

# Streamline Practice To Boost Cash Flow

**M**ost physicians are finding it harder than ever to run a profitable practice, thanks to rising overhead costs, malpractice insurance premiums and declining reimbursement rates. While surveys indicate that doctors are spending more time practicing medicine, their efforts seem to be producing less in the way of income.

Decreasing or stagnating earnings is a constant complaint among medical professionals. According to the latest data from the Medical Group Management Association (MGMA), based in

**“There is a variety of issues that may be contributing to [group practices’] financial challenges: cutbacks in Medicare reimbursement, rising liability premiums, increasing uncompensated care, unfunded legislative mandates such as HIPAA, among others,” says Donald W. Fisher, Ph.D., American Medical Group Association president and CEO.**

Englewood, Colo., compensation is not keeping pace with primary-care physicians’ workloads. Moreover, the costs associated with medical practice are increasing at a higher rate for primary-care physicians than for specialists, MGMA says.

Another survey, by the American Medical Group Association (AMGA), based in Alexandria, Va., reports that in 2002 the average medical group practice lost \$3,977 per physician. The biggest

average losses were found in the northern (\$11,943 per physician) and southern (\$12,954) regions. “The data demonstrate that, although medical groups are making great strides to achieve financial success, many are still struggling,” said Donald W. Fisher, Ph.D., AMGA’s president and CEO. “There is a variety of issues that may be contributing to their financial challenges: cutbacks in Medicare reimbursement, rising liability premiums,

increasing uncompensated care, unfunded legislative mandates such as HIPAA, among others.”

In such an environment, good cash flow is essential to your practice’s financial health. Improving cash flow entails speeding up reimbursements for the services you provide as well as controlling practice expenses whenever possible. Too often, it can take weeks or months to get reimbursed for services—and collecting that money can end up costing you even more in administrative expenses.

For many physicians, wasteful or duplicative administrative

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tasks are siphoning cash from the practice, according to research conducted by the MGMA Center for Research. It discovered, for example, that in a 10-physician group practice more than \$247,500 per year was spent on unnecessarily complex or redundant administrative jobs (*see box on next page*).

Further, the research found that \$9,248 was spent per year resubmitting denied claims, 73 percent of which was eventually paid. On

average, 4.6 claims per full-time-equivalent physician are denied each week because of lack of information about insurers’ requirements. Costs were calculated based on compensation, the number of staff and physician minutes spent and the number of administrative tasks conducted each year.

Keith Borglum, a practice management consultant based in Santa Rosa, Calif., says that family practices lose the most money as a result of lost productivity. This occurs when physicians “see fewer patients than optimum, provide fewer services per visit or have visits of less-than-optimum complexity,” he points out in an article in the June 2003 issue of *Family Practice Management*. “For example, missing one fee-for-service patient visit per day results in approximately \$15,000 in annual losses (assuming 210 days of visits at an average charge of \$72),” he writes.

Many physicians are also spending more time on administra-

tive paperwork, such as billing, coding and regulatory compliance, than they did in the first two to three years of their practice, according to a 2004 survey of physicians ages 50 to 65 conducted by the national physician search and consulting firm Merritt, Hawkins and Associates. For example, 30 percent of those surveyed said they now spend five to eight hours a week on administrative paperwork, compared with only 17 percent who did so in the first two to three years of their practices. Some 37 percent of the survey's respondents said they devote nine hours or more a week to administrative duties, compared with only 8 percent who did so early in their practices. (For more on the survey, go to

### **Wasteful Administrative Tasks Consume Practice Resources: Study**

Large amounts of staff time, physician time and cost are devoted each year to administrative tasks that are redundant, wasteful and duplicative, and add no value to a practice or its patients, according to a study conducted by the Medical Group Management Association Center for Research.

The research findings, which include costs for a small list of administrative duties, indicate that in a medical group practice with 10 physicians:

- More than \$247,500 per year was spent on unnecessarily complex or redundant administrative tasks.
- \$19,444 per year was spent on phone calls with pharmacies resolving drug formulary issues.
- \$38,761 was spent per year verifying patient coverage, co-payments and deductibles for thousands of varying health plans.
- \$9,248 was spent per year resubmitting denied claims—73 percent of which are eventually paid. On average, 4.6 claims per full-time-equivalent physician are denied each week because of lack of information about insurers' requirements.
- \$7,618 was spent per year submitting credentialing applications for each physician. Practices submit 17 credentialing applications per physician each year on average.
- \$33,800 was spent per year negotiating insurance contracts with an average of 20.5 different health plans per year, and renewing 14 of those each year. Administrators spend 5.5 hours negotiating each insurance contract.

