve some or all of these readiness issues before proceeding or concurrently with implementation.

A readiness assessment involves asking yourself the following questions:

1. What is the financial status of the practice?

Why this is important: If your practice is having a cash flow problem and finding it difficult to keep up with bills, or the physicians have not yet been able to achieve projected earnings, then purchasing an EHR will only compound the situation. Similarly, if you have a financial challenge on the horizon (perhaps you are planning to hire a new physician and subsidize the salary until that person can pay his or her own way), an EHR may not be the best purchase for your practice at this time.

Considerations:

• Is there a significant identifiable accounts receivable problem?

• Are financial challenges on the horizon?

• Can the practice afford an EHR?

2. What is the practice's strategic plan?

Why this is important: If acquiring and implementing an EHR is not part of your strategic plan, you may need to consider delaying or reprioritizing.

Considerations:

• Are there competing corporate priorities such as practice merger/acquisitions or affiliations?

3. Are you implementing other technology?

Why this is important: Implementing other technology (for example, a new diagnostic device or practice management system) may require significant staff resources for a period of time. It may not be wise to place competing demands on already limited staff by concurrently implementing an EHR.

Considerations:

• What kind of technology is being implemented?

• How much staff time or resources will be allocated for implementation of the other technology?

4. Are there any major staffing changes on the horizon?

Why this is important: Any change of key physicians or staff can be a strain on a practice, and an EHR project could wind up creating a competition for resources. Training staff to use an EHR as they prepare to leave the practice is also problematic. And the stress of losing or replacing a physician, office manager, or key billing person makes concurrent implementation of an EHR impractical.

Considerations:

• Which staff or physicians are leaving?

• What role do they play in the practice?

• What is the retirement or leave date?

• Do you have a succession plan in place?

5. Is the practice understaffed today?

Why this is important: If the practice is understaffed today, introducing a new EHR system will compound that problem, and failure of implementation could result.

Considerations:

• In what areas is the practice understaffed?

• Do you have plans to hire new staff?

6. Where will the new computer server be placed? Is there enough room for any additional equipment?

Why this is important: Often a practice's existing server sits in a closet that is not air-conditioned and has inadequate power. An EHR system may entail bigger servers and more workstations. The server certainly must operate in an air-conditioned environment with enough space to be accessible to support personnel.

The server location must also be physically secured and protected from unauthorized access.

Considerations:

• Is there adequate space?

• Is there adequate power?

• Is the facility capable of additional cabling for computers (i.e., asbestos or mortar walls)?

• Do you have ergonomic furniture to support computer workstations? Will you need to adjust heights of desks or chairs?

• Is there fire suppression for the computer servers?

• How is the power quality and reliability in your area?

• Do you have power backup?

• Is there adequate air-conditioning?

7. Are your existing charts ready for conversion?

Why this is important: Usually a practice will develop some form of conversion plan for existing charts. If the charts currently are out-of-date or too thick, you might consider reviewing them before implementing an EHR. Thinning of the chart might immediately bring some relief in terms of space and ease of filing for new information in the physical chart. However, before you discard any medical

THE IMPORTANCE OF COMPLETE MEDICAL RECORDS

Incomplete medical records can also jeopardize a physician's ability to obtain proper reimbursement. With increased cost containment efforts by third-party payors, physicians' medical records are subject to increased scrutiny. Incomplete medical records also interfere with other physicians' ability to perform peer review and therefore maintain the quality of health care delivery, exposing a physician to possible disciplinary action or severe sanction by outside review agencies. Finally, medical records are often a physician's best evidence in a professional liability lawsuit, and inadequate records may undermine the ability to defend oneself. ✹

✹ ON CALL

For more information on medical record retention and contents of medical records, see CMA ON CALL Document #1160, "Retention of Medical Records" and Document #1135, "Contents of Medical Records."

record information, we strongly recommend you consult with an attorney or your malpractice carrier or both. Medical records serve as a basis for planning and maintaining quality of patient care and when patient records are devoid of important information, other treating physicians and health professionals may remain unaware of important aspects of a patient's condition. Additionally, if medical records are to be destroyed, precautions should be taken to protect the privacy of this information. It is a violation of the Confidentiality of Medical Information Act to negligently dispose of, abandon, or destroy medical records in a manner that fails to preserve their confidentiality (Civil Code §56.101).

Considerations:

• Are you out of space at this point in time, or will you be soon?

8. Do you have plans to relocate?

Why this is important: If your practice is about to relocate, seriously consider postponing the new-system implementation until after the move. Relocation demands significant staff and management resources.

Considerations:

• When do you plan to relocate?

• Does the new facility have enough room for any additional equipment?

9. Do you have physician champions for the EHR?

Why this is important: It is essential to have as many physician champions as possible who will lead or support the cause for implementing an EHR. Often practices include some physicians who want to move ahead with this change and others who find it difficult to give up old ways of doing things—making implementation very challenging. Moreover, staffers may feel anxious that the EHR will replace their jobs, which creates some tension and opposition.

Considerations:

• Do champions exist?

• Do you anticipate resistance?

External enviroment readiness factors:

10. Do you have quality high-speed Internet connectivity?

Why this important: High-speed connectivity is essential for data exchange, such as electronically receiving laboratory results.

Considerations:

• Is redundant high-speed connectivity, such as DSL or cable, available in your area?

• Is it affordable?

11. Is your IPA or area hospital offering a discounted or subsidized EHR?

Why this important: If you belong to an independent physician association (IPA) or network, it may offer a discounted solution. Similarly, some hospitals offer discounted or subsidized systems and may also provide implementation and hosting support.

Considerations:

- Does the discounted or subsidized EHR include an integrated practice management system?
- Are there any drawbacks to the deal?

PERFORMING A WORK FLOW ANALYSIS

Concurrent with the readiness assessment, you should begin the work flow analysis. A work flow analysis involves reviewing how your practice completes the work associated with the patient encounter and all related components. Some examples:

1. Scheduling the initial visit

2. Scheduling follow-up visits

3. Scheduling referrals or diagnostic tests

4. Receiving and reviewing tests or referral results

5. Prescribing medications and handling refills

6. Entering clinical notes

7. Billing and collections

The work flows or processes in your practice require information intake as well as output. Some examples:

Information you may obtain from patients and enter into their medical records:

- Demographic and billing information

- Medical history form, list of current medications, etc.

- Forms the patient signs that are then filed, such as the HIPAA acknowledgment of receipt of the Notice of Privacy Practices, a waiver form, informed consent, and so forth

- Provider notes, including vital signs, chief complaint, and notes from the examination/consultation and assessment/plan

- Documentation of calls to verify insurance eligibility and benefits, which is entered into the billing software

- Copies of prior medical records

Information you may export from the patient's chart:

- Referral forms for diagnostic services, such as reference laboratory requisition forms or radiology referral forms

- Referrals to other physicians or health care providers

- A report or narrative to send to the referring physician

- Prescriptions

- Referral authorization forms to send to the health insurer

HIPAA AND ELECTRONIC HEALTH RECORDS (EHR)

Implementing an EHR often requires a new evaluation and assessment of existing HIPAA privacy and security practices. This assessment must focus on whether existing safeguards are sufficient or in need of improvement. Many practices currently have weak HIPAA compliance plans in place or have allowed their HIPAA compliance plans to lapse. This problem can be exacerbated by implementation of an EHR.

EHR systems greatly expand vulnerabilities of protected health information. In a paper-based practice, a chart or medical record must be physically accessed in order to be compromised. Since there is only one "copy" of the record available, it can be guarded and protected from unauthorized access with relatively simple safeguards (locking the office, locking the chart racks, restricted access after-hours, and so forth).

With paper charts, identity thieves seeking to steal all your paper records to extract Social Security numbers or info on health status or benefits would need to find a way to break into your facility undetected and probably use a truck to cart away all the charts. With an EHR they can simply break in and steal the computer server, or if you use an unencrypted or weakly encrypted wireless system to transfer information internally, they can park nearby and hack into your system using wireless Internet access.

It is very important to be wary of any vendor's claim that a system is "HIPAA compliant." It is not possible for a system itself to be HIPAA compliant. Only a covered entity such as a physician can be "HIPAA compliant." A covered entity is an organization that, by virtue of providing health care services and billing for them using electronic means, is subject to the provisions of HIPAA. The vendor's EHR can simply help your practice be HIPAA compliant by offering a high level of security or allowing you to quickly identify whether, for example, the Notice of Privacy Practices has been given to the patient. So while a system's features and capabilities are important, equally important is your own implementation and configuration of its features and capabilities. For more information on determining whether an organization or individual is a covered entity under HIPAA, visit CMS's website at http://www.cms.hhs.gov/HIPAAGenInfo/Downloads/CoveredEntitycharts.pdf.

You can simplify the work flow analysis by breaking it down into typical classifications of patient encounters. These classifications are called domains. Each domain has its own set of processes that can be mapped. For example:

• New patient for well visit or preventive care

• New patient for sick or problem-oriented visit

• Established patient for chronic condition periodic care

• Established patient for a sick or problem-oriented visit

• Patient medication management including refills

• Patient billing, calls, and interaction

WHY DO A WORK FLOW ANALYSIS?

The work flow analysis will create a baseline for each patient encounter, domain, or process. This baseline can identify:

1. Time taken per task

2. Labor or personnel resources per task

3. Information needed to complete the task

4. Difficulties receiving this information in a timely manner

5. Information that must be generated and sent out for each task

6. Difficulties generating or sending this information

7. Errors that may occur while performing these tasks

8. Other obstacles

By analyzing each domain, a medical practice can identify problems and possible solutions. Often the solutions do not require computerization or EHR systems, but may be corrected by other system changes such as use of chart note templates, improved document management, or even better transcription systems.

Ultimately, the benefit of the work flow analysis is to ensure you don't apply a computer solution to a broken process. Applying a computer solution to a business process that doesn't work will only exacerbate the problem rather than alleviate it.

For more detailed information on performing a work flow analysis, please see Chapter V.

HIPAA CONSIDERATIONS IN SELECTING AN EHR

Most practices are relatively familiar with the HIPAA privacy rule. Practices with paper charts often rely on sticky notes, labels, and other notes on the front of the chart (or inside the chart) related to HIPAA privacy obligations. Key HIPAA privacy obligations that typically are documented this way:

1. Charts flagged to indicate a patient was not given a Notice of Privacy Practices.

2. Any special privacy protections requested by the patient (restrictions on use and disclosure of his/her data).

3. Any "confidential communications channels" or special ways the patient would or would not like to be contacted (for example, appointment reminders only on a cell phone and not a home phone).

4. Information about family or friends who are authorized by the patient to call or be called regarding the patient's condition and care.

5. Disclosure accounting log that lists any disclosure of protected health information not pursuant to the patient's signed authorization or for routine treatment, payment, or health care operations.

Implementing an EHR requires a new work flow for these documents and alerts. Evaluating the ease-of-use and functionality of these should be a key consideration in vendor selection. ✷

WHAT IS IT YOU NEED?

The needs and readiness assessments and the work flow analysis are important to help you decide if an EHR is the right solution for your practice. Often this process identifies other steps that can (and should) be taken first. Some practices will wind up postponing EHR implementation for a defined period of time; others opt for an indefinite delay; still others conclude they are ready to move ahead.

WHAT ABOUT DISEASE REGISTRIES?

Just as document management or visit templates are an excellent solution prior to implementing an electronic health record, online disease registries can also be of value. Online disease registries allow a medical practice to record clinical notes, patient vitals, and lab results into a preset disease-specific template. The registry then provides physicians and clinicians with prompts or alerts related to clinical best practices. The online registry can simplify management and reporting of patients with certain chronic diseases. Once a practice implements an EHR; however, it will be able to replace the online registry with an integrated solution.

READY FOR AN EHR? THE NEXT STEPS

The work flow analysis will assist you in selecting and purchasing a system. As we suggested earlier, each medical practice should analyze the key patient domains and work flows, to get a specific outline of the typical patient care scenarios that are relevant to your practice. For example, a pediatric practice will typically have a well-child visit with accompanying scheduled immunizations, whereas a cardiology practice may have consultations and follow-up care as their typical patient encounter.

In mapping the work flow for these tasks, you can learn what kind of functionality or features are important in an EHR. These key features also become part of the scenarios you will present to the vendor when asking for a demonstration during your selection process. Rather than relying on a vendor-driven demonstration (where they show all the "bells and whistles" but perhaps ignore the details) we recommend asking the vendor to demonstrate how a patient record is created and managed based on several of your most common scenarios. That way you can compare one vendor to another and get a detailed view of how you must use the software for your common work flows. If a system is hard to use and looks like it will create more work for the physicians, the implementation may fail. Only a scenario-based demonstration provides this level of information. Once you have narrowed your selection, it is also important to "test-drive" the system yourself. You will want to see how a system handles all steps of the patient encounter process.

CREATING AN EHR ROAD MAP

A road map is a simple-to-follow outline of the steps a medical practice should take relative to the search for, selection of, and implementation of an electronic heath records system. Because implementing an EHR is likely to be one of the most complex and comprehensive business moves any medical practice can make, it is important to have a well-defined plan.

The road map should identify the steps needed to improve your practice's readiness and preparation prior to implementation; it should also help guide the process of selecting vendors and system candidates, evaluating systems, making a final selection, and negotiating the agreement. In addition, it outlines the many steps needed for a successful implementation, such as conversion of records, training, accommodating reduction in resources and productivity, change in work flows and processes, and so forth.

Below is an example of what a very high-level road map might look like for a medical practice, after the needs, readiness, and work flow analyses are conducted. Each of these tasks in turn will entail numerous individual tasks.

XYZ Family Physicians of Central California—EHR Implementation Roadmap

Task	Due Date
Upgrade Windows network and renovate office to create a server room	
Set user access for all new users	
Implement paper templates	
Complete Medicare fraud and abuse plan and begin regular chart audit	
Complete chart thinning and archiving	
Complete final needs assessment and key functions for the EHR	
Prepare scenarios for vendor review	
Choose three vendors and review via web-based demonstrations	
Select two finalists and conduct detailed on-site reviews	
Check references and visit other practices using these systems	
Negotiate best price configuration with both systems	
Final selection	
Contract signed	
Initial training and conversion planning	

Selection, timing, and implementation of an EHR require careful consideration and planning and will consume an enormous amount of resources. But when done correctly, it helps practices realize work flow efficiencies, improve communication and coordination, and most important, improve the quality of patient care. ⚙ ■

8

Building a Defensible Fee Schedule: An Analytical Approach to Establishing and Maintaining Charges

By Frank Cohen, MPA, MIT Solutions Inc.

Important Note: The fees and other amounts referred to in this chapter are shown as examples only. The publisher makes no suggestions or recommendations as to fees charged by individual practitioners.

The fee schedule, sometimes referred to as the charge master, is the single most important financial tool within the medical practice. As with any other business, the fees charged reflect the value of the products and services delivered. When you strip away the clinical component of a medical practice it is, in reality, just another business. And like any other business, a medical practice must deal with expenses, employees, insurance, taxes, and just about every other business-related issue.

If we accept the importance of the fee schedule, it is surprising that so many practices create and maintain their fee schedules without a solid understanding of the basic methodology involved. Practices use a broad array of methods—some that follow logical paths and others that are tied to models that favor the payors rather than the physicians. We believe physicians should subscribe to a philosophy of independence; that their decisions should be based on sound economic and market-driven principles; and that they should not be held hostage to payors.

The methods for establishing a defensible fee schedule outlined in this chapter are complex. You may find you need the assistance of a bookkeeper, accountant, or practice consultant to complete the steps it outlines. But because a defensible fee schedule is so vital to a practices success, the process of establishing such a schedule is well worth it.

In this chapter, we will look at fee scheduling from six basic perspectives:

1. Benchmarking using RBRVS

2. Econometric models, such as cost plus markup

3. Volumetric methods, such as time and RVU (relative value unit)-based methods

4. Comparative analyses using national and local average fees

5. Global analytical modeling using categorical conversion factors

6. Acuity factors, which measure the level of complexity of the services and procedures provided to a patient population

Absent some logical method, a practice is left with two alternatives: guessing and asking other physicians. The former makes so little sense it does not bear discussion; the latter, in the broadest stroke of interpretation, could expose you to antitrust charges if it looks like you had an agreement with those other physicians on rates. Besides, basing fees on those of another practice (whose methodology may itself be in question) significantly lowers your chances for having a reasonable fee schedule.

Fee schedules need constant review and evaluation. If the practice is losing money on a particular procedure, you won't fix that by doing more of this procedure or betting

on the "make it up in volume" principle. If the fee for a particular procedure seems higher than reasonable, it is just as important to consider reducing that fee as it is to consider increasing a procedure fee that is below a reasonable threshold.

A proper and thorough fee schedule analysis involves much more than raising fees and may actually have nothing to do with fee adjustments at all. Raising fees is easy; anyone can do it with the stroke of a pen or tap on the keyboard. But it won't steer your practice toward an accepted and viable business model.

