

VitalSigns

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The health care industry is bracing itself for the possibility of some drastic changes. Depending on the future of the proposed health care plan, the industry could be facing a large overhaul. Unfortunately, these possible changes and the direction of the proposed plan are both uncertain at this time. So instead of waiting and wondering, it's best to keep working on the things that you can control.

For instance, though patient complaints can't be totally controlled, they can be used as a tool for learning and improvement. In this issue, we discuss how to turn negative patient feedback into positive aspects for your practice. We also provide advice about how to manage denials to increase your revenue, discuss the proper steps involved in partnering with a health system and suggest some ways to appropriately manage sample medications.

With so many unknowns thrown into the equation, there may not be a lot you can do to prepare for potential changes to the industry, but you can focus on the internal management of your practice. Albert Einstein once said, "In the middle of difficulty lies opportunity." Make sure everything is functioning smoothly so that you're able to make the most of the opportunity health care changes bring, if and when they occur.

Patient complaints

Turning negatives into positives

Every medical practice receives the best marketing by patient word-of-mouth. For every happy patient, you might get as many as 10 new referrals over the lifetime of your practice. So, doing the math, if you have 100 happy patients, you could obtain direct referrals of 1,000 new patients, and 1,000 happy patients could potentially result in 10,000 new patients.

Conversely, what do you get from patients who are *unhappy* with your practice? As you would expect, you stand to lose not only the patient who is unhappy, but also all those potential referrals! With the advent of online doctor reviews, patients have even more ways to spread the word about the good, bad and ugly of their experiences with a particular office.

Web sites such as vitals.com, healthgrades.com and e-physician.info give patients the power to write anonymous reviews of their doctors. The impact of a negative online review to your practice could be significant without you, the doctor, having any control or say.

Listen to your patients

What are the ways you can prevent a patient's negative opinion or turn it into a positive one? Understand that you can't change what you don't know. So the first basic tactic is to listen and encourage all your staff to listen. Many times it's your clinical assistant or front-line staff with whom a patient chooses to share a point of discontent. Make sure your staff understands the concept of customer service, and adopt a policy that all patient complaints should be discreetly shared with the manager or doctor.

Use a suggestion box in the patient waiting room to ask for comments to improve practice performance. Also consider posting a bulletin board with a "Dear Patient" letter that provides information about how to contact the manager if a complaint or problem arises.

Patient surveys can provide valuable feedback to a practice, too. Gear your questions to use a one-to-five rating system from good to poor, and include fill-in-the-blank questions. Send these to new patients after their first visit or have the medical assistant take the survey into the patient's exam room and ask the patient to complete it before he or she leaves. Have a box ready at the front desk that allows the patient to anonymously deposit the survey.



Conduct exit interviews

Just as businesses conduct exit interviews with departing staff, your manager should conduct exit interviews with patients who request to transfer records to another practice.

Exit interviews are effective for many reasons. Take the following example: A patient calls in to request a transfer of her records to another specialist. During the exit interview, the patient explains that she was tired of having to wait five weeks to get in to see the doctor and then wait an hour in the waiting room before finally having time in the exam room.

What the patient didn't know is that the practice leaders were already aware of this problem and had just hired a nurse practitioner to work collaboratively with the doctors to better manage case volume. When this was explained to the patient, she decided to stay with the practice and see whether things would change.

If you don't feel exit interviews are warranted or feasible in every instance, be sure to at least conduct one in the event you receive a formal letter of complaint along with a transfer-of-records request. In these cases, you might even want to call the patient and invite him or her to participate in a meeting with the physician in question and other members of the patient's care team.

Sometimes having this honest, open dialogue with a focus on partnering with the patient and doctor will convince him or her not to leave your practice. And if you can't convince the patient to stay, at the very least you'll learn from the situation and, ideally, defuse his or her dissatisfaction to minimize the number of patients you might lose because of the incident.

Be ready for anything

Let's face it, patient complaints are virtually inevitable. No matter how conscientious and hard-working your staff may be, mistakes will likely occur from time to time that leave valued patients unhappy. For this reason, you need to keep your practice's eyes and ears open — and be ready for anything.

Increasing revenue by managing denials in a rough economy

We all realize that we're going through hard economic times that are causing an increase in job loss. This, in turn, is causing medical practices to increasingly write off accounts because of bad debt.