*www.merrithawkins.com/pdf/2004\_physician50\_survey.pdf*.)

These types of administrative burdens simply impede the cash flow in a medical practice. More than ever before, a medical practice needs to run efficiently to be profitable. Reducing redundancies and improving the cash flow of a practice are crucial for physicians who want to be adequately compensated for their time and effort.

## Up-to-Date Patient Information

Focusing on your coding and billing methods is the first step to improving profitability. Fine-tuning these two functions can help maximize practice profits since they remain the major ways to bring cash into the practice. It is also important to have a good staff in place to make sure your office runs smoothly.

**Setting up a Website** for your practice offers many advantages. For one, patients can go to your site to complete a patient information form before they even come to the office, which makes the checking-in process more efficient, says Dr. Stephen Brodsky, chief medical director for the data storage company Kardex in Paoli, Pa.

Do not overlook the importance of cultivating patient loyalty to your practice's bottom line, says Cleveland practice management consultant Jack Valancy. Patients who are happy with your practice are more likely to pay their bills on time, follow your treatment directives and have confidence in you, he says. As a result, your practice will save time and money because your staff won't have to spend time transferring medical records to another practice. In addition,

loyal patients help your practice grow by helping to generate more referrals.

An important part of billing accurately and efficiently is to verify patient personal and insurance information before the physicians in your practice see patients. For new patients, be sure your staff asks them to arrive 10 minutes early to complete the necessary paperwork.

If you haven't already done so, consider establishing a practice Website. Setting up such a site offers many advantages. For example, patients can go to your site to complete a patient information form before they even come to the office, which

makes the checking-in process more efficient, says Dr. Stephen Brodsky, a practice management consultant and chief medical director for the data storage company Kardex in Paoli, Pa.

In addition, a practice Website allows prospective patients to learn something about the practice and its physicians. You can list accepted insurance plans and hospital providers. A Website also gives you a way to communicate with current patients about practice developments and new services.

Before you have a Web developer design your site, check out the sites of other physicians to see what you like and don't like about them. Not all patients will be computer savvy, so your staff should determine which patients can complete new patient information using the Internet.

For all returning patients, instruct your staff to check the accuracy of their home addresses, business and home phone numbers and insurance information. If the patient is using a carrier that is different from the one you have listed, be sure your front-desk staff person gets all the correct insurance information. Also, ask each patient for an e-mail address. This is helpful when staff members need to communicate with a patient.

Be sure that patient information is verified at each visit by having the front-desk person ask the patient if he or she still lives at the address you have on file and still has the same insurance carrier. If the patient has changed carriers, make sure your front-office person requests the new insurance card and makes a copy of it.

## Dealing With No-Shows

Improving the efficiency and profitability of your practice involves making sure your patients show up for appointments. No-shows cost your medical practice revenue, which can't be recouped. Determine how many no-shows you have each month and undertake a plan to reduce that number.

Experts say the typical no-show rate at a practice can be as high as 10 percent to 15 percent. Attacking the problem of no-shows is one relatively simple way to improve the bottom line, according to practice management experts.

If you have two patients who are no-shows each day, that adds up to about \$2,000 a month in lost revenue, calculates Dr. Brodsky. Calling patients a day or two before the scheduled appoint-

ment to confirm helps cut down on the number of no-shows, he says. While having staff make these calls may seem tedious, it keeps no-shows to a minimum.

You may also want to consider an automated calling system to send out reminder messages to your patients with upcoming appointments. Automated systems can make anywhere in the range of 50 to 65 phone calls an hour. A personal call from a staff member, on the other hand, can last as long as three minutes—and often

**You may want to consider an automated calling system to send out reminder messages to your patients with upcoming appointments. Automated systems can make from 50 to 65 phone calls an hour, with automatic callbacks to patients who were not reached on the first try.**

employees forget to call back patients who don't answer the first time. But a computerized system will call back the patient automatically if it is unable to reach the patient on the first try.

It's also a good idea to maintain a waiting list of patients who will take appointments on short notice in the event that one of your patients won't be able to make an upcoming appointment. "This [wait-

ing list] is a simple courtesy that medical offices should provide," Dr. Brodsky says.