Establishing and maintaining a fee schedule for a medical practice can be as easy as calculating a ratio of Medicare reimbursement or as complex as incorporating real-time market econometric dynamics, such as the Consumer Price Index (CPI), the Medical Economics Index (MEI), labor rate fluctuations, and other related financial indicators. For most practices, reality falls somewhere in the middle.

The primary purpose of the information in this chapter is to help your practice reach a level of profitability that allows it to thrive within a market and deliver a consistently high quality of patient care.

WHAT IS A FEE SCHEDULE?

It is important to define what constitutes a practice's fee schedule.

It may actually be easier to define what a fee schedule is not. A fee schedule is not simply a database that assigns a charge to each procedure or service delivered by a physician. Also, a fee schedule is not a knee-jerk reactionary instrument that is used to validate an amount a payor claims to be reasonable. A fee schedule is a concise tool that gives patients, payors, regulators, and reviewers a clear picture of how every practice defines the value of its services. A well-developed and -maintained fee schedule sends a signal that the practice is market sensitive, fiscally responsible, and organizationally sound.

Fee Schedule Philosophy

It is not easy to conclusively say what drives the decisions health care professionals make when developing their fee schedules. Historically, fee schedules were constructed based on an idea of cost and profitability. A physician provided a service for a patient, billed the insurance company, and got paid—a model that seems nonexistent nowadays. Within the past decade, fee schedule methodologies have been reduced to a race to control write-offs and disallowances, a measure of the unreasonableness of payors. In essence, most practices have settled on a fee schedule that is based on what payors are willing to reimburse.

The fee schedule philosophy advanced in this chapter is that practices should adopt a methodology that takes advantage of accurate internal and external data. Future contract reimbursement levels are based largely on charge levels of today. Establishing practice fees according to what another entity/payor views as fair may very well limit your practice's ability to negotiate accurate fees that cover costs in the future.

METHODOLOGICAL CONSIDERATIONS

Within the fee scheduling methodology, several variables must be considered. Some are directly related to and within the practice's control, including expenses, conversion factors, total compensation, and to some degree, payor mix. Some variables, however, may be outside of the practice's control, such as market dynamics, malpractice costs, population fluctuations, and supply costs. Your fee schedule development should not be driven by specific charges used by other practices within the same market area. It is crucial that your methodology depend on practice-specific variables, to minimize any antitrust concerns and to make sure your fee schedule is based on your practice's own internal dynamics—not on those of another practice that may not have a similar business model.

Additionally, by using large aggregate data sets for benchmarking, a practice can compare its charge structure with that of its peer group. While comparative data should not be the sole determinant for the fee schedule, it is helpful for understanding the value other physicians within the same specialty place on services provided to patients.

WHAT IS A CONVERSION FACTOR?

In its simplest form, a conversion factor (CF) is a value used to convert some unit of measurement into a charge. For example, if you take a car to the shop for repair, you will normally get an estimate of the repair cost. That's done by taking the average number of hours it would take a certified mechanic to fix the problem (from a flat-rate book or a Chilton's manual) and multiplying it by the hourly rate. For our purposes here, the conversion factor is a per-unit value that is multiplied by the relative value units (RVU) to convert it into a fee (or charge) for a particular medical service or procedure.

For calendar year 2008, the Medicare CF is 38.0870, meaning that for every RVU assigned to a procedure, the dollar value is approximately $38.09. This CF is assigned for reimbursement under the Physician Fee Schedule Data Base (PFSDB) as designated by CMS. Other payors may use different CF values, and each practice will have its own CF values for procedures based on the fees that it charges.

WHAT IS THE CF USED FOR?

The CF has several different uses. It can ensure that a practice's fee schedule is not below the Medicare Fee Schedule (MFS) allowable amount. The practice can do a rapid cursory check by simply calculating the conversion factor for each procedure code and ascertaining that the value is not below the current year Medicare CF amount. If it is below, that may mean the fee is too low.

The CF is also used to establish fees for new procedures or to re-price aberrant fees for existing procedures. This aspect is particularly important when you are looking for benchmarks to use in the fee analysis process.

CALCULATING CONVERSION FACTORS

In calculating CF, there are two basic models that we will use. The first calculates a CF for each procedure code and uses that to profile the fee schedule one procedure code at a time. The second model uses these individual CF values to calculate certain CF statistics, such as central measurements (mean, median, mode, etc.) and variability (variance, standard deviation, etc.).

The basic calculation given by CMS to determine the Medicare allowable multiplies the CF by the RVUs given in the PFSDB. The formula, simply stated:

Fee = CF x RVU

For example, let's say we have a procedure with 3.22 geographically adjusted RVUs. Following our formula, we would have the CF (38.0870) x RVU (3.22) = Fee ($122.64). Using some basic algebra, then, we could rearrange the formula to calculate the CF, as follows:

CF = Fee / RVU

In another example, let's say the practice charges $190 for this same procedure. Applying the above formula, we calculate its CF as the Fee ($190) / RVU (3.22) = CF (59.01).

It is important to note here that while the methodology used to create each RVU is the same for all procedure codes, market forces normally affect how the CF is applied. For example, many practices have received calls from prospective patients wondering what it will cost for an office visit. Very few, however, receive the same calls inquiring about the cost of, say, an appendectomy. Even though the methodology to develop RVUs for surgical procedures and Evaluation and Management (E/M) services are exactly the same, E/M procedures are more visible and more competitive in nature. Therefore it is important, in conducting statistical measurements of CF values, that each major coding category be treated individually.

CALCULATING MEASUREMENTS OF CENTRAL TENDENCY

There are three primary methods used to calculate the central CF measurement for any group of procedure codes: the average, the median, and the weighted average.

Average (Least Accurate)

Adding a series of values together and then dividing by the total number of entries or records will result in an average. To determine the average conversion factor, we first calculate the conversion factor for each code, obtain the number of procedure codes in the sample, and then divide the total of the CF values by the number of records.

The table contains a sample of values for seven procedure codes.

Code	Fee	RVU	Frequency	CF
Code 1	$1,087	10.215	1	106.42
Code 2	$365	5.343	7	68.31
Code 3	$1,114	13.713	12	81.24
Code 4	$2,487	14.051	1	177.65
Code 5	$529	6.185	12	85.53
Code 6	$887	14.222	60	63.37
Code 7	$996	14.173	108	70.27
Totals				652.79

If we add up the CF values, we get a total of 652.79. Divide this by the number of records used to get that total (7) and we get an average of $93.26 (652 / 7 = 93.26).

The problem with an average is that it does not consider (or give weight to) the value of one procedure over another. In essence, the CF for each procedure within the sample is given equal value, which may significantly skew the results since some low-frequency procedures may have individual CF values that are outliers, or outside a reasonable range. That's because practices commonly spend more time analyzing and pricing procedures they perform quite often than they do for procedures they perform infrequently.

The Median (More Accurate)

Another option is to calculate the median instead of the average. Even though a large number of outliers may still skew the final result, the median is designed to measure the middle of the sample; half the values are below and half the values are above the median value.

Code	Fee	RVU	Frequency	CF
Code 6	$887	14.222	60	63.37
Code 2	$365	5.343	7	68.31
Code 7	$996	14.173	108	70.27
Code 3	$1,114	13.713	12	81.24
Code 5	$529	6.185	12	85.53
Code 1	$1087	10.215	1	106.42
Code 4	$2,487	14.051	1	177.65

Using the same set of seven codes as above, we first calculate the individual CF using the same method as before. Then, we sort the CF values in ascending order (lowest to highest). The median, rather than taking the average measurement of the values, looks at the position of the values within the database. In essence, the median is a much better measurement of central tendency when there is a great deal of variability of the CF values or the frequencies being reported.

To get the median, take the middle measurement; in this case, it is the fourth entry, or Code 3 ($81.24). This method works well when there is an odd number of records. If there is an even number of records, take the average of the middle two.

The Weighted Average (Most Accurate)

A more accurate method is to factor in the frequencies for the codes and therefore give more weight to those procedures that are used (or reported) more often. This method more accurately represents the activity of the practice. By factoring the frequency, we can calculate the weighted average, which more accurately measures the conversion factor based on the number of times each code is reported. Again, we will use the same data set as the prior two examples.

1	2	3	4	5	6	7
Code	Fee	RVU	Frequency	Total Fees	Total RVU	CF
Code 1	$1,087	10.215	1	$1087	10.215	106.42
Code 2	$365	5.343	7	$2,555	37.401	68.31
Code 3	$1,114	13.713	12	$13,368	164.556	81.24
Code 4	$2,487	14.051	1	$2,487	14.051	177.65
Code 5	$529	6.185	12	$6,348	74.22	85.53
Code 6	$887	14.222	60	$53,220	853.32	63.37
Code 7	$996	14.173	108	$107,568	1530.684	70.27
Totals				$186,633	2,684.45	

The first step is to multiply the fee for each procedure (column 2) by the frequency for that procedure (column 4) to get the total charges for that record (column 5). The next step is to multiply the total adjusted RVU (column 3) by the frequency (column 4) for each procedure to get the total RVU for that record (column 6). Next, we get the sum of the products of the total fees and total RVUs for all entries in our data set (or table). Finally, we divide the grand total fees by the grand total RVU. The result will be the frequency distributed average, or mean, for the group of codes represented.

Using the above table, we calculated the sum of the fees to be $186,633 and the sum of the RVUs to be 2,684.45. Dividing the RVUs into the fees, we get a distributed mean of 69.52. While this is less than the other calculations, it more accurately represents the activity within the practice.

BENCHMARKING FEES

A benchmark is a standard against which something can be measured or judged. Since it is nearly impossible for a practice to calculate market value for any single procedure code or group of procedure codes, it is acceptable for a practice to benchmark its fees against an external set of standards.

In this first step, we begin to establish benchmarks against external metrics. This may, to some, feel like the old way of doing business, but in fact it represents a model for setting reasonable and logical limits. Using benchmark methods may prove to be the most complex of what we will discuss here, however, they also tend to be the easiest to defend, so they can be a powerful tool for negotiating profitable contracts.

While not considered even a reasonable fee schedule by many, the Medicare Fee Schedule (MFS) is used to ensure that charges are not below the MFS's allowable amount or, for many practices, below a ratio of the MFS allowable.

The Resource-Based Relative Value Scale (RBRVS), a component of the MFS, establishes and compares the conversion factor (CF) levels for each code and, more important, each coding category. Global CF values help us see the bigger picture as it relates to overall charge levels within homogenous groups. For example, comparing the mean (average) conversion factor for all surgical procedures for general surgeons against the same metric for a general surgery practice would give the practice a high-level view of the overall charge structure for its surgical procedures.

The Physician/Supplier Procedure Summary Master File (PSPSMF) contains 100 percent of all claims submitted to Medicare during a calendar year. This database contains 5 billion claims representing every billable procedure code performed by nearly every physician in the United States. And because the majority of practices submit their "reasonable" charges to Medicare, the PSPSMF is an excellent data source to determine average charge levels by national and state aggregates for each procedure code by specialty.

COMPETITIVE FACTOR

After financial aspects are considered, competition drives fees in nearly every industry. Practices that choose to be competitive, either by specialty or location, may want to be more sensitive to the fees they charge. This is particularly true for E/M codes, as they are often "shopped" by patients in highly competitive areas. For the purpose of the fee analysis, competitiveness is broken down into five levels, from most competitive (Level 1) to least competitive (Level 5). In the most competitive practices, fewer procedures will be recommended for fee increase and for those procedures that do meet the criteria, the increase amount will be less.

Level 1 - Very competitive

Practices that choose to be very competitive in their pricing. These practices are usually located in a highly populated urban area or city, competing with many other physicians for basic primary care business.

Level 2 - Somewhat competitive

Practices that choose to be conservatively competitive. While they recognize the need to adjust their fees reasonably, they may be in a competitive market or may offer only general primary care services, such as a walk-in center or urgent care center.

Level 3 - Average competitive

Practices that choose to maintain an average competitive presence. They want their fees to fall in the central range for similar types of physicians in their area.

Level 4 - Not very competitive

Practices that choose to be somewhat less competitive than those in Level 3. This will result in more procedures being flagged for increase and a slightly higher increase for those flagged.

Level 5 - Not competitive at all

Practices that choose to be noncompetitive in their pricing structure. At this level, the increases will be much more significant than in lower levels, as will be the amount of the increases.

COST-BASED METHODS

In many businesses, fees are established based on a standard cost-plus-markup methodology, as is used in retailing. For example, a hardware store may want a 70 percent markup on certain building products, so the pricing for such products is easy: Add 70 percent to the cost of the product. Many small businesses, especially sole proprietorships, fail because the owner doesn't understand the concept of the method. When a lawyer charges $500 per hour, that isn't what the lawyer makes; that's the gross revenue before expenses, taxes, etc. If a consultant wants to earn $50 per hour, he or she can't charge $50 per hour; one needs to charge $50 per hour above and beyond the cost of delivering the services.

Note here that the critical component is knowing the cost of delivering services, and that knowledge has been a holy grail among health care providers for a very long time. Think about the basic concept here: Do you know what your hard cost is to perform an office visit? Or to perform a minor surgical procedure? Or to see a patient as a follow-up to a major surgical procedure? The overwhelming majority of practices don't. The full implications of knowing (or not knowing) the costs of delivering services to a patient population is beyond the scope

of this chapter. Yet how can we intelligently sign a managed care contract that promises a certain fee for a certain procedure when we don't know if that fee is above or below our cost? The answer, of course, is we can't.

From the perspective of a fee analysis, we can use costs either on an individual basis for determining contract profitability or globally to create a fee schedule based on this cost-plus-markup method. The first step is to determine our costs. That is a lot easier than most people think.

The first step involves building a basic RBRVS table like the one in Figure 3 below. Only include procedures that have an RVU. Items that don't are usually supplies, such as drugs, casting material, etc., and developing a fee for those is relatively simple; you know what you paid for them, so adding a markup is as simple as adding your markup ratio to the cost.

For RVU-based procedures, we multiply the RVU by the frequency and then divide this into the total expenses for the data period. For example, if a practice were to report a total of 18,000 RVUs during the data period and its expenses (minus the cost of non-RVU supplies) were $615,600, we could calculate $34.20 as the cost per RVU ($615,600 divided by 18,000 RVUs). This allows us to do two things: calculate the average cost per procedure and create a cost-plus-markup fee schedule.

The former is a relatively simple procedure: Multiply the cost per RVU times the RVU value for that procedure, which is readily found in the public domain. So, for example, a mid-level outpatient consult (99243) has an associated non-facility unadjusted total RVU of 3.43. Multiply this by the cost per RVU ($34.20) and you get a hard cost of $117.30. Remember, this is the cost based on what you included in your total expenses. If you included physician compensation, this represents total costs, including what the physician earns.

Using this model to create or maintain a fee schedule is quite a bit simpler than approaching it from a line-item perspective. Take the cost per RVU, add a markup, and multiply this number by the RVU for the individual code. For example, let's say we want to have a 100 percent markup over our expenses. Multiply the cost per RVU in this example of $34.20 by 2 and you have a charge-per-RVU value of $68.40. Multiply this by the RVU for the individual procedure and you have the new fee. If we extend this to the above example, the new fee for the 99243 procedure is $234.60 (total RVU of 3.43 multiplied by the charge-per-RVU of $68.40).

It is important to remember that just because you bill using a particular fee doesn't mean you will be paid the amount you charge. That rarely if ever happens. When you're considering using a charge-based methodology, it's vital to have a handle on your average collection ratios by payor type to ensure that, in any case, your costs do not exceed collection.

BENCHMARKING USING RBRVS

RBRVS has, since 1992, undergone quite a bit of review and revision and as a result has become a universally accepted method for financial benchmarking within medical practices. Some misconceptions do still prevail, such as the notion that every payor uses RBRVS to develop its fee schedule. That simply isn't true and it can be easily disproven just by calculating the conversion factor for each fee.

What is true is that RBRVS, as a relational model, works very well within a closed system, such as a medical practice. Since it is relational, it is quite effective in balancing a fee profile between categories of codes and between codes within a given category. RBRVS helps to assign a real part to a fee—that of resource consumption. Contrary to popular opinion, RVUs do not measure productivity, but rather consumption—in other words, the value of the resources that are consumed when a service is delivered or a procedure is performed. Later, when we look at using a cost-plus-markup method, you will see how well RBRVS works at first establishing line-item cost values for each procedure.

Establishing Charge Thresholds

The Minimum Charge Threshold (MinCT) is measured as a ratio of the Medicare Fee Schedule (MFS) and enables a practice to determine the point at which the fee for a procedure may be considered below the minimum amount. However, while a drop below this threshold may trigger a review, when you're considering competitiveness, it does not always mean the fee should be adjusted.

The CF amount is calculated by multiplying the MinCT ratio (below) for each competitive category by the current Medicare CF. The following table illustrates how that would work using the current year's Medicare conversion factor and multiplying it by the MinCT factor. In this case, we used the 2008 CF of 38.0870.

