Early Warning

Signs of Practice Financial Problems

Through training and experience, medical practitioners are well versed in the distinct warning signs of various health conditions — the telltale signs that health problems are afoot. However, the clear signs of financial problems in the practice often go undetected.

Following are a few key warning signs of potential problems in practice finances that you should keep an eye out for:

• **A drop in receivables** — A significant drop in accounts receivable can signal a drop in production. It could simply be a bump in the road — a physician returning from a two-week vacation wouldn’t be expected to have much in the way of charges in AR. Or, it could be a signal of something more worrisome, like a loss of referrals, for example.

  *Action: Prepare a monthly summary accounts receivable report showing comparisons over several months as well as year-to-year.*

• **Lagging collections** — A steady increase in receivables over 90 days old may signal a problem with collections. A high percentage of AR in the 90-day bucket could be due to anything from delayed claim submissions to dirty claims or a host of other issues that require attention.

• **A jump in adjustments** — Substantial variations to your normal adjustment rate can be a sign of anything from embezzlement to changes in billing patterns or payer mix. Or, it may just be a recurring data entry error.

  *Action: Depending on your billing cycles and productivity, adjustments can follow charges by two to eight weeks. To accommodate for this, compare the current month’s adjustments to charges and collections from the prior month or even the month before.*

• **A surge in overhead** — Even with a firm hand on cost control, a practice’s overhead will inevitably rise in step with the consumer price index. Yet a sharp and sudden increase in medical supply costs, for example, demands investigation. When running the numbers, it’s important to remember that the other part of the overhead equation is revenue. Your overhead percentages may be inflated if revenues are declining.

  *Action: Make sure you understand the averages for your area of practice or specialty, and then compare costs from month to month and year to year. Better: Monitor practice expenses by category — staff, facility, office supplies and medical supplies.*

• **Unexpected late charges and penalties** — A medical practice that can’t pay its bills within 30 days may be suffering from serious cash flow issues. Getting dinged with late charges and penalties is compelling proof.

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Patient Engagement

This Is the Year to Make Patient Portals Work

If you met EHR Stage 1 Meaningful Use requirements, you probably already have your patient portal up and running. But 2015 is not the year for resting on your laurels. In fact, you’ll need to not only ensure that you have a functioning portal, but also that patients are using it.

Specifically, Stage 2 Meaningful Use core objectives require the following:

1. **Secure messaging** — At least 5 percent of unique patients must engage their provider through secure electronic messaging within the full-year reporting period. This sounds ominous, but it really only entails patients sending an e-mail that they initiate or in response to one that you’ve sent.

2. **Online records** — At least 5 percent of patients must view, download or transmit their health information through the portal. Simply put, this means they must actually log in to the portal and see what’s there. This could be as simple as viewing their health information or downloading something — a clinical summary, results of a cholesterol check or a list of current medications, for example.

**A Case of the Shakes**
The thought of having their Medicare reimbursement docked is making some providers very nervous. In essence, it is the first time they are not in direct control of meeting core Meaningful Use objectives. Providers are essentially at the mercy of patients deciding to use the portal or not.

The good news is that a dose of marketing savvy may be all that’s needed. First and foremost, you’ll need to give patients a reason to visit your portal. This starts with providing the services they find valuable — the ability to schedule appointments, request a referral or refill prescriptions online.

You might also include patient downloads, links to health resources and interactive tools (a BMI calculator, for example). Compare this to a static portal that amounts to little more than an online Rolodex card with a phone number, hours of operations and a few downloadable “new patient” forms.

Other patient-friendly options include making online test results available, allowing patients to pay bills online, and sending targeted reminders to particular patient populations (HbA1c and eye exam reminders to diabetes patients, for example).

**Make the Case**
In study after study, the single most important factor in portal engagement is simply having the provider ask the patient to register, log in and use it. This starts with selling the benefits — the ability to check lab results online, not having to come into the office every time they have a minor question, etc.

Explain the portal in terms patients understand. For instance, the Healthit.gov website suggests providers might say, “The portal is just a secure e-mail system that we can use to communicate. You can send me a message and it goes right into your chart, so I have all of your information at hand when I read it and respond.” Be sure to remind them that if they use it and don’t like it, they don’t have to continue using it.

The website also suggests setting expectations with patients, explaining what kind of questions are appropriate, and how and when providers will use the messaging — for example, “I’ll be placing your test results on the portal in 2-3 days.”

Once patients are on board, providers will need to do their part and follow through by actively communicating results, responding to patient messages, and better engaging patients in their healthcare through the online portal tools.

**Engage During Visits**
Ensure that patients hear about the portal from multiple sources during each clinical visit. This could include providing talking points for front office staff to encourage patient registration and use, posting materials about the portal and distributing fliers and mailers.

• Mention your new patient portal on your office voice mail and encourage patients to ask the staff about setting it up.