Thus, cash flow is more important than ever for providers. One of the biggest factors in improving cash flow is reducing the frequency and occurrence of denials and ensuring clean claims on the first submission. To effectively manage denials, you must identify the type of denial, educate staff, know how to edit claims and prepare appeals, and monitor progress.

Identify the type of denial

Some of the most notable denials that practices see include:

- Type of provider (NP, PA, etc.) that the patient is permitted to see under their plan,
- Global charges billed when only the professional or technical component should have been billed,
- Patient ineligible for service,
- Lack of supporting documentation to support services — attachments not provided,
- Medical necessity not met,
- Claims resubmitted numerous times that were previously denied, without addressing the denial reason,
- Incorrect insurance address,
- Wrong insurer billed,
- Claim not submitted within the timely filing guidelines,
- Service not covered under a plan, and
- Incorrect modifier used.

Most of these denials are caused by administrative errors consisting of inaccurate data entered into the system, lack of eligibility verification, authorizations not executed correctly, clinical errors and the inaccuracy of physician documentation. Something as simple as employing a Revenue Cycle Manager and a Certified Coding Professional can greatly improve your chances of submitting error-free claims as well as diagnosing denial problems.

Educate staff members

To help resolve the denial dilemma, physician practices should create a "denial team" to collect data regarding denials, review the data and put a process into place to educate the staff based on a corrective action plan to minimize further denials of the same type.

One primary area of education to focus on is the Advanced Beneficiary Notice (ABN). This form allows the provider to bill a patient for services that are not covered by the insurance plan. Education should include how to fill out the forms properly and what needs to be explained to the patient at the time of service.

Another important point is understanding payor guidelines. Designate one person to receive and read all newsletters from payors. He or she needs to be well-versed in each one's specific guidelines, too. Staff education also needs to address:

- Policy and procedures for insurance coverage issues and eligibility,
- Modifiers usage,
- Billing for more complex services, units or line items and what the limits on units are, if applicable,
- Appropriate ICD-9 to use with the CPT/HCPCS code billed,
- Clinical Laboratory Improvement Amendments (CLIA) certificate,
- Frequency/global rules for specific procedures,
- Proper use and necessary information needed on patient consent forms,
- Durable Medical Equipment (DME),
- Providing copies to an insurance company to support a claim in a timely manner, and
- Basic terminology and anatomy skills.

The investment in training and education will build confidence in those who are working the denials. This investment will pay for itself with more fluid cash flow and less time spent working the accounts receivable.



Increase revenue by editing

In addition to educating staff, step up your efforts to edit claims. Efforts to do so should encompass:

Back-end editing. Having a certified coder working on the back end can help the physician practice capture revenue that might be overlooked. Examples include:

- Noting discrepancies between procedures documented and supplies ordered but not billed,
- Finding missed charges based on the coder's review of the physician's documentation in his or her progress note, and
- Verifying that the diagnosis codes being billed for are appropriate for the service(s) rendered at that time.

The cost of having a certified coder could be minimal compared to the amount that your practice

may be losing by sending out erroneous claims. By editing on the back end, you're more likely to save time reworking later, reduce denials and number of days in accounts receivable, and increase revenue.

Front-end editing. By having a certified coder on the front end, the physician and medical staff will be able to immediately interact with the coder to ask questions, clarify the proper diagnosis, and verify the scope of visits allowed as dictated by coding policies. Certified coders have access to online manuals and coding software that can greatly enhance the accuracy of code combinations, modifiers and definitions of what's a medical necessity.

Appeals. Writing and preparing appeals takes time and a lot of research. Five items to include in any appeal are:

1. An account of the patient's treatment,
2. The connection between the treatment and the patient's medical history and complaints,
3. How the treatment benefited the patient,
4. If inpatient, the reasoning behind the length of stay in the hospital, and
5. The accountability from other practitioners and medical societies that the type of treatment a patient received is based on the condition.

One must supply unwavering proof that the provider is entitled to the denied payment. Also, ensure that you're fully aware of all appeal rights and using the proper forms per payor.

Monitor your progress

Remember, successful denial management requires both recovery and prevention. Offices cannot fully prevent denials from occurring but, with teamwork among practice staff, Revenue Cycle Managers and coders, denials can be reduced significantly. So be sure to regularly monitor your progress in the area of denials management and take swift action to correct shortcomings.