Figure 1

Very Competitive	1.1250	42.84788
Somewhat Competitive	1.3125	49.98919
Average Competitive	1.5000	57.1305
Not Very Competitive	1.6875	64.27181
Not Competitive at All	1.8750	71.41313

The Maximum Charge Threshold (MaxCT) is also measured as a ratio of the MFS and enables the practice to determine the

point at which the fee for a procedure may be considered above the maximum amount. In essence, the MaxCT is the ceiling for the fee schedule model. However, while the fee for a procedure above this threshold may trigger a review, in considering competitiveness it does not always indicate the fee should be adjusted.

The CF amount is calculated by multiplying the MaxCT ratio for each competitive category (below) by the current Medicare CF. The following table illustrates how this would work using the 2008 Medicare conversion factor of 38.0870.

Figure 2

Competitive Factor	Min. Charge Threshold	CF Amount
Very Competitive	3.0000	114.261
Somewhat Competitive	3.5000	133.3045
Average Competitive	4.0000	152.348
Not Very Competitive	4.5000	171.3915
Not Competitive at All	5.0000	190.435

It is important to remember that the charge thresholds are established to trigger an event only—reviewing the fee for a procedure in depth and against other benchmarks. Also, just because the fee for a procedure meets one of the above criteria does not necessarily mean the fee should be automatically adjusted.

Data Elements

In order to perform a fee schedule analysis, you will need access to the following information:

• Fee Schedule

  o Procedure code w/ modifier, if any

  o Usual, customary, and reasonable (UCR) amount or your billed charge

  o Annual (or other periodized) frequency

  o Medicare Physician Fee Schedule Database (www.cms.hhs.gov), which contains all RVU, GPCI, and critical usage info

• Physician/Supplier Procedure Summary Master File (PSPSMF) (located on the CMS website at www.cms.hhs.gov). This file is produced by CMS and represents 100 percent of all Medicare claim submissions.

• Local econometric data (inflationary rates)

• Consumer Price Index, Medical Economic Index, and local, regional and national information

With this data in hand, we can move on to talk about the tools necessary for a physician practice to conduct a proper fee analysis.

Building the Spreadsheet

To begin, we build a worksheet to serve as the basis for many of the different fee analysis models we will discuss.

1. Start by listing the procedure code in column 1 and the modifier (if any) in the next column.

2. List the fee charged to commercial or private payors (your UCR) in column 3.

3. Then, in column 4, enter the frequency (total per year or TPY below) at which you billed this code during the analysis period.

4. Next determine the gross charges for each procedure code. To do this, multiply the frequency for each code (column 4) by the fee (column 3) and place this number in column 5 (TotFee).

5. In order to develop both MFS and CF comparisons, the total geographically adjusted RVU for each code (column 6) and the total RVUs based upon frequency calculations (column 7) must be included. To obtain the MFS (non-facility) amount (column 8), multiply the geographically adjusted RVU by the current Medicare CF (38.0870 for 2008). You can locate the geographically adjusted RVU data online at www.cms.hhs.gov/PFSlookup. Click on "Physician Fee Schedule Search."

6. Next, calculate the practice conversion factor (column 9) for each procedure code by dividing the fee (column 3) by the adjusted RVU (column 6).

7. Once you have performed this exercise for each CPT code that you bill, you will want to calculate the distributed CF (bottom of column 9) by major code category. A major code category is defined by CPT as the following:

      a. Surgery (10000 -69999)

      b. Radiology (70000 -79999

      c. Pathology (80000 -89999)

      d. Medicine (90000 -99199 and 99500 -99999)

      e. E/M services (99201 -99499) Medicine -90000 through 99999 (excluding E/M codes)

      f. HCPCS II -prefix A through prefix V

For more information on CPT codes and where to obtain them, see Chapter II.

8. To calculate the distributed CF, divide the grand total fee (bottom of column 5) amount by the grand total RVU (bottom of column 7) amount for each major code category.

Figure 3 provides a sample of what a completed table would look like:

Figure 3

1	1a	3	4	5	6	7	8	9
Code	Modifier (if applicable)	Fee	TPY	TotFee	RVU	TotRVU	MFS-NF	CF
10060		$70	59	$4,130	2.07	122.13	$78.45	33.82
10140		$55	33	$1,815	2.51	82.83	$95.12	21.91
11040		$95	919	$87,305	1.01	928.19	$38.28	94.06
11050		$35	40	$1,400	0.81	32.40	$30.70	43.21
11422		$300	12	$3,600	3.53	42.36	$133.78	84.99
11720		$35	61	$2,135	0.74	45.14	$28.04	47.30
11730		$115	358	$41,170	1.77	633.66	$67.08	64.97
11750		$379	208	$78,832	3.76	782.08	$142.49	100.80
20550		$37	42	$1,554	1.93	81.06	$73.14	19.17
28090		$250	10	$2,500	9.16	91.60	$347.14	27.29
28126		$510	103	$5,2530	8.67	893.01	$328.57	58.82
28286		$775	313	$24,2575	9.76	3,054.88	$369.88	79.41
28296		$1450	409	$59,3050	18.45	7,546.05	$699.21	78.59
28298		$1410	403	$56,8230	16.70	6,730.10	$632.89	84.43
29540		$29	116	$3,364	0.94	109.04	$35.62	30.85
29580		$375	9	$3,375	2.47	22.23	$93.61	151.82
Total				$1,687,565		21,196.76		79.61

Adjusting the Fees

The first step in determining which procedures may need a fee adjustment is to identify fees that are under the MFS allowable amount, by comparing the CF for each procedure code to the current year's Medicare CF (38.0870 for 2008). If the CF for the code falls below the Medicare CF for the current year, it is identified as being below the MFS allowable amount, or the amount published by CMS for a practice in a given geographic location.

The next step is to identify codes where the cost of providing the service exceeds the collection amount. That is accomplished by reviewing results of the cost accounting analysis. (This is only valid if the cost per RVU is less than 120 percent of the Medicare CF.) If the cost per RVU for the practice, as calculated in the cost accounting analysis, is greater than 120 percent of the Medicare CF, then it normally indicates that the practice has expense problems, not fee problems, and simply raising the fee for a procedure in this case will not result in an associated increase in reimbursement.

Next, identify codes below the minimum charge threshold (MinCT). This is based on a CF calculated as a ratio of the Medicare CF (38.0870 for 2008). Procedure codes in the table that have a CF (column 8) less than this value are identified with a "Y" in column 10 and included in the analysis for possible fee adjustments later. Finally, identify groups that have fees in excess of the MaxCT, where the CF (column 8) is in excess of the MaxCT ratio (see figure 2).

Figure 4 demonstrates what a completed table may look like.

Figure 4

1	2	3	4	5	6	7	8	9	10	11
Code	Fee	TPY	TotFee	RVU	TotRVU	MFS-NF	CF	MFS	MinCt	MaxCT
10060	$70	59	$4,130	2.07	122.13	$78.45	33.74	Y	Y	
10140	$55	33	$1,815	2.51	82.83	$95.12	21.87	Y	Y	
11040	$95	919	$87,305	1.01	928.19	$38.28	94.06			
11050	$35	40	$1,400	0.81	32.40	$30.70	43.16		Y	
11422	$300	12	$3,600	3.53	42.36	$133.78	84.99			
11720	$35	61	$2,135	0.74	45.14	$28.04	47.30		Y	
11730	$115	358	$41,170	1.77	633.66	$67.08	64.97			
11750	$379	208	$78,832	3.76	782.08	$142.49	100.80			
20550	$37	42	$1,554	1.93	81.06	$73.14	19.13	Y	Y	
28090	$250	10	$2,500	9.16	91.60	$347.14	27.29	Y	Y	
28126	$510	103	$5,2530	8.67	893.01	$328.57	58.82			
28286	$775	313	$24,575	9.76	3,054.88	$369.88	79.41			
28296	$1450	409	$59,3050	18.45	7,546.05	$699.21	78.59			
28298	$1410	403	$56,8230	16.70	6,730.10	$632.89	84.43			
29540	$29	116	$3,364	0.94	109.04	$35.62	30.98	Y	Y	
29580	$375	9	$3,375	2.47	22.23	$93.61	151.82			Y

Note that the letter 'Y' has been placed in the MinCT/MaxCT fields for codes that met one or more of the criteria outlined above. The practice, of course, may use any method to identify codes that meet or fall within the criteria. In this table, for example, procedure code 10060 has been identified as having a fee below both Medicare and the MinCT. Code 29580 is identified as having a fee that is greater than the designated MaxCT. This does not mean the fee will automatically be reduced; however, reducing the fee may be an option based on reimbursement from all payors. Δ

Determine the Fee Adjustment Amount

Now that you have determined which codes should be reviewed, you need to determine whether an adjustment is warranted. While the determination of how much to adjust a fee can get quite complex, for most people it is based on an understanding of and experience with the economy, both nationally and in a specific locale. Listed below are several sources that may be consulted in the percent adjustment.

• Categorical conversion factors.

• Medicare Economic Index (MEI).

• Medical component of the Consumer Price Index (CPI).

• Local and national inflationary indices.

• Other relevant data (i.e., Department of Housing and Urban Development info, to determine increase in lease amounts, or the Department of Wage and Labor, to determine the average salary by specific SIC code).

If the information or indicators are unknown, look online. For example, typing "consumer price index" into any Internet search engine will yield considerable material on these financial metrics.

△ **NOTE**

Negotiating the RVU/CF model can be tricky. For calendar years 2007 and 2008, CMS has included what is known as the Budget Neutrality Act reduction factor. This policy requires that the work RVU is first reduced by about 12 percent before being used to calculate the MFS. The reason we mention this is to avoid confusion with regard to backing out the conversion factor. For example, if you were to take the published MFS allowable amount and divide it by the calculated geographically adjusted total RVU, you would not get the current year conversion factor. Unfortunately, there is not sufficient space to discuss this in detail; however, you can find adequate resources on the CMS website (www.cms.hhs.gov) or through an Internet search.

Establish RBRVS-Based Adjustment Amount

For procedures that are below MFS, under the MinCT, or over the MaxCT, the goal is to utilize either the mean or the median conversion factor for that code category—whichever most effectively measures the central tendency of the category conversion factor.

If this central measurement of the CF for the code category is below the minimum charge amount established earlier, the minimum charge amount could be used. Similarly, if the central measurement of the CF for the code category is above the maximum charge amount that was previously established, the maximum charge amount could be used.

The modifier, total fee, and total RVU columns calculated in previous tables have been hidden, as they are not required to perform this exercise. Based on the work completed so far, a fee analysis table may look something like the following:

Figure 5

1	2	3	5	7	8	9	10	11	12
Code	Fee	TPY	RVU	MFS-NF	CF	MFS	MinCt	MaxCT	New Fee
10060	$70	59	2.07	$78.45	33.82	Y	Y		$165.19
10140	$55	33	2.51	$95.12	21.91	Y	Y		$200.20
11040	$95	919	1.01	$38.28	94.06				
11050	$35	40	0.81	$30.70	43.16		Y		$64.56
11422	$300	12	3.53	$133.78	84.99				
11720	$35	61	0.74	$28.04	47.30		Y		$58.92
11730	$115	358	1.77	$67.08	64.97				$125.32
11750	$379	208	3.76	$142.49	100.80				$413.00
20550	$37	42	1.93	$73.14	19.13	Y	Y		$153.98
28090	$250	10	9.16	$347.14	27.29	Y	Y		$729.40
28126	$510	103	8.67	$328.57	58.82				$638.17
28286	$775	313	9.76	$369.88	79.41				
28296	$1450	409	18.45	$699.21	78.59				
28298	$1410	403	16.70	$632.89	84.43				$1,536.48
29540	$29	116	0.94	$35.62	30.98	Y	Y		

Calculating the Net Financial Impact

The final impact to the practice of a fee schedule adjustment is normally less than the difference between the new fee and the current fee. This is due to collection based on payor mix. Unless the billed charge for the procedure is below the Medicare rate, an increase in a fee will not result in an increase in Medicare reimbursement. The same holds true for most managed care plans and insurers.

One simple way to calculate the net financial impact is to multiply the gross impact by the average collection percent for the practice. To do this:

1. In Figure 6, below, subtract column 2 from column 12 to determine the variance and enter that number into column 13.

2. Next, multiply the frequency (column 3) by the variance (column 13) to get the gross impact and enter that value into column 14.

   A more detailed calculation will take into account the payor mix that would be affected (primarily true indemnity or commercial fee-for-service payors).

3. To calculate the net impact, multiply the percent collection expected (47.58 percent for this example) by the expected frequency (column 3) and enter this value into column 15.

The modifier, total fee, RVU, total RVU, and MaxCT columns calculated in Figures 3 and 4 have been hidden, as they are not required to perform this exercise.

Figure 6

1	2	3	9	10	12	13	14	15
Code	Fee	TPY	MFS	MinCt	New Fee	Variance	Gross	Net
10060	$70	59	Y	Y	$165	$95	$5,605	$2,667
10140	$55	33	Y	Y	$200	$145	$4,785	$2,277
11040	$95	919						
11050	$35	40		Y	$65	$30	$1,200	$571
11422	$300	12						
11720	$35	61		Y	$59	$24	$1,459	$694
11730	$115	358						
11750	$379	208						
20550	$37	42	Y	Y	$154	$117	$4,914	$2,338
28090	$250	10	Y	Y	$729	$479	$4,790	$2,279
28126	$510	103			$638	$128	$13,184	$6,273
28286	$775	313			$775	$0	$0	$0
28296	$1450	409						
28298	$1410	403		Y	$1,536	$126	$50,778	$24,160
29540	$29	116	Y	Y	$75	$46	$5,336	$2,539
29580	$375	9						

TIME-BASED CALCULATIONS

Lawyers do it. Accountants do it. And many consultants do it. What do these professionals have in common? They charge by time. This is an age-old institution of fee scheduling; charging by a unit of time. Notice that we didn't say "charging by the hour." Those of you who have dealt with attorneys of late may have noticed that they charge by smaller increments, such as 15-minute or even six-minute periods. So, here's the $64,000 question: If other professionals can do it, why can't physicians? And the answer is that they can!

There are basically two ways to go about constructing a time-based fee schedule. The first is simply to pick an hourly amount out of the air—say $450. The second is to incorporate existing data—such as cost, charge, or revenue per hour—to create a benchmark for these types of calculations.

New Time-to-Charge Ratios

This is where we pick a rate out of the air. This doesn't mean that there isn't some link to reality. It just means that we aren't considering existing internal data to do so. For example, let's say the local attorneys are getting $400 an hour for services rendered. Most physicians have spent more time in school and training that the typical attorney, so a unit charge of $450 per hour would certainly pass muster as a reasonable amount.

Converting this hourly rate to a charge for a procedure, however, is a little trickier than it would be for an attorney. The physician's services are more redundant—they

do the same things over and over, and while the variety of diagnoses and treatment issues is huge, the charge is based on the procedure, not the final outcome. And physicians want to maintain the same charge for the same procedure for all payor models. In effect, this requires figuring out the average time spent for each procedure. This means we need some kind of standard reference to define the amount of time spent on each procedure. This reference can be arrived at in one of two ways: The practice can either create it or use an established standard. Creating it from scratch would entail an experimental process of recording the amount of time spent on each procedure, with a sample size large enough to create a mean or median time that is statistically significant. The other option would be to use the Relative Value Scale Update Committee (RUC) time study. A link to the time study can be found at www.cmanet.org/bestpractices.

Regardless of the standard used, the model will be the same. For the following example we are going to use the RUC study. The methodology is actually very simple: Multiply the average number of minutes for the procedure by the charge per hour (in this case, reduced to charge per minute).
Following from above, let's look at an example for this.

Let's assume the practice has decided on a hypothetical rate of $450 per hour. Dividing by 60 minutes, this comes out to $7.50 per minute. The RUC study reports the average number of minutes for E/M visit 99213 as 23. Multiply the $7.50 per minute by the reported 23 minutes and it equals a charge of $172.50. Because this is a common procedure and we understand patients' sensitivity to office visit charges, it probably isn't a surprise that this seems excessive. Some practices, seeking to be sensitive to the needs of their community, reduce the value for E/M codes in accordance with internal standards. This step always warrants consideration. For example, within the same practice you may find that the physicians work at different paces.

If we run the same analysis for a surgical code, say 49000 (exploration of abdomen), the charge would be the charge per minute ($7.50) multiplied by the average RUC minutes (304) to end up with a charge of $2,280.

Existing Charge-to-Time Ratio

The data source references are the same here as in the above example. The difference is that the practice has existing data supporting a charge-to-time ratio. For example, suppose the practice reported (for a particular physician) 2,080 work hours with total charges of $500,000. Dividing out, we get approximately $240 per hour (or $4 per minute). Going back to the 99213 used in the example above, we see that the fee would be $92 ($4 per minute times 23 minutes). For the surgical procedure example, the fee would be $1,216 ($4 per minute multiplied by 304 minutes).