An automated system will also document the reminder calls. This kind of documentation is important, especially for post-op patients or others with an equally risky health condition who fail to show up for an appointment, he adds.

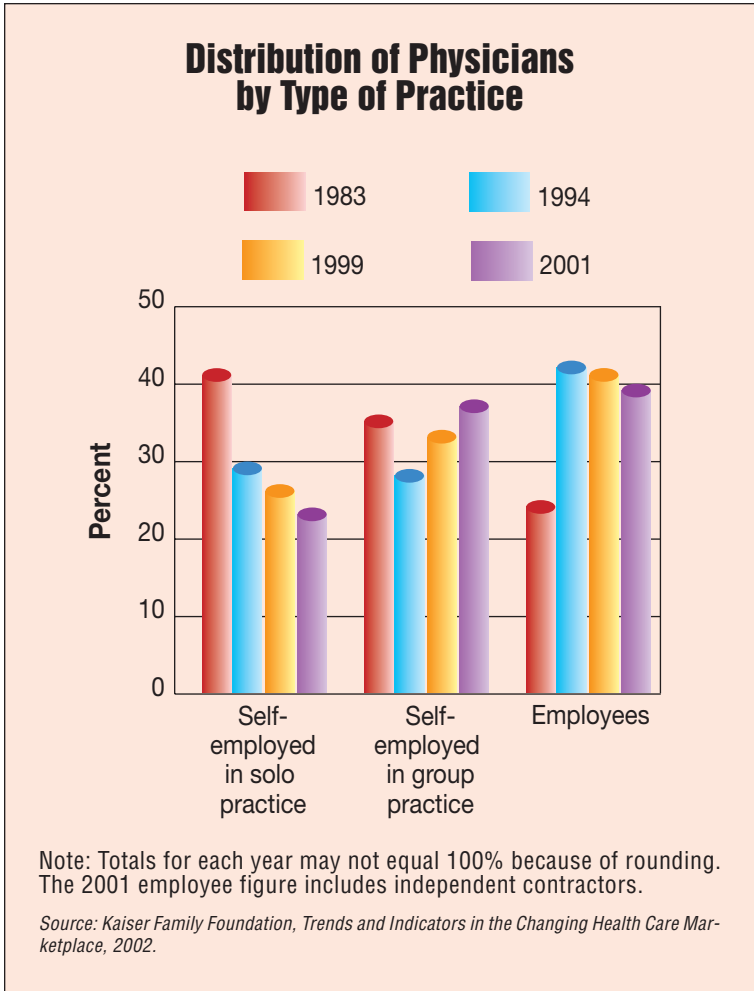
Automated systems also can be used to get other types of messages and information to your patients, such as having to cancel an appointment or letting the patient know that his or her test results are back. In addition, these systems have the advantage of being able to leave messages in multiple languages.

While an automated system can cost from \$6,000 to \$7,000, the return on your investment is likely to be recouped quickly, especially when you consider the staff time that is spent making these calls.

Another way some physicians try to reduce the number of patients who fail to arrive for an appointment is to charge for not keeping the appointment. Mr. Valancy, however, does not favor charging for no-shows because this policy tends to antagonize

patients. “Since most people make honest mistakes, it’s not a good idea to be too hard on patients who occasionally miss appointments,” he maintains. Trying to impose a charge could even cause some patients to become so angry that they decide to leave your practice.

Rather than charge for a missed visit, Mr. Valancy recommends that you make a note in the patient’s chart that he or she failed to



## Characteristics of Visits to Primary-Care Physicians

- Accounted for 62.7 percent of all visits in 2002, with 75 percent to the patient's designated primary-care provider.
- Major reason for visit to primary care specialists:
  - ✔ Acute conditions—41.5 percent
  - ✔ Chronic conditions—29.6 percent
  - ✔ Preventive care—23.3 percent
- Top five illness-related diagnoses:
  - ✔ Hypertension—7.8 percent
  - ✔ Acute upper respiratory infections (excluding pharyngitis)—5.1 percent
  - ✔ Diabetes mellitus—3.1 percent
  - ✔ Otitis media—2.4 percent
  - ✔ Arthropathies—2.1 percent
- Injury visits accounted for 9.4 percent of all visits to primary-care specialists.
- Common services ordered or provided:
  - ✔ General medical examination—60.8 percent
  - ✔ Blood pressure check—60.1 percent
  - ✔ Urinalysis—12.8 percent
  - ✔ Complete blood count (CBC)—10.9 percent
  - ✔ Diet/nutrition counseling—19.3 percent
  - ✔ Exercise counseling—12.2 percent
- Top therapeutic drug classes prescribed:
  - ✔ Vaccines/antiserum—5.7 percent of drug mentions
  - ✔ NSAIDs—5.5 percent of drug mentions
  - ✔ Antihistamines—4.8 percent of drug mentions
  - ✔ Antidepressants—4.0 percent of drug mentions
  - ✔ Antihypertensives—3.9 percent of drug mentions
  - ✔ Antiasthmatics—3.8 percent of drug mentions
- Disposition of visit:
  - ✔ Return for an appointment—53.4 percent
  - ✔ Return if needed—33.4 percent
  - ✔ Referred to another physician—8.0 percent
- Average face-to-face duration—17.4 minutes