The process of partnering with a health system

The “sell” meeting with the administration is over, the coffee is gone, and everyone has shaken hands and looks happy. Now it’s time to get prepared for the hospital’s evaluation of your practice. What does that mean? During the “sell” meeting, hospital representatives typically say that they’re going to look at five factors: 1) productivity, 2) compensation, 3) profitability, 4) overhead and 5) staffing. Basically, this means they’re going to evaluate the efficiency of your practice and providers to see what type of group you have, which factors affect performance and how the practice is managed.

Then they give you a stack of paper that represents their data request. It asks for a binder of paper with management, productivity, operating and financial reports. For some practice leaders, the overwhelming nature of the request may foster fear or resentment. But rest assured the hospital needs this information to meet the requirements that are necessary to perform a comprehensive review and meet all Stark requirements.

Various components

The purpose of the information a hospital requests is to help the health system evaluate the various components of the practice and make a fair and legal offer to the group. As mentioned, these components include:

Productivity. Many health systems are now basing some component of physician compensation on Work RVUs. As such, analyzing the CPT makeup of each provider will assist the health system in doing a comparative analysis of the industry benchmark to the analyzed provider. To truly understand the productivity of each provider in the practice, this analysis must be performed based on the rendering provider, not the billing provider. Health systems are required to set compensation at a level commensurate with industry benchmarks based on pure dollars, productivity or organizational role.

Compensation. Physician compensation is the main driver in any discussion with a health system. Because compensation levels are scrutinized so thoroughly by regulatory agencies, the health system must look at all forms of compensation that’s being realized from the practice. What health systems look at is not only the “salary” realized, but also factors such as:

- Monthly draw/salary,
- Benefits paid by the practice,
- Pension and other retirement benefits,
- Other direct, nonoperational expenses paid by the practice on the provider’s behalf, and
- Undistributed profit.

The health system must combine all of these types of compensation when comparing compensation levels to industry benchmarks. Total compensation packages will be compared to benchmark data to ensure fair compensation arrangements are offered.

Profitability. Financial statement and management reporting reviews are performed to assess the impact of operations and external factors on the financial performance of the practice. Factors such as collection ratios, payor mix, days in accounts receivable, debt repayment and cash flow are all reviewed to assess practice viability. In addition, coding patterns are reviewed to ascertain the coding practices of each provider.

Overhead. The hospital will typically analyze overhead levels by comparing them with industry benchmarks. The key component of this analysis is comparing “like” expenses. All non-practice-related expenses must be stripped out of the comparison. Expenses need to be categorized and grouped into the same groupings as the benchmark data. This analysis will help the health system determine whether the practice is run “within its means” or is using debt to fund any shortfalls.

Staffing. Analysis of the current staff roster and compensation levels is another key component in the practice assessment process. To help the health system better understand the sophistication and experience of the staff, review staff levels/ratios to provider, compensation levels, benefits and staff training/specialization.

Due diligence on your part

Of course, while a health system is evaluating your practice, you should be doing some due diligence of your own. Specifically, your group should evaluate seven factors:

1. Makeup of your physician network,
2. Vision of the health system with respect to your physician partnership,
3. Basis of compensation plan and factors affecting future compensation,

4. Disposition of current practice structure — whether the arrangement will be a lease of the current corporation/entity or whether it’s a pure employment arrangement with no future option on the current corporation/entity,
5. Staff disposition — whether the staff will remain a part of the practice or be replaced by others outside the current practice,
6. What administrative role the health system will play in the daily operations of the practice, and
7. How patients may react to the partnership.

The information you gather in reflecting upon these seven factors should serve as the basis for in-depth discussions with the health system’s representatives. Ideally, you’ll be able to identify and alleviate many conflicts before they become operational problems.

An objective look

Overall, a prepartnership practice assessment is meant to be a collaborative effort done with an open and honest eye. Think of it as merely a way for the health system to be introduced to your practice and how it operates, not as an intimidating or judgmental process. In fact, to avoid bias, a third party is usually hired to perform the assessment on behalf of the health system.

Throughout the country, hospitals are looking at ways to partner with physicians in order to create comprehensive health systems that will serve the needs of their service community as well as the physicians with whom they partner. When health systems evaluate a practice, they’re doing the due diligence necessary to help any partnership or business relationship succeed.