Work RVUs

Using work RVUs does a bit of an end run around the time-to-charge ratio, but it is just as effective a methodology. The work RVU is calculated primarily based on the number of minutes reported in the RUC study, which gives us a powerful relationship between charge per work RVU and charge per RUC minute. The difference is that the work RVU includes both RUC time and effort, so some consider it a more accurate metric.

Back to our above example, let's take the physician who reported the $500,000 in gross charges for a given year. In that same data period, that physician reported 5,656 work RVUs. Divide out and you get an average charge-to-work RVU ratio of $88.40.

Moving into the analysis, we take the work RVUs reported for 99213 (0.92) times the ratio of $88.4 and we get a fee of $81.38. For the surgical code 49000, the fee would be $1,100 ($88.4 times 12.44 work RVUs).

The only caveat: In establishing the fee using work RVUs only, the practice is discounting the relative cost associated with these procedures. In some cases that can be significant. The practice may want to consider using the total RVU rather than just the work RVU as, in the current RBRVS model, the practice expense RVU is also a derivative of the same RUC time.

GLOBAL CONVERSION FACTORS

Conversion factors are dollar values that are used to convert the RVU value for a procedure into a fee. For example, the Medicare conversion factor is currently 38.0870. For 2008, procedure code 99213 has a total (non-geographically adjusted) total RVU of 1.68. Multiplying the two together, we see a Medicare non-adjusted allowable amount of $63.67 for participating physicians.

For our purposes, we want to apply a little algebra and, using the practice's current fee, divide it by the RVU to get the practice's conversion factor for a code (or group of codes) . For example, if the practice currently charges $92 for a 99213, dividing by the total RVU of 1.68, the practice's conversion factor is then $54.76. Accumulating this data by major code category, the practice is then able to calculate the median and/or mean conversion factor.

For our purposes here, we suggest calculating conversion factors by the major code categories as referenced earlier in this chapter:

• Surgical -10000 through 69999

• Radiology -70000 through 79999

• Laboratory and pathology -80000 through 99999

• Evaluation and management -99201 through 99499

• Medicine -90000 through 99999 (excluding E/M codes)

• HCPCS II -prefix A through prefix V

To calculate the median CF for the surgical group, the practice would list the individual CF for each surgical procedure in a spreadsheet, sort them in ascending order by CF, and then take the middle value as the median. If there is an even number of values, take the average of the middle two. For example, if the practice listed nine CF values in the spreadsheet, it would use the fifth as the median as there would be four values below and four values above the fifth. If there were 10, you would just take the average of the values in position five and six.

Let's take a practice that has gone through this scenario, calculated surgical conversion factors, and come up with a median CF of 100 for the surgical group. The median for all physicians with their specialty from the national database is 111. In this case, the practice's surgical CF is around 90 percent of the national average, indicating that its global charge model is below that of its peers.

Figure 7 gives some examples of global CF values by category for different geographic locations:

Figure 7

State	Surgical	Radiology	Pathology	Medicine	E/M	Weighted Avg
MD	86.52	98.94	80.87	76.90	56.27	73.67
ME	81.56	99.39	103.30	63.66	54.54	68.94
MI	70.34	86.10	86.51	73.54	51.72	65.12
MN	74.18	75.17	61.40	64.06	58.11	65.32

Remember, the global CF calculations don't necessarily pinpoint issues with individual codes but rather point the practice to other methods, such as average charge comparisons, to help you understand the comparative relationships by individual code.

CHARGE DATA COMPARISONS

Once a new recommended fee schedule has been established, the revised fees should be compared to national and state average charge levels (available at at www.cmanet.org/bestpractices) for those codes. This comparison can be performed using data that is specialty-specific or specialty-agnostic. The data is also compiled from the Physician/Supplier Procedure Summary Master File. Remember, the overwhelming majority of physicians and practices submit their commercial charges to Medicare, as opposed to just the Medicare allowable. Therefore, the charge database contains reasonable charges and, simply put, the database is huge. In calculating the averages, if the practice chooses to do so itself, it should use total charges submitted, and do so only for non-modified codes, since philosophies for charging for modifiers are inconsistent.

In using this data, be careful not to make adjustments to the recommended new fees based solely on average charge levels, or at least don't do so expecting to get a one-to-one ratio of reimbursement. This data may, however, be used to assess the fees within the community, defined by both specialty and geographic boundaries. It

can be assumed that the charge data for all practices, all claims, and all specialties is the average charge data representing just that: the average for all practices. Therefore, if the practice does something special (cancer center, tertiary facility, etc.), it would reasonable to expect the practice's charges to be higher than average. The same holds true for the other side of the spectrum.

The only time this data should be used in considering a fee schedule adjustment is when there are major variances between the practice's fee schedule amount and the average charges. The charge database is really no more than a tool to understand the value that other providers place on the work they do.
Figure 8 provides a sample fee comparison:

Figure 8

Code	Description	Fee	National Median	National Mean	Local Mean	Below National Mean	Below State Mean
10060	Drainage of skin abscess	$70	$120.00	$130.56	$122.74	1	1
10140	Drainage of hematoma/fluid	$55	$150.00	$176.24	$109.56	1	1
11050	Trim skin lesion	$35	$44.74	$50.68	$55.81	1	1
11720	Debride nail, 1-5	$35	$38.45	$49.05	$45.66	1	1
11730	Removal of nail plate	$115	$103.63	$112.49	$116.64	-	
11750	Removal of nail bed	$379	$250.00	$265.28	$204.33	-	
20550	Inj tendon sheath/ligament	$37	$100.00	$109.99	$91.05	1	1
28090	Removal of foot lesion	$250	$610.00	$659.33	$551.09	1	1
28126	Partial removal of toe	$510	$567.30	$604.78	$505.55	1	
29540	Strapping of ankle and/or ft	$29	$48.63	$51.99	$53.87	1	1

THE COHEN ACUITY FACTOR (CAF)

The final step in establishing a fee schedule is consideration of special services, procedures, or work the practice does that exceeds that of its peer group. Remember, as in any other business, experience, time in specialty, special services, uniqueness, and other such factors all play a part in determining the value of the practitioner. A CPA who specializes in forensics, for example, may command a higher fee than other CPAs. A health care consultant who specializes in compliance litigation support may command a higher fee than other consultants. And similarly, a physician who special-izes in a more arcane area or simply does something better than other physicians may also command a higher fee.

Since this is a chapter on the importance and power of analytics, we propose a method to measure the level of acuity or overall complexity of the services and pro-cedures provided by a physician to a given patient population. The theory is this: If what you do is more complex than your peer group, then it is easy to defend a higher fee schedule.

The Cohen Acuity Factor (CAF) is a value that measures the relative complexity of the services and procedures provided to a specific patient population by a medical practice and/or medical provider. It is named after its developer, Frank Cohen, and is reported as a ratio of work RVUs to procedure. Developing the CAF is accomplished using the national Medicare database through factoring of RVU values in connection with the procedures and services delivered to that patient population.

While the data can be calculated by physician, specialty, and/or practice, comparisons to the national averages are always specialty-specific.

How It Works

RVUs measure consumption of a resource, whether time, effort, fixed or variable expenses, risk, etc. The higher the RVU value, the greater the consumption of those resources. Therefore, in most circumstances the higher the consumption of resources, the greater the complexity of the service or procedure being measured. This is particularly true with the work RVU and is most apparent in E/M codes, although certainly not restricted to that category. For example, CPT code 99204 has a higher RVU value than CPT code 99202 and therefore consumes more resources and is generally more complex in its approach.

Using the work RVU, we can isolate the consumption of resources to physician time and effort. This is important, as it intentionally obscures what is sometimes a potentially inflated assessment of the cost of the technology associated with some procedures. As noted above, the higher the RVU value, the greater the resources, and hence the greater the overall complexity of that procedure or service.

Using this assumption, if we were to average the ratio of work RVUs per procedure for a given patient population by physician or specialty, we could measure the average level of complexity of the services and procedures delivered to that population by that provider entity.

Calculating the CAF is a relatively simple affair and can be completed using the initial RBRVS table we created at the beginning of this chapter. The key is to only list procedures that have work RVU (or total RVU) values. Then, total the specific RVU values and divide by the total frequency in the table.

1. The first step is to multiply the RVUs for each code (column 5) by the total frequency (column 4) for that code and calculate the sum of the products to get a grand total for this column (column 6).
2. Next, we total the frequency of use (column 4) codes to get the total frequency for all codes in the table (448 in this example).
3. Add the total RVUs (column 6).
4. Divide the grand total RVUs by the total frequency for the RVU-based procedures performed during the study period.

In the below table, you can see if we divide the total RVUs by the total frequency, we would get the following acuity factor for this sample:

934.63 Total RVUs / 448 total frequency = 2.09 Acuity Factor

That means that for the patient population measured, the average number of RVUs per procedure (or Acuity Factor) is 2.09. Figure 9 provides an example of a CAF calculation:
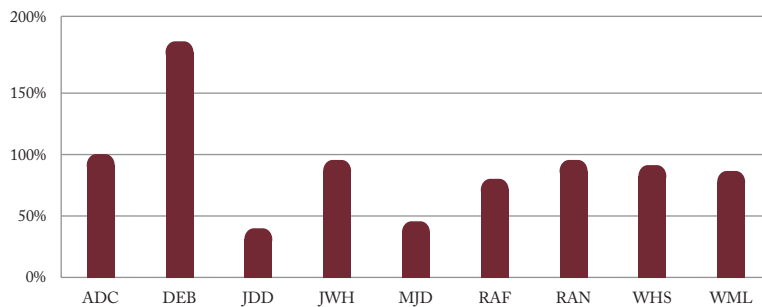
Figure 9

1	2	3	4	5	6
Procedure Code	Modifier	Description	Annualized Frequency	Factored adjusted Non-Facility RVU	Total RVUs
19240	58	Removal of breast	1	30.59	30.59
19240	78	Removal of breast	4	30.59	122.38
20200	51	Muscle biopsy	4	2.68	10.70
20200		Muscle biopsy	8	5.35	42.80
20520		Removal of foreign body	1	4.83	4.83

| 1	2	3	4	5	6
Procedure Code	Modifier	Description	Annualized Frequency	Factored adjusted Non-Facility RVU	Total RVUs
20550	51	Inj tendon sheath/ligament	1	0.86	0.86
20550	59	Inj tendon sheath/ligament	7	1.72	12.05
20550	LT	Inj tendon sheath/ligament	15	1.72	25.82
20550	RT	Inj tendon sheath/ligament	11	1.72	18.93
20550		Inj tendon sheath/ligament	218	1.72	375.24
20551	59	Inj tendon origin/insertion	1	1.69	1.69
20551		Inj tendon origin/insertion	23	1.69	38.87
20552	RT	Inj trigger point, 1/2 muscle	1	1.65	1.65
20552		Inj trigger point, 1/2 muscle	106	1.65	174.71
20553		Inj trigger points, =/> 3	2	1.86	3.71
20600	LT	Drain/inject, joint/bursa	7	1.55	10.88
20600		Drain/inject, joint/bursa	38	1.55	58.90
		Totals	448		934.63

The key is to compare the CAF for the practice to that of a peer group. Comparisons can be made between physicians within the group can be compared to national and/or local data calculated using an appropriate database. If the practice's CAF is greater than the comparison group's, that would provide greater defensibility for a higher fee.

The following graphs illustrate a comparison to other physicians within the group and the national average for this specialty.

Figure 10 - Work Acuity as a Percent of Practice by Physician

Figure 11 - Work Acuity as a Percent of National Ave by Physician
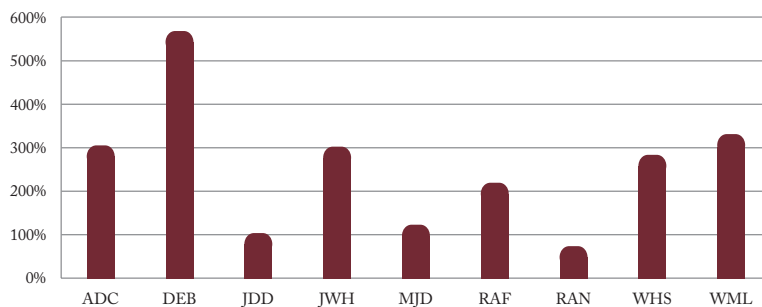
If the CAF for the practice is lower than the CAF for the national average, as demonstrated in this example, it would indicate that what the practice does is less complex, and sometimes lower-than-average fees would be reasonable.

SUMMARY

A primary goal of the physician practice is to be profitable. Developing and maintaining a fee schedule for the physician practice is a simple task, but developing and maintaining a fee schedule correctly is not. Failure to follow standard business principles is what frequently keeps a physician practice from achieving financial success.

When a proper fee schedule has been developed, practices should remember to routinely measure the fee schedule's performance by measuring it against EOB and other validation data. It is recommended that practices establish a regular schedule for review. This review may be done every quarter, every six months, or once a year. The frequency of review isn't important; the action is. Practices that allow too much time to pass between reviews may find themselves starting the entire process over—an unnecessary and burdensome chore. ■

9

Surviving Out-of-Network: One Physician's Experience

By Frank Cohen, MPA, MIT Solutions Inc.

Important Note: The fees and other amounts referred to in this chapter are shown as examples only. The publisher makes no suggestions or recommendations as to fees charged by individual practitioners.

In 1897 a Swedish immigrant, caught up in gold rush fever, took all the money he had and journeyed from Seattle to the Alaskan frontier to find his fortune. Two years of prospecting in the wilderness finally paid off when he struck gold. His newfound wealth was short lived, however. The stake to his claim was disputed. He eventually settled the argument by selling his stake to the other claimant for $13,000. His adversary eventually extracted $5 million worth of gold from the strike.

The Swedish immigrant retreated back to Seattle and moved in with his sister. He and a friend enlarged the friend's shoe repair shop into a retail shoe store. They grew the business, expanding to other locations. Decades later, after buying out his friend to provide employment opportunities for family offspring, his family business added clothing lines, all the while depending on superior customer service to maintain a competitive edge.

To keep up with changes in the world around him, this Swedish immigrant who began as a failed gold prospector ended up creating what has evolved into perhaps the premier clothing retailer in America. His name was John Nordstrom. His company came to be named Nordstrom Inc.

It all started when a prospector in the Alaskan wilderness, the loser of a dispute, decided to go in a new direction. He could have wandered the mountains of Alaska or the streets of Anchorage until he died of old age, complaining that he'd been treated unfairly. He could have fought the bitter fight with his gold strike adversary to preserve what he had worked so hard to acquire.

Yet he chose to look for new opportunity. In so doing, he frequently changed and evolved his business model to meet the needs of changing economic times. And as it is often said, "The rest is history."

CREATING AN OPPORTUNITY

So what does this have to do with the practice of medicine anyway?

While I claim to be no John Nordstrom and my children most certainly won't be left with the employment opportunities left to a Seattle Nordstrom offspring (sorry kids), I've found inspiration in how a crusty prospector not only found a way to succeed when change came upon him, but he used extraordinary customer service to make it happen.

The practice of medicine is not what I thought it would be. The business of medicine is considerably more complicated than when my father was a practicing physician. It is controlled by forces far beyond my personal reach. Much of the way things are now, I do not like.

For a while I complained bitterly that the practice of medicine is not as it should or used to be. Yet, I don't want to be a failed prospector wandering in the wilderness complaining that things are not fair. This is where I find inspiration in the story of John Nordstrom.

A few years ago, practicing medicine outside of health insurance networks was a concept that never crossed my mind. I didn't' even know what an "out-of-network provider" was. But that's what I've become. Morphing my practice to an out-of-network environment has not been a particularly easy process, but it has worked and I'm glad I'm on that road.

I'm an ophthalmic plastic surgeon. When I tell my story to fellow physicians, those in other specialties lament that it is easier for a specialist such as me to do this. The paradox for me in all this is that a family medicine doctor down the hallway in my medical office building is my role model. He made it work years ago. We're at the two extremes of specialization. If we both made it work, so can you.

I've made up my mind that medicine is not all doom and gloom. It is not the way I wanted it to be, but there is enormous opportunity before us. There's opportunity to find a better way to take care of patients. There's opportunity to take back the practice of medicine. There's opportunity to stop your personal income from its unrelenting contraction.

There is enormous opportunity before us.

PLAN YOUR STRATEGY FOR SUCCESS

We physicians cling dearly to the implicit promise that if we work hard to become doctors, and thereafter spend endless hours taking good care of our patients, then American society will reward us with an income commensurate with our education and training.

This implied promise is fading. No more can a doctor complete years of training, set up a private practice, unlock the front door, turn on the phone, and live happily ever after. The economics no longer work that way.

Our reaction to this fading promise is often to feel frustrated or defeated. From this perspective we're often tempted to react to changes in the business of medicine without adequate forethought, or, even worse, we react impulsively.