*Source: 2002 National Ambulatory Medical Care Survey, Centers for Disease Control and Prevention/National Center for Health Statistics.*

keep an appointment. The next time the patient is in the office, take the time to speak to the patient about failing to arrive for the appointment. For patients who chronically miss appointments, you can warn them that they risk being discharged from the practice, he says.

If you do decide to charge for missed appointments, make sure that your patients understand this policy and that you provide this information in writing, preferably in a letter that explains your fees and policies. It's also a good idea to post a sign in your office stating this policy.

According to American Medical Association policy, physicians may charge a patient for a missed appointment or for one not cancelled 24 hours in advance, as long as the patient is fully advised that the physician will make such a charge.

Another step that practice management experts recommend to help improve no-show rates is to make sure you don't schedule appointments too far out in the future, like six months in advance. Try to give patients appointments within a reasonable amount of time after they call to see you—this makes it more likely that they will show up for the appointment.

**You can help improve your practice's no-show rate by not scheduling appointments too far out in the future, like six months in advance. Try to give patients appointments within a reasonable amount of time after they call to see you—this makes it more likely that they will show up.**

## Appropriate Coding

While most physicians use a number of the same codes on a regular basis, it pays to stay on top of the latest changes so that you receive the correct reimbursement for your services. "Coding really should be the physician's responsibility," says Geoffrey Anders, president of The Health Care Group, a practice management consulting firm in Plymouth Meeting, Pa. "A physician should not be delegating the coding to a staff person. If this means he or she has to learn the CPT codes, that is fine."

In addition, you should also be sure that your fees are appropriate. Are they higher than the allowances established by insurance payers? Experts say it is a good idea to review your fees on a yearly basis to ensure they accurately reflect the cost of the

services you provide.

An updated annual Current Procedural Terminology (CPT) book is an essential reference for keeping track of the latest coding changes. The American Medical Association (AMA), which developed the code set, updates the CPT each year in accordance with changes in medical technology and practice. The most recent version, CPT 2005, contains 8,568 codes and descriptors, according to the AMA.

In addition to the CPT reference publications prepared by the AMA, medical specialty societies have annotated versions that

**Undercoding**—selecting a code that reflects a less-complex or lower-level service than the one provided—can result in loss of a substantial amount of money. While it is important not to code inaccurately or inappropriately, “you don’t want to leave money on the table,” says Cleveland practice consultant Jack Valancy.

are geared to codes used most frequently in a particular specialty. The American Academy of Family Physicians (AAFP), for example, offers a number of coding tools free of charge on its Website ([www.aafp.org](http://www.aafp.org)); click on “coding” for a list of resources.

There are also newsletters and other publications available for sale. The AMA publishes a number of books, software products and newsletters that cover various aspects of using CPT codes;

visit [www.ama-assn.org](http://www.ama-assn.org) and click on “bookstore” for more information. Independent publishing companies also produce coding guides. The Coding Institute in Naples, Fla. ([www.codinginstitute.com](http://www.codinginstitute.com)), for example, sells subscriptions to newsletters for a long list of specialties from allergy to urology. These publications provide tips on coding and up-to-date information that you will find useful for your practice. Another newsletter, Part B News ([www.partbnews.com](http://www.partbnews.com)), focuses specifically on Medicare reimbursement issues, including coding.

You may also want to send your billing and coding staff to coding seminars and workshops to stay abreast of the latest developments in this area. They can help gather useful coding information for you. In addition, make sure staffers pay close attention to the information sent to your office by insurance

carriers. While it may be tedious, your office risks a loss of revenue if someone on your staff isn't keeping current on code changes.