• Print messaging on the bottom of patient summaries when they leave.

• Have staff assist patients with the portal registration process. Here, a registration kiosk in the office can be a good tool.

• Follow up with patients who have not registered for the portal by phone and e-mail.*

In the end, Meaningful Use requirements for patient portals are not a set-it-and-forget-it proposition.

*Source: The Office of the National Coordinator for Health Information Technology (ONC)
The Office of Inspector General is keeping a close eye on “incident-to” billings to ensure they are appropriate. Consider the answers to these common questions to ensure proper compliance and appropriate reimbursement:

Q: Can a new patient visit be billed as “incident to” when handled by an NPP?
A: No. For services to be considered incident to, there first must have been a “direct, personal and professional service furnished by the physician to initiate the course of treatment,” according to Medicare regulations. Care provided to a new patient or an established patient with a new health care problem may never be billed as incident-to a physician service. To bill for the NPP, the physician must have seen the patient first at a previous encounter and established the plan of care.

Q: If the doctor is on his way in, does that count toward supervision requirements?
A: No. For follow-up services to be billed as incident to, they must be furnished by an employee or independent contractor under immediate personal supervision of a physician. Therefore, an incident-to bill is not permitted for visits occurring while the physician is out of the office for lunch or on other business.

Q: Is it more efficient and profitable to have the NPP see patients in the office or the hospital?
A: The regulations state that NPPs can bill incident to for services that are normally furnished in a physician’s offices. Therefore, if NPPs perform rounds in the hospital for the physician or visit a skilled nursing facility to see the physician’s patients, they must bill under their own provider number.

Q: What is the difference between incident to and shared visits?
A: In general, incident-to services are for office-based services, and shared visits are for hospital services. Specifically, shared services are E/M services that a physician and an NPP provide jointly and are reported in the emergency department, outpatient department or inpatient department of the hospital. Both the physician and the NPP must provide a face-to-face service to the patient on the same calendar day and both must document their portion of the work. The combined work is then billed under the physician’s provider number for 100 percent of the Medicare physician fee schedule — even if the NPP performed the majority of the work.

The difference in reimbursement between incident-to (100 percent) billing and billing under an NPP’s own provider number (85 percent) can be substantial. So make sure you follow the rules.

Questions and Answers
How to Avoid Incident-to Overbilling

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Action: Review practice bank statements for overdrafts or returned checks.

Where There’s Smoke …
When it comes to financial problems, the trick is to act while the flames are still small. For many practices, this starts with an ongoing monitoring program that includes the following:

Benchmarking — Obtain data from your state medical society or organizations such as the Medical Group Management Association to establish benchmarks for your practice. A simple digital dashboard of relevant metrics and key indicators makes it easier to spot variances. The idea is to create a system that will draw your attention to critical issues quickly.

Monitoring — Have a practice administrator, physician manager or independent advisor conduct monthly monitoring of the practice’s financial indicators. Of course, this entails having accurate data — billing, collections, accounts receivable, payer reimbursement and practice financial statements — available on a timely basis each and every month. If financial information is late or is being withheld, it could be a sign of trouble.

Reviewing — Schedule a regular monthly meeting to review and discuss the information from your practice management software and bookkeeping reports with all stakeholders in the practice.

Just as you monitor the vital signs of your patients, you will also need to monitor the signs that reveal your practice’s financial health.

Contact our office to learn more about monitoring your practice’s financial indicators — or for help in understanding what your current indicators are saying.
ICD-10: Master What Matters

When it comes to tackling the new ICD-10 code set, the solution may lie in the old wisdom about eating an elephant one bite at a time and breaking ICD-10 implementation into digestible bits. For example:

**Master what you can master.** Rather than focusing on all 155,000 codes, focus on mastering the codes relevant to your specialty (e.g., make a short list of the codes you have to be good at).

**Bone up on documentation.** ICD-10 requires a much higher level of specificity. Sit down with your billing staff to talk through documentation issues. In particular, work with your coders to understand what information they’ll need to document more specifically.

**Run a documentation readiness assessment.** Pull a few charts and have billing staff evaluate whether current documentation would support coding with ICD-10. If not, determine what additional information would be needed to make it ICD-10 ready.

**Train everyone who matters.** Anyone who “touches” the system should be trained in the new coding procedures. For instance, a medical assistant who fills out lab forms will need to list patients’ diagnoses using the proper codes.

**Make it manageable.** Even with practice management and EHR vendors doing much of the heavy lifting, practices still must invest sufficient time and money in training themselves and their staff. Avoid a mad rush by scheduling some time every month between now and October to work on it.

**Cash up.** Payment delays are almost inevitable as improperly coded claims work their way through the system. Avoid a cash-flow crunch by establishing a financial reserve that will see you through three to six months of payment delays.

Contact our office for guidance on managing ICD-10 conversion in your practice.