Many physicians have thoughtfully planned out and succeeded in offering their services outside traditional health insurance physician networks. Others who've angrily announced without planning, "We're cancelling all our network contracts today!" have failed.

I implore you to plan thoughtfully for your success as an out-of-network provider. Be thorough and complete.

APPROACHING THE DECISION

So you're wondering if you should step away from your contractual relationship with an insurance carrier. No doubt you're aware that many people think physicians are poor business people and you'd like to prove them all wrong. I suggest you delve into your practice finances for answers.

Propose a Salary for Yourself

To date, your personal income probably boiled down to whatever was left in the account after the bills were paid. That amount is probably shrinking or you wouldn't be reading this. Start at the opposite end. Rather than settle for what's left, identify a reasonable salary for yourself. For the purposes of example, let's propose a gross salary of $240,000 per year.

Calculate the Hourly Cost of Doing Business

Decide how many hours you want to work to generate that personal income. Determine the proportion of those hours that will be spent generating charges (seeing patients, for most of us), versus the proportion that will be spent performing nonreimbursable duties. Nonreimbursable duties will include practice management, coordination of patient care, vacations, and continuing education.

You might say for example that you'd like to work 50 hours per week spending 40 hours per week seeing patients, with six weeks out of the office per year. This will annualize out to 40 chargeable hours per week multiplied by 46 weeks per year (52 weeks minus 6 weeks of vacation) or 1,920 hours per year.

Next determine the gross receipts you will need to receive per hour to generate the salary you'd like to receive. To expand upon our example, if you divide $240,000 (gross salary) by 1,920 hours, you will need to generate $125 per hour.

Next, calculate the hourly overhead cost. Look at the annualized cost of running your practice aside from your salary. Let's say for example, that over the past 12 months your total expenses were $300,000. Divide this number by the number of hours you plan to spend generating income, in this case, 1920. This calculates to an hourly overhead cost of just over $156.

You'll now want to calculate the gross receipts per hour you'll need to generate to meet your budget. To do this, add your salary ($125/hour) to your hourly overhead expense ($156/hour). This equals $281 per hour. This is the amount of money you'll need to generate per hour of time spent seeing patients, to meet your proposed budget.

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[9] Please note this is an arbitrary figure and is for illustration purposes only.

Finally calculate the charges or usual and customary rates (UCR) per CPT code required to fit your budget. Let's use a hypothetical Evaluation & Management (E/M) code 99XXX. Let's say you typically spend 10 minutes with a patient for this code, and that you can complete six of these exams per hour. If you're calculating the time necessary for a code with a global period, don't forget to include average time spent in follow-up visits. Calculate the required UCR for this CPT code by dividing your proposed hourly income by the time spent for this code. For example, dividing your required hourly $281charge by six visits, leads to a charge of just under $47 for CPT code 99XXX. You will need to repeat this analysis for each of your most commonly used CPT codes. For example:

Gross receipts per hour ($281) / 6 visits = $47 UCR for CPT 99XXX.

Going through and determining how many of each procedure or service you currently provide each month on average will provide a basis for your UCR per code. This analysis will also allow you to identify whether your UCR should be adjusted (up or down), will identify services that don't add value, or whether you should consider promoting services that do.

Determine Whether Contracted Fees Meet Your Budgetary Requirements

Once you've gotten this far, it should be easy to compare your budgeted CPT charges to the fee schedules in your third party contracts. If you find shortfalls with more than a handful of CPT codes and these shortfalls aren't balanced out by other codes where reimbursement is greater than your budgetary goal, you've identified this carrier as a problem.

Pay attention to Medicare fees for two reasons. First, Medicare rates are slated to decrease by up to 30 percent over the next few years. Many commercial payors offer fee schedules that are based on a percentage of current year Medicare rates. If any of your contracts are based on a percentage of Medicare, you can expect them to decline accordingly.

Second, most insurance contracts include coordination of benefits language that states that when Medicare is primary and the commercial payor is secondary, the commercial payor will only pay up to the contracted rate.

Example

For a particular service, Medicare allows $100 but the commercial payor contract pays only $80.

• *Physician bills Medicare $100.*

• *Medicare pays $80.*

• *Commercial Payor pays nothing.*

Increasingly, commercial payors are offering rates that are below the Medicare fee schedule. Moreover, the coordination of benefits language prohibits the physician from billing the patient, requiring the practice to write-off the unpaid balance.

Quantify the Hassle Factor

This is a good time to identify carriers that cause undue grief in the practice of medicine. Quantifying the "hassle factor" is difficult, but can and should be done. For example, you should note those payors with which your practice has the most problems on a regular basis. Consider the amount of time and work both the physician and staff devote to inappropriate treatment authorization denials, claim denials, appealing unfair medical policies, obtaining prior authorizations, checking claims status, unfair bundling edits, and other unfair policies that result in unnecessary rework. When you add up the amount of time and resources the practice must spend addressing these administrative hassles and multiply that by the average hourly rate, you will likely find that certain payors are draining your resources. Your assessment may find that the highest negotiated rates will turn out to be the lowest.

If you identify a payor that appears to meet your budget requirements, but leads the pack in administrative hassles, you may want to rethink your contractual relationship. Sometimes the administrative burden of continuing to work with a payor is simply too costly and no longer brings added value to the practice.

Choose to Make a Change

If you've identified a problematic payor, you'll need to act. Among your options at this point are to adjust your budget by lowering your proposed salary or reducing your office overhead. Alternatively, you could consider increasing the number of hours you see patients. You should setup a compliance program to insure your CPT coding is accurate. Regular review of your coding compared with your billed charges not only helps prevent over coding, it also helps to ensure that you are not leaving money on the table by under coding or inadvertently omitting services that should have been billed.

If you are like most physicians, you've probably already exhausted these options, which is why you're still reading this

article. Your remaining choices are to negotiate reasonable terms with the payor or to become an "out-of-network provider."

If the payor is unwilling to negotiate reasonable terms and you have already attempted or given thoughtful consideration to the options above, it may be time to consider becoming an out-of-network physician. The freedom of controlling your own practice by rejecting the remarkable encumbrances inherent in practicing inside insurance networks can be fulfilling. I have found that it is a way to take better care of patients on terms that I and my patients mutually agree upon. Ω

IDENTIFY A STRATEGY

Have you identified that you will need to leave a single network, multiple networks, or perhaps all networks? If so, you will need to determine what percentage of your practices finances are derived from each of the payors in question. Moreover, how will you market your services to those patients as an out-of-network provider?

Review and Understand Contract Exit Criteria

Most of us signed payor contracts as they were presented to us, presuming we had no choice but to do so. In so doing we may have unwittingly agreed to prohibitive terms that limit your ability to terminate when you want to.

Examples of issues that you may have to deal include but are not limited to: duration of termination notification period; gag clauses that seemingly prohibit you from talking to an attorney, consultant, or patient about the matter; and restrictions on your ability to limit or close your practice to new patients unless you do the same with other payors. For example, one payor contract in existence will only honor terminations that are received within 180 days of the anniversary of the date the contract was effective. To further compound the problem, if you fail to terminate the contract within the required timeframe, by even one day, you are stuck for another two years.

Before you exit a payor network, you'll need to obtain a copy of the contract and review the termination provisions. It is important that you follow those provisions to ensure that you have successfully terminated the agreement. If you do not have a copy of the contract you should request one from the payor in writing via certified mail with return receipt. Ω

Determine How Your Practice's Finances Will be Affected

The strategy you choose will depend primarily on the percentage of your practice finances affected by the third party contracts in question. Clearly, it would be unwise to cancel a contract that turns away a large percentage of your patients, unless you have a plan to replace them.

You can quickly determine the percentage of receipts from each payor by creating a report called the payor mix. This report compares the total billed charges and payments received from each payor to the grand total payments received to determine the percentage from each. Just because Payor B comprises 20 percent of your gross billed charges does not mean that Payor B contributes 20 percent of the receipts.

In the example below (Figure 1), 24 percent of the overall billed charges are attributed to Payor B, yet this payor only contributes to 18.40 percent of the total receipts. This indicates there is an issue with this contract, whether it be the reimbursement rate or particular payor policies, the data indicates a thorough review of this contract is warranted.

BALANCE BILLING

California physicians should be aware that on January 8, 2009, the California Supreme Court put an end to the controversy surrounding "balance billing" of HMO enrollees in the emergency care context -the practice by out-of-network providers to bill patients the balance of an emergency care bill that the patients' Knox-Keene plan refused to pay. The Court in Prospect Medical Group v. Northridge Emergency Medical Group, __ Cal.Rptr.3d __, 2009 WL 36855 (2009) (Prospect), ruled that the Knox-Keene Act prohibits this practice of balance billing. The court clarified that providers may only seek recourse against the payors, not patients, for underpayments. The Department of Managed Health Care too has taken action to prohibit noncontracted providers from balance billing for emergency care services, promulgating a regulation, 28 C.C.R. sec. 1300.71.39, that defines such practices to be an "unfair billing pattern." The Prospect decision and the DMHC's regulation make it clear that balance billing for emergency care services is no longer permitted if the patient is covered by a Knox Keene-regulated plan (HMOs, certain PPOs, and any delegated medical groups or risk bearing organizations). For more information about the Prospect decision and its implications, see CMA's Balance Billing Toolkit at www.cmanet.org.

Figure 1 - Sample Payor Mix: Time Period - January 1, 2008 through June 30, 2008

Payor	Total Billed Charges	% of Total Billed Charges	Total Payment	% of Total Payments
Medicare	$33,000	12%	$14,850.00	11.19%
Medicaid	$13,750	5%	$3,437.50	2.59%
Managed Medicade (if applicable)	$19,250	7%	$5,197.50	3.92%
Medicare Advantage	$8,250	3%	$3,712.50	2.80%
Worker's Comp	$27,500	10%	$16,500.00	12.43%
Payor A	$52,250	19%	$26,125.00	19.68%
Payor B	$66,000	24%	$24,420.00	18.40%
Payor C	$33,000	12%	$19,800.00	14.92%
Self-Pay	$22,000	8%	$18,700.00	14.09%
Total	$275,000	100%	$132,742.50	100.00%

In addition, you will want to run a report of patient names by payor. Ideally, this report will include the patient's mailing address that can later be used to create mailing labels for notices you will want to send to your patients should you decide to terminate any of your contracts. **Δ**

The strategy you choose should be one that does not substantially disrupt the flow of patients through your practice. If you have only one problematic payor and the percentage of your gross receipts is small, your approach will be far different than if you have a large payor or numerous small payors with which you must resolve issues.

Tailor a Strategy to Your Circumstances

Wean Your Practice from a Contract

If a problematic carrier has too great an influence on your practice finances to sustain an abrupt cancellation, your approach will need to be more methodical. First you'll need to decide whether patients from more reasonable carriers will "fill in the blanks" in your appointment schedule, should you decide to cancel your contract with that carrier.

If you believe they will, the best strategy will be to orchestrate a slow unwinding of your relationship with the payor by limiting or closing your practice to new patients with Payor X. This gives you the ability to slowly decrease the percentage of Payor X patients in your practice while allowing time to adjust financially. It can also be easier on your existing patients. Depending on the volume of business from Payor X it could take 6 months or longer to successfully wean your practice from the payor. Once the volume has been reduced to a level of minimal financial impact, you can comfortably terminate the agreement.

Terminate a Contract Outright

Perhaps you've determined that most payors meet your budget and "hassle factor" criteria and no action is necessary, but a single payor with minimal influence on your practice's finances is your only problematic contract. In this scenario, the best approach will likely be to simply terminate that single contract. If you've got a busy practice wherein patients with less problematic payors will fill in the appointment slots, you are less likely to notice any disruption. When communicating with third party payors on matters of this importance, always use certified mail with return receipt. **Ω**

Become an Out-of-Network Provider

Over time, you may also decide that you would like to leave the world of contracting and become an out-of-network provider. This strategy is near and dear to my heart because I believe it returns management of patient care where it belongs and used to be -between the doctor and patient. It can afford you the opportunity to markedly improve the care you offer patients and, for me, has returned the joy and fulfillment to the practice of medicine. As an out-of-network provider you will care for patients outside the constraints of third party contracts. This will allow you to follow CPT coding guidelines without being victimized by arbitrary and capricious third party medical and payment policies, allowing you to be paid appropriately for the services you provide.

However, leaving all payor networks at the same time is not recommended. The decision to become an out-of-network provider is one that requires careful consideration and planning. Abrupt termination of all of your payor contracts at once could have a deleterious effect on the viability of your practice.

When I began practicing medicine in the early 1990s, the reimbursement crunch was hitting. Every year at national meetings we were advised to counter the cuts by seeing perhaps two more patients per day in the clinic. That strategy worked great. But then we went back the next year and received the same advice, and the next year, and the next year….. Now we're all seeing twice as many patients as we did twenty years ago and patients are complaining and rightfully so, in my opinion, that they feel like they're being herded like cattle.

Perhaps it's time for you to set your professional GPS on a new target.

DEVELOP AN OUT-OF-NETWORK STRATEGIC PLAN

It is beyond the scope of this chapter to thoroughly analyze specific contract termination or contract weaning strategies, except to say that maintaining a diversified third party "book of business" will allow you to maneuver better among third party payor issues than if you maintain dependence on a few payors for the majority of your practice receipts. (Refer to payor mix figure above.)

Change Your Practice Mindset

Wipe from your innocent lips the statement "We don't take that insurance," and politely admonish your staff to do the same. Instead, replace that mindset with:

"We work with all insurance carriers. We are contracted providers with some, but have found it necessary to care for some patients from outside their carrier's network. Yet, we desire to care for anyone who seeks our services and will work very hard to make it work for you even if we're not a contracted provider."

Help Patients Understand What It Means to Be Out-of-Network

One of your earliest and perhaps greatest challenges will be helping your patients understand the impact of your out-of-network (OON) status on them. Understandably, patients are fearful of seeking your services when "you're not in my network." They have no idea what will happen if they go to a doctor outside of their network. Your first hurdle will be to confirm for them their out-of-pocket expenses will be affordable. You'll therefore need to be able to help them sort through the sometimes complicated policies of their carrier.

When you start, this will likely seem quite burdensome to your staff, but over time you'll learn to recognize patterns of insurance carrier behavior. You'll develop contacts with third party payors, and the process will become routine.

During the course of the conversation when new patients call, we ask what kind of insurance they have. If we are not contracted with that payor, we inform them that we are an out-of-network provider. As mentioned above, we are very careful NOT to tell them "We don't take your insurance." In the case of an office visit, patients are usually most concerned about whether we will bill and their insurance carrier will pay for the services. We tell callers we will gladly bill their carriers on their behalf and advise them whether or not they have out-of-network coverage. With this degree of assurance, patients generally schedule an appointment. Note: Many payors are now refusing to honor the assignment of benefits the patient signed and are now sending payments for out-of-network services to the patient. It is important to familiarize yourself with which payors in your area do and do not honor assignment of benefits. Some states also have laws requiring payors to honor the assignment of benefits.

We recommend that patients contact their insurance benefits department for specifics of what they can expect when they see a non-contracted provider. We recommend patients ask "How will my benefits change when I see an out-of-network provider?" We then briefly describe the different payment percentages and deductibles that may apply when you see an out-of-network physician.

The handling of out-of-network provider situations from a single insurance carrier can vary widely from one enrollee to the next so we're very careful not to tell someone how their carrier will handle their visit without checking with the carrier first. One popular insurer in our area allows us to verify a patient's policy and benefits over the internet. Others will tell

us over the phone. Occasionally a carrier won't tell us anything, leaving it up to the patient to make the call.

As mentioned above, simply knowing we will bill and that they have out-of-network benefits typically makes a potential patient comfortable enough to make an appointment. I'm a surgeon, so many first appointments lead to surgery. Patients almost always want to know ahead of surgery what their out-of-pocket expenses will be. Once we've evaluated someone and planned a surgical procedure, we don't typically have much trouble finding out from the carrier how much they will pay.

Finding out who to contact at the insurance company is not always easy. Frequently the customer service staff is very unfamiliar with this topic and gives inaccurate answers. Finding the right source at the insurer may be a bit of a project. This is one place where comparing notes with a local out-of-network workgroup can be very helpful.

When you're out-of-network, you'll discover that payors handle modifiers and other payment rules differently. I do a large number of bilateral surgical procedures. Every government and private insurance carrier with which I've worked reduces the fee of the second procedure in multiple procedure situations by 50 percent. One carrier that I now bill out-of-network, ignores the 50 percent reduction rule, paying their percentage of the second procedure the same as the first. This has caused me to alter my OON fee schedule. You may also need to make similar adjustments.

Understand How the Carrier Handles Out-of-Network Patient Care

Finding out all you can about how payors handle out-of-network providers is important. Once you have found the appropriate payor contacts, find out what you can about OON payment policies, fee schedules, copayments, deductibles, etc. As mentioned above, some payors refuse to honor assignments of benefits with out-of-network care and will issue payment to the patient. In this situation it is important to collect payment before or at the time of service. Again, you should be familiar with laws in your state.