## Audit Your Coding Practices

Undercoding—selecting a code that reflects a less-complex or lower-level service than the one provided—can result in loss of a substantial amount of money. Some doctors choose to undercode Medicare claims rather than risk being audited. While it is important not to code inaccurately or inappropriately, “you don’t want to leave money on the table,” Mr. Valancy says. Neglecting to include the proper modifier on a code can result in the loss of thousands of dollars over time, he points out.

On the other hand, upcoding—billing for a more expensive service than the one actually performed or billing for a higher-level service that is not supported by documentation—can lead to a federal investigation of your coding practices and may result in expensive penalties. Therefore, it is a good idea to have your coding practices audited regularly for services on a prospective basis, says Mr. Anders. In other words, have the consultant audit coding that has not yet been billed. If anything is discovered, it can be corrected without penalty.

The audit, which is usually done by an outside company, involves pulling charts at random and reading the clinical notes to see what services were provided and then checking to see how the services were coded. Errors in coding, such as not including the proper modifier, may result in lost revenue.

For guidance on random reviews of your claims, consult the Health and Human Services Department Office of Inspector General’s “Final Compliance Program Guidance for Individual and Small Group Practices” (available at [www.oig.hhs.gov/authorities/docs/physician.pdf](http://www.oig.hhs.gov/authorities/docs/physician.pdf)). Among other steps, the document recommends that bills and medical records be reviewed for compliance with applicable coding, billing and documentation requirements. These self-audits can be used to determine whether bills are accurately coded and accurately reflect the services provided as documented in the medical records.

Another way to fine-tune your coding methods is to make an investment in an electronic medical records (EMR) system that will

document coding at an appropriate level. Those who advocate these systems claim that they help bring more revenue into the practice and provide you with evidence that the code was proper.

The latest technology makes it possible to pair an EMR system with a handheld device to locate diagnostic codes at the time of the examination and send them directly to the billing system. This not only can improve the accuracy of your coding, but can free up staff to work on other important tasks like collecting money from patients.

A survey conducted jointly by MGMA and Pfizer Health found that among physicians who have implemented an EMR system, 26 percent experienced increased reimbursement levels and 21

### **Is an EMR System Right For Your Practice?**

If you are thinking about implementing an electronic medical records (EMR) system, there are a number of steps you should follow before actually purchasing the equipment.

Keep in mind, writes Karen S. Schechter in *American Medical News* (Dec. 20, 2004), that selecting and implementing the best EMR is not an easy task. "It requires a great deal of thought, soul-searching and stamina to do it correctly," she writes.

First, it is important to determine the reasons for wanting such a system. Some important ones include streamlining processes and communications within the practice; having a method to collect information consistently for research and/or other outcome measurement endeavors, and reducing ancillary costs associated with transcription, copying and labor.

You should also determine which features your practice needs most. Some of the many choices include integration of the EMR with scheduling and billing systems, and compatibility with other electronic devices such as PDAs and dictation equipment. Do you need remote access to records and the ability to write prescriptions? Also, do you want to include an in-house server or a Web-based system?

You also need to take into account your budget and the availability of resources to implement and maintain an effective EMR system. Ms. Schechter writes that implementing a system can take anywhere from six to 12 months or more. "Maintaining the EMR so that it continues to be an effective tool in the practice is key to the success of the implementation," she points out.

percent saw an increase in patient volume.

Prices for these systems tend to be steep, starting at around \$15,000 per doctor. Advocates of electronic medical records systems claim that the practice will make the money back over time, and more money besides, as a result of more appropriate coding and other office efficiencies.

Most physicians tend to bill and code on the conservative side and, as a result, are losing about 20 percent of what they should actually be receiving, says Dr. Brodsky. An EMR system will help improve this, he adds.

Mr. Anders says an EMR system is a “wonderful approach as long as the physician doesn’t lose the handheld device.” But assuming that physicians keep track of the device, an electronic system has a number of advantages, such as allowing physicians to record and code their services when they are working in the hospital.

**Communicate regularly** with staff about billing issues, consultants advise. Schedule weekly or monthly billing office meetings to go over the problems staff members are encountering. It is important to communicate regularly with staff about these issues. For example, if errors are discovered, be sure the information is disseminated so that these problems aren’t repeated.

EMR systems also save money on transcription services and staff hours. Other advantages include reducing errors, lowering the risk of malpractice suits and even helping to improve negotiating positions with insurers.