Are you up to speed on sample medication management?

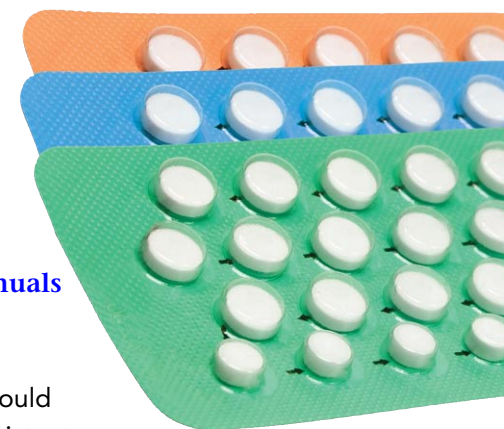
Physician practices that distribute sample medication need to have policies and procedures that guarantee medication safety to its patients and staff. Insurance carriers and auditing entities will review practice manuals and logs to determine whether your office is following appropriate medical management procedures.

The first basic practice policy to have is a statement of the use and distribution of sample medications. Every office employee — whether administrative or clinical — should review and sign off on a policy that states, “All practice medications inclusive of sample medications are not to be taken or distributed for personal use. Failure to observe this policy may result in either suspension or termination of your employment.”

Additionally, a method of inventory or reconciliation of all medications, destruction of expired medication, and access to

distributed lot numbers of samples should be maintained. Typically, a medical assistant or practice nurse is placed in charge of medication inventory and control.

You should also maintain logs and conduct inventory management by keeping an electronic spreadsheet or paper log, with medication stock review done on a monthly basis. Some practice management and electronic medical record (EMR) systems are now incorporating modules that assist in managing sample medication inventory.





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Elliott Davis, LLC
200 East Broad Street
P.O. Box 6286
Greenville, SC 29606-6286

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Key specifics

Some key specifics of the policies you should establish, as well as the names and descriptions of specific logs your practice should have in place, to keep up and demonstrate compliance are:

A pharmaceutical rep (PR) access policy. It should include, for example, a restriction on PRs being able to access locked medication storage. Ask them to leave sample meds with front desk staff or clinical personnel to log into supply.

A sample medication intake log. Important items include:

- Date received,
- Product expiration date,
- Medication name,
- Manufacturer,
- Quantity (for example, four bottles/packets of 12 tablets),
- Dosage (for example, mg),
- Lot number(s), and
- Staff member initials.

An expiration and destruction log. It should indicate which medications were removed from supply as well as:

- Date of inventory,
- Name of drug,
- Expiration date,
- Amount disposed,
- Date of disposal,
- Method of disposal, and
- Staff member initials.

A distribution log. When providing sample medications, you need to record the following to protect patients in the event of a lot recall:

- Lot number provided,
- Manufacturer name,
- Drug name,
- Dosage,
- Quantity,
- Patient name(s),
- Date distributed, and
- Staff member initials.

Clear procedures for following the mandated requirements for sample medication destruction. Check with your state board for information on the destruction of controlled substances. Your state's EPA can likely provide tips on how to identify products considered hazardous to the environment and what special considerations are involved in their disposal. Federal guidelines can be found at whitehousedrugpolicy.gov.

Typically, biomedical waste companies allow you to use a container to dispose of some sample meds as long as all packaging around the product has been removed and only the medication itself is put in the hazardous waste bag inside the container, which should be labeled "Expired Medications."

Otherwise, in certain cases, you may be able to simply crush the sample meds, dilute them with old coffee grounds, put them in a closed container, and place that container in the trash. Again, however, check with the appropriate state and federal authorities on permissible disposal methods for each specific product.

A valuable opportunity

Sample medications give a physician and their patients a valuable opportunity to try a medication and dosage to determine whether it will have the desired effect. Sample medications also remove the burden of paying a co-pay or medication expense for a drug that may not work for the patient. Yet, they create the often complex, time-consuming responsibility of properly managing and disposing of their many varieties.

If you're finding that your practice lacks the adequate staff to keep up on the necessary compliance processes, you may have to give up warehousing sample medications. A number of pharmaceutical companies now offer mail-away coupons that provide the same access to samples without all the headaches of space and medication management. Talk to your PRs and see what programs are available for your patients.