Revisit Your Fee Schedule

Most often your fee schedule bears no relationship to what you expect to be paid for your services. Rather, your fees are likely set right above your most favorable third party payor. In the insurance world, this is important as most contracts include "lesser of" language that says they will pay the lesser of either the contracted rate or the full billed charges.

These numbers might rightfully send your patient into cardiac arrest and will thus need to be revisited. Remember, you can

work with patients on an individual basis based on their ability to pay. Your fee schedule should be revisited annually and based on any increased practice costs plus cost of living increases.

Reinvent Your Services to Make Them Worth the Expense

In short, use the Nordstrom strategy of superior patient (customer) service to validate the increased out-of-pocket expense to your patients. This is the gratifying and fulfilling part.

I believe that while the quality of medical care we are able to offer our patients improves each year, the quality of service we offer continues to deteriorate. However, in response to declining reimbursement and increasing difficulties dealing with third party payors, we are trying to see too many patients in too little time. To contain costs, we're allowing our facilities to age and we're replacing reception staff with answering machines. To cope with an increasingly complex billing environment we're shifting staff resources away from patient care and into the billing department. At the end of the day, we're left with too many reports and paperwork to address because we are seeing more patients than we can comfortably handle. We're undertaking this process of care coordination when we are unduly fatigued. Too often, coordination of care gets delayed beyond what is a "best practice" time frame. Unfortunately, this is the reality as we try to cope with the circumstances being forced upon us, but I believe there is a better way.

This approach can bring your practice closer to the ideal of medical practice you once hoped it would be. You'll quickly find that if you charge fees compatible with the value of your services, you'll be able to spend a greater amount of time with each patient and see fewer patients in a day. Soon, you'll notice that you have a smaller stack of charts to deal with and your staff will likely be happier.

I, like you, believe the quality of service I offer my patients is far above average. In fact, 90 percent of doctors probably think the quality of service they offer is above average. Even if you're part of that 90 percent, I encourage you to be open to the possibility that there is still room for improvement when pursuing competitive edge.

To improve the patient experience, you will want to put yourself in the patient's shoes. What happens when patients call your office? Are they exposed to a mind-numbing choice of recorded messages and menu options or consistently placed on hold for minutes at a time. Once the patient gets to a live person, how knowledgeable, personable, and helpful is the staff member? Is your schedule so overburdened that the patient must wait three weeks for an appointment to treat a bladder infection? Once a patient arrives for an appointment, what is the experience like? Is the carpet warn and the upholstery dirty? Does your read-

ing material belong in a museum? Is the staff frazzled? Is the typical wait time long enough to read a tattered two-year-old Reader's Digest from cover to cover?

And when the patient is finally taken to the exam room, how harried is the staff person who possibly has already worked up 35 patients today? How long does the patient sit in a cold stark examining room on a hard exam table wearing a disposable paper gown? When you finally arrive on the scene do you appear to be in a hurry? Have you had time to review their chart ahead of time so that you know why they are being seen? Do you have the time to look the patient in the eye, visit with them and hear the long unedited version of the health condition at hand? Do you have the time to thoroughly address the patient's concerns? Is the staff left answering the patient's questions after you hurriedly move on to the next exam room? Did you really take care of the patient in the heartfelt manner consistent with what you thought you would be able to provide back when you were in medical school? For more information on patient satisfaction, refer back to Chapter IV.

My intention is not to beat up the modern American physician who has dedicated his or her career and life to care for people. But our efforts to cope with the changes put upon us have had negative consequences not only for us, but also for the patients we desire to help. I think there's a better way. My practice has gone through a metamorphosis. It has been a gratifying experience. Yet if you talk to my patients, some would tell you I have not reached the service goals to which I strive. There are so many things we can do to be better to serve our patients. The following is a partial list of suggestions and goals that should be considered regardless of the type of insurance your patient has:

a. **Reinvent your philosophy.**

Decide in your heart that you want your practice to be a place where people will receive exemplary service, not just good medical care. Make up your mind that you really care about whether your office wastes patients' time. Embrace the idea that patients deeply appreciate the time you spend with them. Make it your personal concern that patients have incredibly good experiences whether they contact your office by telephone or in person. If you adopt this philosophy, everything else will fall into place. Reinvent your philosophy about patient care and share that philosophy and expectations with your staff.

b. **Spruce up the waiting room and other patient areas.**

Shampoo the carpet and upholstery, dust the baseboards, and get rid of the clutter. Provide current reading materials. Care about the environment your patients are in and make it look that way.

c. **Shorten waiting room time.**

I have heard all the excuses and, sadly, have used them myself over and over. I still believe that if we really try, we don't have to make patients wait. There are no good excuses.

d. **Lengthen patient visit times.**

If you are paid what your services are worth, you will be able to offer the time to deliver the service you want to deliver.

e. **Offer more personalized care.**

From the receptionist to the billing person, treat people as though they are special.

Develop a Pay-at/Before The-Time of Service Policy

One of the many things I knew I should do but never quite got around to doing right was to implement a policy to collect payment at the time of service. I'll admit that we are still not as good as we should be with office visits, but have discovered it is a necessity with surgical procedures. Even if you don't choose to see patients as out-of-network provider, the increasing prevalence of high deductible plans will likely force you to collect payment prior to elective surgical procedures.

When we are working with a patient prior to elective surgery, we find out in advance the carrier's out-of-network pay rate for the CPT code(s) we're proposing. We then determine the remaining portion the patient will owe by subtracting the carrier's payment from our out-of-network fee schedule. We tell the patient in advance they will be responsible for this amount plus any deductible. Roughly ten days before surgery we check the patient's remaining deductible. Many times we can do this online. We collect the patient's portion of the fee ideally one week (five business days) prior to surgery.

Next we submit the claim to the payor. As mentioned previously, some carriers send payment directly to the patient rather than the provider for out-of-network services. We try to soften the financial blow to patients by collecting only the patient's out-of-pocket portion prior to surgery, presuming the patient sends us payment as soon as their insurance company pays.

Unfortunately, we found that patients didn't follow through and we had to rescind that policy and collect full payment from these patients at the time of service. **Δ**

Develop a Strategy to Keep Track of Stuff

Often, I get the feeling that payor personnel know very little about their company's out-of-network policies. Frequently, they appear to be learning along with us. We occasionally receive information from them that just wasn't plausible. We call back hoping for a different customer service representative and

receive more appropriate answers. Thankfully, we carefully document each of these conversations in the medical record. A few times we have had to look back on that documentation to prove we were acting on information given by a carrier representative.

While we submit claims electronically due to the speed of payment and decreased costs, we try hard to communicate important transactions by certified mail or fax so we have a record of interaction. In situations where we handle matters by phone, we carefully record not only the facts of the conversation in the medical record, but also the time, date, and name of the person with whom we are dealing.

Create a Spreadsheet

I mentioned above that we never tell a patient how their insurance carrier will handle our out-of-network status until we've specifically verified the patient's own policy information with the payor. That's largely because a single payor may offer hundreds of different types of policies with differing deductibles, co-pay amounts, and utilization and authorization requirements. In our area, local government entities are insured through the same payor that some unions and self-insured businesses are, yet their out-of-network provider practices are very different. We think we are better able to help our patients if we know how carriers handle out-of-network provider issues for each of these contracted entities so we're in the process of collecting data to better assist our patients. It is great information to share with others in an out-of-network provider workgroup.

Train Your Staff

Like most doctors, I've approached the role of employer with no training, and no expertise. I've made plenty of mistakes over the years. But I now have myself convinced that I've learned a few things through the years.

The most valuable lesson I've learned as a manager of people is that almost all people will do the right thing almost all the time if given the right tools to do so. Usually when mistakes are made it is because I've set up a problem-prone situation where failure is a likely outcome.

To successfully navigate this new way of doing business as an out-of-network provider, take the time to adequately train your staff. If you do, your chances of success increase dramatically.

Start by obtaining staff buy-in to the concept. Make them aware of the problems you're trying to overcome. My staff and I concluded together that we needed to leave networks as we jointly searched for ways to cope with impending cuts in our contracted fees. We did everything we could to put off contract termination. By the time we made the decision to terminate, it was obvious to all that it was the only option.

My great staff was very motivated to do what was necessary for our practice to transform as it has. They did not see this transformation as a disruption to their lives. They saw the benefit and wanted to make it work.

Get ready to Apologize

For the first few months we spent a great deal of time explaining to patients that we were navigating in uncharted waters as an out-of-network physician. We asked for their patience and promised them we would do the right thing when we made mistakes. Inevitably, you'll find that much of the learning will be done after you've left a

payor network. Our patients, surprisingly, understood. We made some mistakes and had to swallow our pride on a few occasions. As the months wore on, the apologies became less frequent as we became more experienced.

BE OPTIMISTIC

History is replete with examples of how good things have evolved from difficult circumstances.

The modern medical marketplace is evolving. The hand of outside forces invading our practices is real. Our ability to care for patients has been woefully impacted.

Caring for patients outside of an insurance network is a decision that each physician must make individually. I've found the challenge gratifying. I feel much less pressed to maintain an unsustainable patient volume and I love being able to spend more time with my patients.

As I mentioned earlier, my inspiration in this matter was the primary care doctor down the hall in my medical office building. He likes taking care of his patients, limiting his practice to t24 patients per day. He spends around 45 minutes doing a complete physical exam. He knows his patients well and they love him.

He told me recently of a conversation in a hospital doctor's cafeteria. Colleagues were lamenting about the ill state of medical practice, agreeing it was so bad that they were all encouraging their children to go in different career directions. When the conversation turned to him, he explained that not only was his son heading off to medical school but it was with his blessing. This family practitioner has found a way to make a good living, delivering medical care that both he and his patients believe is superior, and he likes his career. If he had to do it over again he would.

John Nordstrom found opportunity when things didn't turn out as he had hoped. So did the family practitioner down the hall. So can you. ■

Appendix

CMA On-Call

This toolkit references many documents that explain in more detail the issues and laws discussed. These documents are known as "CMA On-Call" documents. CMA On-Call is the California Medical Association's online information-on-demand library. CMA On-Call is a repository of thousands of pages of medical, legal, regulatory, and reimbursement guidance. All documents are available free to CMA members on the members-only website at www.cmanet.org/member. Nonmembers can purchase these documents for $2 per page in the CMA bookstore at www.cmanet.org/bookstore.

You will need Adobe Acrobat Reader to view and download all CMA ON- CALL documents. If you do not have this program on your computer, it is available free in the CMA On-Call area online. Just click on the Adobe icon and follow the instructions.

To locate an On-Call document, you can search in three ways:

Document Number: If you know the number of the document you're looking for, enter that number into the search box. If you are attempting to search by keyword, the search result will list all documents that contain that keyword.

Keyword: Type a keyword search into the search box. When searching for two or more words, use "and" or "or" (e.g., needles or syringes, HMO and contracts).

Topic: Select from the topic list on the On-Call page. Topic headings for the most part parallel the chapters of CMA's California Physician's Legal Handbook, such as "Managed Care," "Medical Board," and other familiar medical-legal terms. To see a list of documents by topic, simply select that topic.

On-Call Documents Referenced in this Toolkit

Doc. #	Title
0233	Pre-Employment Inquiries (Chapter 1)
0217	Overview of Select Physician Practice Employment Issues (Chapter 1)
1810	Cal-OSHA Compliance and Inspections (Chapter 2)
1606	HIPAA Electronic Transaction Rule (Chapter 2)
0805	Termination of the Physician-Patient Relationship (Chapter 3)
0124	Late Payment (Chapter 5)
1606	HIPAA Electronic Transaction Rule (Chapter 5)
1609	Electronic Funds Transfer (Chapter 5)
1160	Retention of Medical Records (Chapter 7)
1135	Contents of Medical Records (Chapter 7)
1603	HIPAA ACT SMART-Introduction to the HIPAA Privacy Rules (Chapter 7)
1600	HIPAA Security Rule (Chapter 7)
1606	HIPAA Electronic Transaction Rule (Chapter 7)
1132	Electronic Medical Records (Chapter 7)

Position: Medical Receptionist

Reports to: Office Manager

Responsibilities: Responsible for receiving patients and visitors, determining their needs and directing them accordingly. Answers telephone, makes appointments, receives payments, and issues receipts. Performs other clerical and administrative tasks as required.

Duties of the Position:

- Greets visitors and patients, determines their needs, and directs them accordingly.
- Answers questions and gives information directly or via the telephone within the limits of knowledge and medical practice policies.
- Makes and checks off appointments, giving routine non-medical instructions in preparation for the patient's visit to the practice.
- Retrieves and files medical records, letters, reports, and miscellaneous items as requested. Purges medical records monthly.
- Collects fees, issues receipts, and counsels patients concerning their accounts when necessary. Counts and balances money at the end of the day.
- Types hospital lists. Types hospital orders for physicians. Schedules hospital admissions. Schedules surgery. Secures information from hospitals concerning consultations.
- Researches files to determine if patient has visited practice before. Organizes medical records for new patients.
- Opens practice, does housekeeping chores, runs errands, and closes practice as required.
- Handles refills for prescriptions according to medical practice policy.
- Performs other duties as required.

Position Requirements: Graduation from high school with courses in English and typing. Certified Medical Office Manager (CMOM) certification is desirable. Previous patient contact work in a medical practice would be an advantage. If the applicant does not have experience, three months on-the-job training will be provided. Be able to operate a transcription device and operate a computer (word-processing) and type 60 words per minute with accuracy. Possesses the tact required for work situations that involve dealing with patients to secure payment of delinquent accounts. Possess the tact to work effectively with patients, physicians, and other employees. Possess a preference for dealing with people who are ill and need help. Possess the verbal ability to discuss medical and financial problems with patients and be clearly understood.

Position Relationships: Does not supervise any other employees. Receives supervision from the office manager.

Authority Boundaries: Reports to the office manager in all matters.

Position: Business Manager

Reports to: Physicians

Responsibilities: Responsible for all administrative, financial, personnel, clerical, housekeeping, and maintenance functions. Plans, programs, allocates, and assigns duties to the employees. Monitors the activities of all clinical operating components to ensure the practice successfully meets its objectives. Advises and seeks consent from physicians to coordinate and manage the activities of the clinic.

Duties of the Position:

- Supervises and coordinates the activities of all clinic personnel.

- Organizes and assigns duties to employees relating to bookkeeping, payroll, collections, insurance claim filing, typing, medical records, answering the telephone, housekeeping, appointment scheduling and x-ray.

- Monitors clinic personnel to ensure employees are performing their duties in a manner designed to maintain a high level of patient care.

- Maintains a sufficient flow of work throughout the clinic by evaluating production and revising procedures accordingly.

- Standardizes procedures and initiates changes where necessary. Constantly reviews procedures to determine if there is a more efficient and less costly way to conduct the business without sacrificing patient care.

- Directs operations to prepare and retain records, files, and reports according to various governmental and practice standards. Prepares and implements a records retention and disposition program for the practice.

- Interviews, tests, hires, and terminates employees, and verifies information on employment application forms. Arranges for background checks on applicants for employment. Conducts periodic performance and salary reviews.

- Reviews and approves weekly time records of all clinic employees. Approves all sick and emergency leave in accordance with clinic policy. Establishes and schedules vacations for all employees.

- Prepares, maintains, and provides security for the personnel records of all employees. Retains applications from applicants for employment.

- Creates and administers an on-the-job training program for new employees as required.

- Schedules and conducts periodic staff meetings with the employees to inform the staff of changes in the clinic policy and to resolve problems that are affecting operating effectiveness. Prepares and retains minutes of such meetings.

- Schedules meetings for the physicians. Notifies those who are to attend. Handles the logistics of meetings. Attends physician meetings as directed. Reports on the status of the clinic. Takes or arranges to have taken minutes of each meeting. Maintains the physician's master schedule. Prepares the agenda for all physician meetings.

- Ensures that a high level of cleanliness exists in the clinic at all times. Takes steps to ensure the physical plant is in good operating condition.

- Prepares the various clinic payrolls or arranges to have an outside agency prepare them. Types or writes checks.

- Prepares income statements and balance sheets on the various sets of books maintained by the clinic. May prepare other financial and statistical reports for review by the physicians, either on a scheduled basis or as requested. Works with the clinic accounting firm and legal counsel as necessary.

- Reviews the entire accounting system to ensure it is operating within the limits of well-defined internal control standards.

- Works with physicians and clinic accountant to prepare a budget for the clinic. During the year, compares actual to projected budget performance to ensure adherence to the budget.

- Reviews all invoices and statements received from vendors for payment. Checks all invoices for discounts earned. Consults with physicians before ordering any supplies or equipment exceeding $100 in value. Secures competitive bids for supplies and equipment.