Be prepared to encounter transition problems if you decide to take the technology plunge. The size of the practice often has an impact on how well the switch is likely to go. “In my experience, groups of more than three physicians often wind up with more implementation problems, possibly because they have more decision-makers to appease, more to consider when planning and less flexibility to respond to unanticipated events,” writes Dr. Jerome H. Carter in an article entitled “Implementing an EMR? Five Mistakes You Should Avoid,” published in ACP Observer (December 2003).

Factors to keep in mind when considering an EMR system include the size and specialty of your practice, your budget and the computer literacy of your staff. Keep in mind that no matter how

you decide to accomplish the job of coding, the physicians in the practice are ultimately responsible for this task.

## Review Billing and Collections

To improve cash flow, practice management experts say, take a close look at your billing and collection systems. Several of the larger carriers, including Medicare and Blue Cross Blue Shield, provide software free of charge that will electronically post payments into a practice-management system.

One of the most important things to look for in a billing system is its ability to report back the information staff members have entered. You will need a system that organizes the data and tracks it.

For example, the system should be able to track charges, claim denials and allowable payments. Your staff must be able to see whether the insurance carrier is paying you what it agreed to pay. If the payment is less than expected or if the claim is denied, your staff will want to find out the reasons for those developments.

In addition, track all of these factors and review them monthly to look for trends that may be affecting your bottom line. For example, a number of your denials from carriers may be caused by an invalid member number simply because the front-desk employee is reading insurance cards incorrectly.

Without a review of denied charges, the practice will not be able to take steps to prevent denials in the future or to make the necessary corrections to receive the appropriate reimbursement. If some of your denied claims are for procedures that are not covered by carriers under the patient-insurer contract, it is a good idea to bill the patient as soon as possible with an explanation stating that the carrier denied the claim.

Communicate regularly with staff about billing issues, consultants advise. Try scheduling weekly or monthly billing office meetings to go over the problems that staff members have encountered. For example, if the billing meeting uncovers a pattern of errors, the staff can then devise better methods so that the problems won't be repeated.

Another important step to streamlining fee collection is to make sure you receive patient co-payments and deductibles at the time of service and offer patients the option of paying by credit

card, check or cash.

“Collecting fees at the time of service is one of the tasks that doesn’t get done because front-desk staffers aren’t comfortable asking for money,” Mr. Valancy says. Of course, you should post a sign in the office stating that payment is due at the time of service, but this is no guarantee that patients will volunteer payment, especially if staff members do not ask for payment.

Often staff members don’t understand the importance of collecting fees because they see it as the billing department’s job.

### **Tips on Preventing Employee Theft**

Improve your cash flow by taking steps to keep your office cash drawer safe. Practice management consultant Keith Borglum, in an article in *Family Practice Management* (June 2003), points out that petty theft will occur in most practices, and embezzlement will occur in about half of all practices.

You can take steps to plug these holes, writes Mr. Borglum, who is based in Santa Rosa, Calif. For example, you can set up an office policy that specifically tells staff that taking supplies from the office is considered theft. He also advises physicians to thoroughly check employment references, credit reports and court and police records when hiring employees who will be handling money.

With regard to financial matters, Cleveland practice management consultant Jack Valancy recommends putting one staff member in charge of tallying up the cash, credit card receipts and checks each day. Make this individual responsible for checking the daily posted balance. To double-check totals, ask another staff member to recount all the cash, credit card receipts and checks.

The individual who does the daily close should not be the same person who has access to the money, so that no entries can be changed and the cash pocketed. Carefully stay on top of the voids and adjustments because this is an easy way for cash co-payments and other payments to disappear.

Experts say it also makes sense to establish a refund-check policy in your office. The process of listing, reviewing and signing these checks should involve more than one of your staffers so you don’t make it easy for anyone to embezzle funds. If patients have credits of \$10 or less, experts say it is a good idea to keep these small amounts as a credit on their accounts.

Impress upon them the importance of collecting fees and insist that this be done in a professional manner, he says.

You can also provide staff with incentives for doing their jobs well. For example, give them a small monetary reward if they are able to boost the amount of funds they collect at checkout over the previous month.

They should have the information they need to request payment, such as knowing what the various insurance plans pay for specific services and the amount of deductibles and co-payments. This information can be recorded in the computer on the newer

**Using a collection agency to try to collect long-overdue balances should be your last resort, says Jack Valancy, practice consultant. These agencies charge high fees that range from 30 to 50 percent of the amount recovered. However, it may be a better alternative than simply writing off overdue balances.**

practice-management systems. But if your office is not equipped with an up-to-date computerized system, it is important to develop an in-house chart that lists all the different health plans you are dealing with, and the information staff needs to request payment.