- Reviews orders for supplies, equipment, narcotics, etc., from the various operating sections for the clinic. Orders all supplies, equipment, narcotics etc. Uses prenumbered purchase-order forms.

- Monitors outstanding accounts receivable. Works with credit and insurance counseling clerks to ensure constant attention is paid to the balances outstanding, and steps are being taken to reduce the receivables.

- Performs other duties as required.

Position Requirements: Graduation from a recognized college or university with a baccalaureate in business administration, personnel administration, or accounting. Experience may be substituted for education. If experience is substituted, the second job requirement becomes mandatory and the applicant must have experience in accounting or personnel administration. Four or more years of progressively responsible experience in a hospital, business office, or a multi-physician medical practice is desirable. Possess the tact necessary to deal effectively with patients, physicians, and employees. Be able to motivate employees. Possess the ability to think clearly to make judgment decisions in initiating business office policy. Possess knowledge of modern office equipment, systems and procedures. Be able to operate an electric adding machine typewriter, calculator, and computer.

Position Relationships:
Supervises receptionists, medical transcriptionist, registered nurses, and a combination laboratory/x-ray technician. Receives supervision from the physicians.

Authority Boundaries: All major policy and operating decisions are carried out by the business manager, but made by the physicians.

Application for Employment

All applicants for employment are required to complete and submit this Employment Application.

Name of Company/Location   **Please Print**

Applicant Information

LEGAL NAME as shown on your Social Security Card			SOCIAL SECURITY NUMBER
Last	First	Middle	

HAVE YOU EVER WORKED UNDER ANOTHER NAME?
☐ Yes
☐ No

IF YES, UNDER WHAT NAME(S):

COMPLETE HOME ADDRESS include PO Box, Apt. #, etc.

Street	City	County	State	Zip Code

HOME PHONE	BUSINESS OR OTHER PHONE	E-MAIL ADDRESS
( ) -	( ) -	

Position Applying For

JOB TITLE/TYPE OF WORK	DESIRED SALARY	AVAILABLE START DATE
	$	

ARE THERE ANY LIMITATIONS ON THE HOURS, DAYS OR TIME YOU ARE AVAILABLE TO WORK? (If so, explain) YOUR AVAILABILITY?

Full time	Part time	Over time	Temporary
☐ Yes	☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No	☐ No

WILL YOU BE ABLE TO PERFORM THE ESSENTIAL JOB FUNCTIONS FOR THE POSITION YOU ARE APPLYING FOR WITH OR WITHOUT REASONABLE ACCOMMODATION?

☐ YES
☐ NO (If no, describe the function(s) that cannot be performed:

IF EMPLOYED, CAN YOU SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE U.S?

☐ Yes
☐ No

HAVE YOU WORKED FOR OR APPLIED FOR A POSITION AT THIS COMPANY BEFORE?
☐ Yes If yes, what position(s)?
☐ No

DO YOU HAVE ANY RELATIVES WORKING HERE?
☐ Yes   If yes, who:
☐ No

HOW DID YOU LEARN ABOUT THIS OPENING?

ARE YOU OVER EIGHTEEN YEARS OF AGE?
☐ YES   ☐ NO

IF UNDER 18, DO YOU HAVE A WORK PERMIT? ☐ YES ☐ NO

HAVE YOU EVER BEEN CONVICTED OF A CRIME? (Exclude convictions for marijuana-related offenses for personal use more than two years old; convictions that have been sealed, expunged or legally eradicated, and misdemeanor convictions for which probation was completed and the case was dismissed.)
☐ Yes   If yes, please describe the nature of the crime(s), the date and place of conviction and the legal disposition of the case. The Company will not deny employment to any applicant solely because the person has been convicted of a crime. The Company, however, may consider the nature, date and circumstances of the offense as well as whether the offense is relevant to the duties of the position applied for.

☐ No

Education Begin with most recent college/university/technical school

NAME OF EDUCATIONAL INSTITUTION/LOCATION	MAJOR	NO. OF YEARS	GRADUATE Yes/No	DIPLOMA/DEGREE Yes/No

ANY PROFESSIONAL DESIGNATIONS OR OTHER TRAINING/EDUCATION RELATED TO THE JOB YOU ARE APPLYING FOR:

BE SURE TO COMPLETE PAGE 2

Application for Employment

COMPLETE ALL JOB HISTORY REGARDLESS OF RESUME ATTACHMENT

May we contact your current employer?   ☐ Yes   ☐ No

Employment History list current/most recent position first

NAME OF EMPLOYER	ADDRESS/LOCATION	DATES EMPLOYED From	To
TYPE OF BUSINESS	POSITION/TITLE	SALARY Starting	Final
MANAGER'S NAME	MANAGER'S TITLE	PHONE ( ) -	
REASON FOR LEAVING:			

NAME OF EMPLOYER	ADDRESS/LOCATION	DATES EMPLOYED From	To
TYPE OF BUSINESS	POSITION/TITLE	SALARY Starting	Final
MANAGER'S NAME	MANAGER'S TITLE	PHONE ( ) -	
REASON FOR LEAVING:			

NAME OF EMPLOYER	ADDRESS/LOCATION	DATES EMPLOYED From	To
TYPE OF BUSINESS	POSITION/TITLE	SALARY Starting	Final
MANAGER'S NAME	MANAGER'S TITLE	PHONE ( ) -	
REASON FOR LEAVING:			

APPLICANT'S CERTIFICATION AND RELEASE

I certify that the facts given in my resume' and/or Application for Employment are true and correct. I understand that if employed, any false or misleading statements, omissions, or failure to fully answer any requested item on this application or on any document used to secure employment shall be grounds for rejection of this application or for my termination from employment, if I am employed, regardless of when such information is discovered. I authorize the Company to secure background information on my work record, education, and other matters related to my suitability for employment. I authorize my references and background sources to disclose information about me to the Company, without giving me prior notice of such disclosure. I hereby release the Company, my former employers, and all other sources from any and all claims, demands, or liabilities arising out of or in any way related to securing such information or disclosures.

I understand that nothing contained in the application, or information conveyed during any interview, which may be granted, or during my employment, if hired, is intended to create an employment contract between the Company and me. I understand that any employment with this Company is "at will," which means that either I or the Company can terminate the employment relationship at anytime with or without prior notice, and for any reason not prohibited by statute. All employment is continued on that basis. I understand that no supervisor, manager, or executive of the Company has any authority to alter the foregoing unless a specific term of employment is in writing and signed by the Company President.

APPLICANT SIGNATURE	DATE

02/24/04 HS
F-CHR001a   2 of 2

Completed by: _____ Date: _____

Applicant Name: _____ Position Applying for: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

Requirements for Position: _____
_____
_____

Requirements Held by Applicant: _____
_____
_____

Skills: _____
_____
_____

Appearance: _____
_____
_____

Interpersonal Skills: _____
_____
_____

Questions Asked: Responses Given:
1. _____   1. _____
   _____   _____

2. _____   2. _____
   _____   _____

3. _____   3. _____
   _____   _____

4. _____   4. _____
   _____   _____

Results of Skill Test: _____
_____
_____

General Remarks: _____
_____
_____

Applicant's Full Name: _____

Position Applied for: _____   Dept.: _____

Person Contacted: _____   Phone #: _____

Completed by: _____   Date: _____

This is [your name] from Dr. _____'s office. [Candidate's name] has applied for a position with us and has listed you as a personal reference. If you have a few minutes, I would like to ask you a few questions.

1. How long have you known [candidate's name] and in what capacity?

_____

_____

_____

2. How would you describe [candidate's name]'s ability to get along with others?

_____

_____

_____

3. How about his/her dependability? Have you had the opportunity to observe his/her work habits? Does he/she complete projects, show up on time?

_____

_____

_____

4. Have you observed traits of personal responsibility?

_____

_____

_____

5. What about his/her judgment in making decisions? Is he/she a self-starter?

_____

_____

_____

6. What are some of his/her strengths/accomplishments?

_____

_____

_____

7.What do you admire most about [candidate's name] ?

_____

_____

_____

Comments

_____

_____

_____

This form can also be used as a template for written verification form sent to personal references.

SAMPLE FORM: Past Employer Reference Check

Applicant's Full Name: _____

Position Applied for: _____ Dept.: _____

Person Contacted: _____ Dept.: _____

Company & Address: _____ Phone #: _____

Completed by: _____ Date: _____

This is [your name] from Dr. _____'s office. [Candidate's name] has applied for a position with us and has listed you as a previous employer. If you have a few minutes, I would like to ask you a few questions.

1. Dates of Employment: _____

    Position (title): _____

    Salary upon Leaving: _____

2. Job Responsibilities: _____
_____

3. Quality/Quantity: _____
_____

4. Personal Qualities/Work Relationships: _____
_____

5. Dependability/Attendance: _____
_____

6. Strengths: _____
_____

7. Weaknesses: _____
_____

8. Reason for Leaving: _____
_____

9. Rehire Status: _____
_____

Comments: _____
_____
_____

This form can also be used as a template for a written verification form sent to previous employers.

SECTION 1: General Information

Last: _____ First:_____ MI:_____

Department:_____ Employee ID: _____ Job Title: _____

Type of Review: _____ Date of Review: _____ Date of Hire: _____

SECTION 2: Job Performance

FOR EACH CATEGORY, RATE EMPLOYEE WITH CORRESPONDING NUMERICAL APPRAISAL.

Example: "Good" should be rated as either "5" or "6." Circle the number and enter in far left column.

(1) QUALITY	1 or 2 Always below acceptable standards	3 or 4 Often below acceptable standards	5 or 6 Usually meets acceptable standards	7 or 8 Often exceeds acceptable standards	9 or 10 Consistently exceeds most standards

Comments: _____

_____

(2) QUANTITY	1 or 2 Seldom finishes required volume within allotted time	3 or 4 Meets minimum time and volume requirements	5 or 6 Completes satisfactory volume of work within time given	7 or 8 Frequently completes more than expected volume within allotted time	9 or 10 Completes more than expected volume within allotted time

Comments: _____

_____

(3) JOB KNOWLEDGE	1 or 2 Always needs assistance executing routine tasks	3 or 4 Often needs reminding and clarification to execute routine work	5 or 6 Performs routine tasks; occasionally needs assistance	7 or 8 Accepts full responsibility for performing routine tasks; questions are infrequent & relevant	9 or 10 Executes tasks without assistance; often functions as source of information

Comments: _____

_____

Work Habits

(4) ATTENDANCE & PUNCTUALITY	1 or 2 Undependable; often tardy or absent without proper notice	3 or 4 Poor attendance; sometimes late	5 or 6 Acceptable attendance and punctuality	7 or 8 Rarely absent or late	9 or 10 Perfect attendance record; consistently punctual

Comments: _____

_____

(5) FOLLOWING DIRECTIONS	1 or 2 Routinely does not follow directions/ procedures; insubor- dinate to supervisors	3 or 4 Frequently does not follow directions/ procedures; tries to do many things his/ her own way	5 or 6 Usually follows instructions; abides by established procedures	7 or 8 Consistently follows accepted procedure and looks for direc- tion when in doubt	9 or 10 Always follows accepted procedure; often offers sugges- tion to improve es- tablished procedures

Comments: _____

_____

(6) PLANNING/ ORGANIZATION	1 or 2 Seldom sets priorities effectively	3 or 4 Below average in setting priorities	5 or 6 Sets priorities at an acceptable level	7 or 8 Frequently sets pri- orities effectively	9 or 10 Consistently sets priorities effectively

Comments: _____

_____

(7) INITIATIVE	1 or 2 Performs only required work; never volunteers to undertake work	3 or 4 Performs routine work; expresses little interest in work method improvement	5 or 6 Expresses interest in performing work more effectively	7 or 8 Usually seeks ways to do job better	9 or 10 Shares new ideas: has implemented effective changes in the organization

Comments: _____

_____

(8) ADAPTABLE/ FLEXIBLE	1 or 2 Refuses to learn new tasks; reacts poorly to changing procedures and priorities	3 or 4 Slow to accept change; adapts with difficulty	5 or 6 Adapts acceptable with little opposition to change	7 or 8 Adapts well to change with little or no resistance	9 or 10 Adapts with ease; re- sponds to change as a positive challenge

Comments: _____

_____

Interpersonal Skills

(9) COMMUNICA- TION	1 or 2 Has difficulty ex- pressing written/ oral thoughts; inability to correspond	3 or 4 Frequently fails to communicate clearly and accurately	5 or 6 Acceptable commu- nications, both oral and written	7 or 8 Understands and ex- presses clearly, both oral and written	9 or 10 Superior oral and written communica- tion skills; com- municates clearly and accurately

Comments: _____

_____

(10) WORKING RELATIONSHIP	1 or 2 Is a constant source of conflict; distrusted by other staff members; ignores requests	3 or 4 Is often involved in conflict; does not get along well with others; seldom helps others	5 or 6 Works well with others; will give assistance if asked	7 or 8 Is always tactful and courteous; frequently gives assistance without being asked	9 or 10 Has earned respect of others; always gives assistance without being asked

Comments: _____

_____

_____ Total number of quality points

Comments: _____

_____

_____

SECTION 3

Describe the major strengths and assets as they relate to the job performance.

_____

_____

_____

_____

SECTION 4

Indicate areas where training, development, and/or improvements need to occur. Specify what action(s) will be taken by the supervisor and employee to achieve these changes. Please attach an action plan complete with timetable.

_____

_____

_____

_____

SECTION 5 (Employee Comments)

_____

_____

_____

_____

SECTION 6

Check if any attachments accompany this form and list additional attachments, if needed.

❑ Job Description ❑ Specific job duties/responsibilities
❑ Certificates/licenses (if applicable) ❑ Action plan

SECTION 7 (Certification)

I understand my signature indicates this review has been discussed with me, but does not necessarily signify that I agree with its contents. I am aware I can make additional comments in writing following this performance appraisal.

Employee Signature: _____ Date: _____

Administrative Supervisor #1 Signature: _____ Date: _____

Administrative Supervisor #2 Signature: _____ Date: _____

Employee Name: _____

Job Title:_____   **Dept:** _____

Supervisor: _____   **Dept:** _____

Describe Grievance: _____
_____
_____
_____
_____
_____

Suggested Solutions: _____
_____
_____
_____
_____

Employee Signature: _____   **Date:** _____

To be completed by supervisor:

Investigations/interviews: _____
_____
_____
_____

Disposition/Action Plan: _____
_____
_____
_____

Supervisor's Signature: _____   **Date:** _____

SAMPLE FORM: Employee Corrective Action

Employee Name: _____ Hire Date: _____

Job Title:_____ Dept: _____

TYPE OF ACTION: (Check One)

❑ Verbal Warning ❑ Final Warning ❑ Discharge ❑ Written Warning ❑ Disciplinary Suspension

Previous Correction Actions: (Type of action, offense, date)

_____
_____

I. INCIDENT: Describe the situation (behavior, performance, policy violation, etc.) that occurred. Include dates(s), time(s), location(s), people involved, witnesses, effects of incident on employee's work or other employees, and all other relevant circumstances or contributing factors. Please be specific in stating observable behaviors and comments whenever possible.

_____
_____

II. GOALS AND TIMEFRAME FOR IMPROVEMENT: What specific actions are to be accomplished, and within what timeframe, to improve the behavior/performance?

_____
_____

III. FOLLOW-UP REVIEW DATE: _____

IV. CONSEQUENCES: What will happen if employee fails to meet the goals set within the designated time frame?

_____
_____

V. EMPLOYEE'S COMMENTS: My supervisor has reviewed the above situation with me and my comments are as follows:

_____
_____

Supervisor's Signature: _____ Date: _____

I understand that my signature indicates only that this incident has been reviewed with me and does not indicate agreement or disagreement with the action taken.

Employee Signature: _____ Date: _____
(Not required for verbal warning)

Patient Name: _____

Doctor: _____ **Day of Week:** _____

I. Appointment type: (check one)

❑ First Exam ❑ Recheck ❑ Acute Illness ❑ Immunization ❑ InjuryOther

II. Time: (everyone who encounters the patient records the time to the nearest minute)

Scheduled Appointment Time: _____ am/pm

	Timeˇ	**Time Spentˇ**	
a. Pt. arrival time and sign in	_____		
b. Receptionist checks pt in	_____	_____	(*subtract b from a)
c. Chart readied for rooming	_____	_____	(subtract c from b)
d. Pt. called to exam room	_____	_____	(subtract d from c)
e. MA leaves room	_____	_____	(subtract e from d)
f. Dr. enters room	_____	_____	(subtract f from e)
g. Dr. leaves room	_____	_____	(subtract g from f)
h. Pt. check out w/ reception	_____	_____	(subtract h from g)

Total visit time = _____
(Subtract arrival time from pt. check out time)

Total time spent waiting = _____
(Add time spent in rows b, c, d, f, and h)

Total time spent with MA, Nurse, Physician = _____
(Add time spent on e and g)

It is recommended that the office assessment be performed in conjunction with patient wait time calculator on following page.