If patients resist paying at the time of service, you may want to consider imposing a \$5 billing fee if the balance isn't paid within 24 hours, says Mr. Valancy. "That will

help motivate them," he adds.

Getting payment at the time of service greatly improves efficiency and cash flow because your staff doesn't have to generate a bill and wait for the patient to pay, which could take 30 days or longer. Even more efficient is to do away with patient billing altogether, says Mr. Anders. To do this, he recommends getting a copy of the patient's credit card and keeping it on file. When an explanation of benefits arrives and you determine the patient's balance, your staff e-mails the patient explaining how much will be charged to his or her credit card. This eliminates having to send a bill or statement.

## Outsource Billing and Collections?

What about using an outside company to do your billing? Some experts say you may be able to save money by eliminating billing employee expenses (salary and benefits), the high cost involved

in upgrading hardware and software and the expenses involved with your telephone service.

“Outsourcing can be a good idea but you have to understand what you are doing,” says Mr. Anders. On the plus side, the billing company has expertise that you don’t have in-house, which may cost less overall than hiring someone with that expertise and paying the expenses of maintaining that employee.

Further, when you have a billing department in your practice, you are dealing with personnel management. “Outsourcing puts you into contract management,” he explains. As a result, you have to devise your own contract that contains standards you want the

<b>Average Waiting Time for Appointments, 1997-2003</b>				
	Number of Days			
	1997	1999	2001	2003
<b>Primary-care physicians: Checkups</b>				
Privately insured near-elderly (age 55-64)	11.0	11.6	12.7	13.8
Medicare Seniors (age 65 and over)	10.3	10.9	11.8	11.6
<b>PCP: Visits for specific illness</b>				
Privately insured near-elderly (age 55-64)	4.3	5.1	5.3	5.0
Medicare Seniors (age 65 and over)	6.1	8.0	6.9	6.2
<b>Specialists: Checkups</b>				
Privately insured near-elderly (age 55-64)	16.0	17.4	18.2	17.8
Medicare Seniors (age 65 and over)	12.2	14.2	15.2	14.8
<b>Specialists: Visits for specific illness</b>				
Privately insured near-elderly (age 55-64)	12.1	12.6	13.7	14.5
Medicare Seniors (age 65 and over)	10.1	12.1	12.1	12.5

*Source: Center for Studying Health System Change, Community Tracking Study Household Survey.*

billing company to follow. For example, he says, you will want a certain collection ratio that is in line with industry averages, and you should make sure that there are not more than a certain number of day charges in accounts receivable.

Those who don't favor outsourcing practice billings claim it is too expensive because the outsourcing firm takes too large a percentage of your billing. Dr. Brodsky believes it is far better for the practice to keep control of billing.

In addition, no company is going to work as hard at collecting

### Finding the Right EMR Vendor

Once you decide that an EMR system is right for your practice, you will have to undertake a search for the best vendor. Here are some tips on how to go about finding that company:

- Try to determine how long physician productivity will be compromised during the learning phase. Is this something you can live with or not?
- Understand the pitfalls of making the switch and develop reasonable expectations. This may help keep the frustration level down.
- Thoroughly research EMR vendors. In his April 2004 ACP Observer article, "Tips for Evaluating Electronic Medical Record Software," Dr. Jerome H. Carter recommends asking prospective vendors about their yearly sales in dollars; the number of years they have been in business; the total number of systems sold, and the number of employees designated for customer support. If a company refuses to provide this information, strike it from your list of potential vendors.
- Be sure you understand the vendor's product and what kind of service you can expect to receive.
- Avoid showroom demonstrations, but ask for a demonstration copy of the software. Rarely do more than five to 10 vendors survive this step, because they are either unable or unwilling to provide a demonstration copy of their software, writes Dr. Carter. Eliminate companies that will not provide a demonstration copy.
- Conduct site visits when you have narrowed the potential vendors to three or fewer. Be sure the vendor adequately answers all your questions.
- Verify vendor accomplishments, ask for a list of customers from each vendor and check them out yourself. You want to be sure to find out about the product's bugs, features, update frequency and maintenance.

fees as someone who is actually working for the practice, Dr. Brodsky says. While there are some excellent billing companies available, they have many clients, whereas an in-house billing department has only one client—the practice itself.