*If patient arrives early, subtract b from scheduled appt time rather than arrival time.

SAMPLE FORM: **Time Flow Study (Patient)**

(To be completed by patient as part of the office assessment)

Patient Name: _____

Doctor: _____ **Day of Week:** _____

Status	Time (example 9:30)
Time of scheduled appointment	
Time of arrival	
Time checked in for appointment	
Time called to exam room	
Time MA/nurse leaves exam room	
Time doctor enters room	
Time doctor leaves room	
Time of checkout	
Comments:	

Please hand in your completed card at the appointment desk when you leave. Thank you for helping us to improve your experience with our practice.

Day of Week: _____

Time of Day

Issue	9-10am	10-11am	11am-12pm	12-1pm	1-2pm	2-3pm	3-4pm	4-5pm	Total
Scheduling									
Rescheduling									
Authorizations									
Referrals									
Labs/test results									
Rx refills									
Billing questions									
Questions for nurse/physician									
Patient demographics									
Forms									
Labs									
Pharmacy									
Health Plan									
Directions									
Repeat calls									
Other									
Total									

[Insert practice name/logo here]
Patient Satisfaction Survey

We would like your feedback on the services we provide so we can make sure that we are meeting your needs. Your responses will help us to improve the services we provide. All responses will be kept confidential and anonymous. Thank you for your time.

Your Age:_____   **Your Sex:** ❏ Male ❏ Female

Your Race/Ethnicity: ❏ Asian   ❏ Pacific Islander   ❏ Black/African American   ❏ American Indian/Alaska Native
❏ White (Not Hispanic or Latino)   ❏ Hispanic or Latino (All Races)   ❏ Unknown/Mixed

Do you consider this practice your regular source of care?   ❏ Yes   ❏ No

Please circle how we are doing in the following areas:	GREAT (5)	GOOD (4)	OK (3)	FAIR (2)	POOR (1)
EASE OF GETTING CARE:					
Ability to be seen timely	5	4	3	2	1
Hours of operation	5	4	3	2	1
Convenience of practice location	5	4	3	2	1
Prompt return on calls	5	4	3	2	1
WAIT TIMES:					
Time in waiting room	5	4	3	2	1
Time in exam room	5	4	3	2	1
Time spent waiting for tests to be performed	5	4	3	2	1
Time spent waiting for test results	5	4	3	2	1
STAFF:					
Provider: (Physician, Physician Assistant, Nurse Practitioner)					
Listens to you	5	4	3	2	1
Takes enough time with you	5	4	3	2	1
Explains what you want to know	5	4	3	2	1
Gives you good advice and treatment	5	4	3	2	1
Nurses and Medical Assistants:					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
Receptionist:					
Friendly and helpful	5	4	3	2	1
Answers your questions	5	4	3	2	1
All others:					
Friendly and helpful	5	4	3	2	1
Answer your questions	5	4	3	2	1

Please circle how we are doing in the following areas:	GREAT (5)	GOOD (4)	OK (3)	FAIR (2)	POOR (1)
Payment:					
What you pay	5	4	3	2	1
Explanation of charges	5	4	3	2	1
Collection of payment/money	5	4	3	2	1
Facility:					
Cleanliness building	5	4	3	2	1
Ease of locating the practice	5	4	3	2	1
Comfort and safety while waiting	5	4	3	2	1
Privacy	5	4	3	2	1
Confidentiality:					
Keeps my personal information private	5	4	3	2	1
The likelihood of referring your friends and relatives to us:	5	4	3	2	1

What do you like best about our practice? _____

_____

_____

_____

What do you like least about our practice? _____

_____

_____

_____

Suggestions for improvement? _____

_____

_____

_____

Thank you for completing our Survey!

[Insert practice name/logo here]
Encuesta De Satisfacción Para el Paciente

Quisiéramos saber que piensa usted de los servicios de salud que ofrecemos para asegurarnos que estamos satisfaciendo sus necesidades. Sus respuestas se tomarán en cuenta para mejorar nuestros servicios. Sus respuestas serán tomadas confidencialmente y anónimamente. ¡Gracias por su tiempo!

Su Edad:_____   **Su Sexo:** ❑ Musculino   ❑ Femenino

¿Considera esta clínica su Centro de cuidado principal?   ❑Sí   ❑ No

Su Raza/Etnicidad: ❑ No Sé   ❑ Oriental   ❑ Negro / africano Americano   ❑ Isla Pacifica
❑ Indio Americano / nativo de Alaska   ❑ Blanco (No Hispano ni Latino)   ❑ Hispano o Latino (Todas las Razas)

Por favor califique los servicios en las siguientes áreas y circule el número de acuerdo con la calidad de cada servicio:	MUY BUENO (5)	BUENO (4)	REGULAR (3)	POBRE (2)	MUY POBRE (1)
FACILIDAD DE RECIBIR CUIDADO:					
Habilidad para obtener una cita	5	4	3	2	1
Horas de servicio del Centro	5	4	3	2	1
Lugar donde se encuentra el Centro	5	4	3	2	1
Rapidez en contestarle por teléfono	5	4	3	2	1
EL CONSULTORIO:					
Tiempo en la sala del Centro	5	4	3	2	1
Tiempo en el cuarto de examen	5	4	3	2	1
Tiempo que espera para que le hagan un examen	5	4	3	2	1
Tiempo de espera para obtener los resultados del examen	5	4	3	2	1
EMPLEADOS:					
Proveedor: (Doctor, Asistente Médico, Enfermera Practicante)					
Le escuchan	5	4	3	2	1
Se toman suficiente tiempo con usted	5	4	3	2	1
Le explican lo que usted quiere saber	5	4	3	2	1
Le dan buenos consejos y tratamiento	5	4	3	2	1
Enfermeras:					
Son amistosos y amables cuando le ayuden	5	4	3	2	1
Le contestan sus preguntas	5	4	3	2	1
Recepcionista:					
Amables y dispuestos en ayudarle	5	4	3	2	1
Le contestan sus preguntas	5	4	3	2	1

Por favor califique los servicios en las siguientes áreas y circule el número de acuerdo con la calidad de cada servicio:	MUY BUENO (5)	BUENO (4)	REGULAR (3)	POBRE (2)	MUY POBRE (1)
Todos Los Demás:					
Amables y dispuestos en ayudarle	5	4	3	2	1
Le contestan sus preguntas	5	4	3	2	1
Pago:					
Lo que usted paga	5	4	3	2	1
Explicación de cargos	5	4	3	2	1
Colección de pago / dinero	5	4	3	2	1
Lugar:					
El consultorio está en orden y limpio	5	4	3	2	1
Es fácil de encontrar el lugar donde debe ir	5	4	3	2	1
Se siente cómodo y seguro cuando está esperando	5	4	3	2	1
Hay privacidad	5	4	3	2	1
Confidencialidad:					
Mi información personal se mantiene en privado	5	4	3	2	1
La probabilidad de recomendar a parientes y amistades:	5	4	3	2	1

¿Qué es lo que más le gusta de nuestro Centro?_____

_____

_____

¿Qué es lo que menos le gusta de nuestro Centro?_____

_____

_____

¿Tiene sugerencias para mejoramiento? _____

_____

_____

¡Gracias por su tiempo en llenar esta encuesta!

[Physician Letterhead]

[Date]

Referring MD Name
Referring MD Address
City, State, Zip

Dear [insert referring physician name]:

My practice is performing an anonymous referral satisfaction survey. We greatly appreciate your referrals and wish to give you the opportunity to comment on my services to you and your patients.

Please take a moment to fill out the form and mail it in the self addressed and stamped envelope that has our address as the sender and recipient to protect your anonymity.

Comments are especially helpful, particularly if patients have made comments to you. My staff and I sincerely appreciate your honest opinions to continue to provide excellent service and improve where needed. We are committed to the highest quality medical care as well as patient and referring physician satisfaction.

Please complete and return the survey by _____.

Please accept my thanks for your time and cooperation and I look forward to a continued professional relationship.

Sincerely,
Name of Physician

[Insert practice name/logo here]

Referring Physician Satisfaction Survey

We appreciate your referrals! It is our goal to provide patients and referring physicians with excellent service. Please let us know how we are doing.

1. Is our office accessible for you to make referral appointments for your patients? ❑ Yes ❑ No

Comments: _____

_____

2. Is our office staff courteous and helpful? ❑ Yes ❑ No

Comments: _____

_____

3. Does our staff handle referral and prior authorization requests appropriately? ❑ Yes ❑ No

Comments: _____

_____

4. Do you receive progress reports in a timely manner? ❑ Yes ❑ No

Comments: _____

_____

5. Are your patients pleased with the medical care they receive in our office? ❑ Yes ❑ No

Comments: _____

_____

_____

6. Are your patients pleased with the attention and communication they receive from the physician? ❑ Yes ❑ No

Comments: _____

_____

_____

7. Is it important to you that the physicians will accept all patients regardless of the ability to pay? ❑ Yes ❑ No

Comments: _____

_____

Thank you for your time and effort. Please return this form in the enclosed envelope.

Sample Interview and Document Request for HIPAA Compliance Reviews (page 1 of 2)

This list, obtained from the U.S. Department of Health and Human Services' Office of E-Health Standards, is an example of information that might be requested of you during a HIPAA investigation or compliance review. This list should not be relied on as complete. However, it will give you a good idea whether you currently have the appropriate documentation.

1. Personnel that may be interviewed
- President, CEO, or director
- HIPAA compliance officer
- Lead systems manager or director
- Systems security officer
- Lead network engineer and/or individuals responsible for:
  - administration of systems which store, transmit, or access electronic protected health information (EPHI)
  - administration systems networks (wired and wireless)
  - monitoring of systems which store, transmit, or access EPHI
  - monitoring systems networks (if different from above)
- Computer hardware specialist
- Disaster recovery specialist or person in charge of data backup
- Facility access control coordinator (physical security)
- Human resources representative
- Director of training
- Incident response team leader
- Others as identified

2. Documents and other information that may be requested for investigations/reviews
- Policies and procedures and other evidence that address the following:
  - Prevention, detection, containment, and correction of security violations
  - Employee background checks and confidentiality agreements
  - Establishing user access for new and existing employees
  - List of authentication methods used to identify users authorized to access EPHI
  - List of individuals and contractors with access to EPHI to include copies pertinent business associate agreements
  - List of software used to manage and control access to the Internet
  - Detecting, reporting, and responding to security incidents (if not in the security plan)
  - Physical security
  - Encryption and decryption of EPHI
  - Mechanisms to ensure integrity of data during transmission - including portable media transmission (i.e. laptops, cell phones, blackberries, thumb drives)
  - Monitoring systems use - authorized and unauthorized
  - Use of wireless networks
  - Granting, approving, and monitoring systems access (for example, by level, role, and job function)
  - Sanctions for workforce members in violation of policies and procedures governing EPHI access or use
  - Termination of systems access
  - Session termination policies and procedures for inactive computer systems
  - Policies and procedures for emergency access to electronic information systems
  - Password management policies and procedures
  - Secure workstation use (documentation of specific guidelines for each class of workstation (i.e., on site, laptop, and home system usage)
  - Disposal of media and devices containing EPHI

- **Other Documents:**
  - Entity-wide security plan
  - Risk analysis (most recent)
  - Risk management plan (addressing risks identified in the risk analysis)
  - Security violation monitoring reports
  - Vulnerability scanning plans
  - Results from most recent vulnerability scan
  - Network penetration testing policy and procedure
  - Results from most recent network penetration test
  - List of all user accounts with access to systems that store, transmit, or access EPHI (for active and terminated employees)
  - Configuration standards to include patch management for systems that store, transmit, or access EPHI (including workstations)
  - Encryption or equivalent measures implemented on systems that store, transmit, or access EPHI
  - Organization chart to include staff members responsible for general HIPAA compliance to include the protection of EPHI
  - Examples of training courses or communications delivered to staff members to ensure awareness and understanding of EPHI policies and procedures (security awareness training)
  - Policies and procedures governing the use of virus protection software
  - Data backup procedures
  - Disaster recovery plan
  - Disaster recovery test plans and results
  - Analysis of information systems, applications, and data groups according to their criticality and sensitivity
  - Inventory of all information systems to include network diagrams listing hardware and software used to store, transmit or maintain EPHI
  - List of all primary domain controllers (PDC) and servers
  - Inventory log recording the owner and movement media and devices that contain EPHI

[Physician Letterhead]

[Date]

Payor Name
(Contact Name or Department of Provider Relations)
Address
City, State, Zip

To Whom It May Concern:

This letter is to request a copy of the original signed and executed contract between my practice and your organization.

If changes have been made to the original contract since the date it was executed, please forward a copy of each and every letter notifying my practice of each modification, including the date that the modification was effective.

Thank you for your prompt attention to this request.

Sincerely,
(Name of Physician)

[Physician Letterhead]

[Date]

[Payor Name]   SENT VIA CERTIFIED MAIL
Attn: Contract Processing
[Street Address]
[City, State and Zip]

RE: [Payor Name] CONTRACT TERMINATION

Dear Provider Contract Processing,

The purpose of this letter is to inform you that I do not agree with [Payor Name]'s proposal to modify my contract, which is scheduled to become effective [insert date here].

This letter serves as formal notice of my intent to terminate my contract with [Payor Name]. This termination shall be effective [Date].

Sincerely,
[Name of Physician]
[Name of Practice]
[Street Address]
[City, State, Zip]
[TAX ID #]
[NPI]

[Physician Letterhead]

[Date]

[Patient Name]
[Street Address]
[City, State and Zip]

Dear [name of patient]:

[Name of insurer] has recently notified my practice that they are changing the terms of my contract. Unfortunately, [Name of insurer] has offered my practice a contract the terms of which I am unwilling to accept. [You may wish to insert a statement here about the specific terms that you find objectionable.] Based upon [name of insurer]'s offer, I will no longer be participating providers as of [insert date here]. As of that date we will be considered out-of-network providers.

I have greatly appreciated the opportunity to serve as your physician and will be very pleased to continue in that role. If you wish to continue to receive medical services from our office [optional: we are willing to work with you and have payment policies for patients who wish to pay us directly], you may wish to review your benefits under your [name of insurer] insurance policy to determine whether they will provide any reimbursement for out of network services. If you have questions about your benefits, you may wish to talk with your employer's benefit manager, as these matters are determined by them.

As a long standing member of this community, I am deeply committed to the health of the community and regret very much this intrusion into our relationship. I hope I can continue to be of service to you and will work with you should you elect to continue under my care.

Sincerely,
[Name of Physician]

[Physician Letterhead]

The following services are generally not covered by managed care plans and insurance companies: cosmetic surgery, fertility treatments, and services deemed "experimental" and/or "investigational." Each health plan may exclude or limit coverage for other services. The laws of California prohibit some exclusions, but only for health plans that are licensed by the state. You need to discuss with your insurer whether treatment provided in this office is covered and therefore paid for by the plan. If you have questions about the law you may also contact California's Department of Managed Health Care by calling (888) HMO-2219, www.dmhc.ca.gov, or the Department of Insurance at (800) 927-HELP, www.insurance.ca.gov.

You are responsible for payment for services provided to you which are not covered by your health plan.

SAMPLE AGREEMENT: Payment for Non-Covered Services

[Physician Letterhead]

AGREEMENT TO PAY FOR NON-COVERED SERVICES

I, [Patient's Name], understand that the [Type of Service] prescribed by my physician is not covered by my insurer or health plan, [because the plan does not feel that it is medically necessary]. Therefore, the service will not be paid for by my insurer or plan. I therefore agree, in advance, to pay my physician's usual and customary rate for providing such services to me.

_____   _____

Patient Signature   Date

_____

Print Name

[Physician Letterhead]

Co-Payment and Deductible:

You are responsible for your deductible and co-payment. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of service. Your co-payment is also due at the time of service.

Medicare:

We [accept] [do not accept] Medicare assignment. You are responsible for your deductible and co-payment. If you have a secondary insurance carrier, a portion of your co-payment may be covered.

Non-Covered Services:

If we provide services to you that are not covered by your health plan, you will be responsible for payment in full for those services. Your signature, below, constitutes agreement to pay for such services.

Appointment Cancellation Charge:

A full appointment fee may be charged for appointments cancelled without a minimum of twenty-four hours notification.

Payment Arrangements:

Payments may be made in cash, [by check], [or by VISA and MASTERCARD].

Services Charges/Late Fees:

Any balance carried to the next billing cycle will be subject to a service charge:

For a balance less than $_____ $_____ per month

For a balance between $_____ and $_____ $ _____ per month

For a balance over $_____ $_____ per month

Collections:

If it is necessary to assign your account to a collection agency and/or attorney, you will be responsible for all of our collection agency and attorney fees and costs.

We are happy to discuss with you any questions relating to the information above. We thank you for choosing [Name of Practice] for your [Name of Specialty] services. We are proud to be your physician[s].

_____   _____   _____
Print Name   Patient Signature   Date

CONTRIBUTORS

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