If your office has done its best to bill and collect fees, what should you do if patients still have overdue balances? Making use of a collection agency should be your last resort, says Mr. Valancy. These agencies charge fairly high fees that range from 30 to 50 percent of the amount recovered. However, it may be a better alternative than simply writing off overdue balances.

Before using a collection agency, direct your staff to make a systematic attempt to collect the balance, he recommends. Here are some specific steps to follow:

- Send past-due notices printed on or inserted with the second patient bill to show a balance greater than 30 days old (from date of service for co-payments). In addition, continue to bill the patient each month.

- Ask billing staff to telephone patients if they have balances that are greater than 60 days old. Be sure they work out a payment plan with the patient that starts as soon as possible. If they still aren't paying and the balance is substantial, you can tell the patients you plan to send the accounts to collection after you have sent about five or six monthly bills.

- You also can send patients a letter letting them know that you plan to discharge them from the practice if the account balance is not paid in full, or if a payment plan is not put in place and payments become current.

If the above steps fail, then you can send a discharge letter to the patient. At this point you may want to consider using the services of a collection agency, but keep in mind that they typically pay more attention to “younger” high-balance accounts, so that you may not be successful in collecting the funds you are due, Mr. Valancy says.

Another step to focus on is moving insurance claims out of the office as quickly as you can in order to speed reimbursements for services. Electronic claim processing is one way to accomplish that. With electronic claim processing, it is possible to get the claim submitted on the same day service was provided. Within a matter of minutes, your office can transmit the claim either di-

rectly to the insurance company or by way of a clearing house, which means reimbursements to your office will arrive sooner than they would if you sent the claims by regular mail.

Accomplishing efficient billing and coding to improve cash flow greatly depends on making sure you have a well-trained and personable staff. Your aim is to bring out the best in your staff members, says Mr. Valancy. Further, you want staff with good people skills because most of those who work for you will be regularly interacting with patients.

In addition to making wise employment decisions, make sure new hires as well as those who have been with you for years understand your expectations.

If you want patients to pay at the time of service, your front-desk staff must know this and follow through on it. If you want patients to be impressed with the response they get when they

### **Making the Phone Work for You**

Providing a good first impression is one way to attract and keep loyal patients—an important factor in boosting productivity. For many patients, the way your practice manages telephone calls is an important gauge of how well your practice manages care, writes Lyndia Flanagan in an article in *Family Practice Management* (January 1999).

The article offers the following tips for staff on how to make a good impression when patients call:

- Have staff answer the telephone within three rings.
- Give the full name of the practice and have staffers identify themselves.
- Allow callers to speak without interrupting them or placing them on hold.
- Make a point of using the caller's name.
- It may seem obvious, but when speaking to patients, physicians and staff should sound interested, caring and helpful.
- You may also want to give your patients a questionnaire to complete so that you can find out how well your staff is handling the phones.
- Double-check your answering service by actually calling your office to make sure the service handle calls professionally and answers your calls when your office is closed. Also, document how quickly and accurately the service relays important patient information to the physician on call.

call your office, those answering the phones should be courteous and give callers their undivided attention.

Patients don't want to be left on hold, but according to research on the subject, they will be satisfied if they get some kind of response within 40 seconds or less.

Good training is important if you want to make sure patients are adequately impressed with your practice. Unfortunately, says Mr. Anders, "Most training in medical practices is of the folklore type and doesn't follow documented policies and procedures." Having guidelines in place is important if you want to be sure new staff is properly trained.

In addition, too many practices do not spend the time or money to properly train staff on their practice billing systems. "Most staffers use 50 percent or less of the capacity of the practice management systems," says Mr. Anders, which means they aren't as efficient as they should be.

Training staff on new computerized systems should follow a specific method, he explains. For example, arrange for staff to take training sessions and allow 60 days to elapse. Then give staff more training and allow them to ask questions. After the second session, you should allow 90 days to elapse and then give them a third round of training. "After three training rounds, your staff should have a good grasp of the whole system, which ultimately means they will be working more efficiently for the practice," he says.

In the end, Mr. Valancy says, the best intentions of improving your billing and coding to boost profitability will fail if your staff is not properly trained and in harmony with your goals. While there are many training seminars and continuing education opportunities that can improve staff performance, the physicians in the practice should be sure to devise documented policies and procedures and make sure staff is following them.