Managing Your Practice Through Rapid Growth
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Financial Disclosure
Donna McCune is a consultant for Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Corinne Wohl is President of Wohl Associates, Inc., an ophthalmic practice management consulting firm.

Growth
- The process of growing.
- Full development; maturity.
- Development from a lower or simpler to a higher or more complex form; evolution.
- An increase, as in size, number, value, or strength; extension or expansion.

Change
“Things will always change. We don’t have a choice about that, but we do have a choice on how we react to change; and as a leader whether or not we choose to create change. The choice really boils down to this . . . Either we manage change, or it will manage us.”

Source: Change is Good . . . You Go First by Mac Anderson and Tom Feitstein

Objectives
- Consider ways to manage growth
  - New providers
  - New locations
  - Increasing staff
- Government mandates and scrutiny
- Recognize areas of risk during change

Manage Growth
- Starts with Strategic Planning!
- Tactical planning development follows
  - Practice growth – how much?
  - New providers – how many?
  - New offices – how many?
Practice Revenue Growth Rate

- Calculate: Collections this year, minus collections for the prior year, divided by the collections for the prior year; e.g., a practice that collected $1 million last year, and $1.1 million this year enjoyed a 10% growth rate.

- Target: The baseline goal is 3% to 5%, which means that in an environment with slowly eroding fees, efficiency and productivity must materially exceed fee reductions to hit growth targets. Young and aggressive practices should aim at 10% growth rates; mature practices can do just fine with zero net revenue growth.

New Providers

- Challenges of Recruiting MD’s
- OD: MD ratio trends
- Adding new providers as employees produces passive income for shareholders
- Strongest passive income opportunities include a high OD:MD ratio, ASC ownership and optical sales

New Providers

- Revenue enhancement is best developed through practice growth, not reducing expenses
- Adding providers is a key step

New Providers

- On-boarding new providers
- The “paperwork” part is easy if you keep a checklist and assign one person to take responsibility to assure all items are completed in a timely fashion.

Characteristics of New Residents

- More are sub-specializing; fewer generalists
- Fewer pediatric and neuro specialists
- Lifestyle is an important consideration
- Less time devoted to patient care

New Providers

- New Residents

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<tr>
<th>Task</th>
<th>Responsible</th>
<th>Completed</th>
<th>Notes</th>
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<td>Employment contract signed</td>
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<td>Confirm background checks/Medicare exclusion screens</td>
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<td>Announcement to the practice</td>
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<td>Contact professional liability insurance broker</td>
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<td>Credentialing process for all insurance payors/hospitals/ASCs</td>
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<td>Prepare orientation kit (employee manual, staff contact lists, newsletters, new hire forms)</td>
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<td>Prepare orientation schedule with all managers &amp; assigned doctors</td>
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<td>Bio development &amp; photo for website/marketing/announcements</td>
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<td>Update letterhead &amp; order business cards</td>
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New Providers

- Successful Integration
  - By the Practice:
    - Orientation – complete, not partial, more complex
    - Mentor
    - Marketing/Introductions
  - By the Physician
    - Develops strong collegial relationships
    - Shows appropriate interest in business side
    - Expresses appreciation for staff support

Medicare Enrollment

- You cannot file the application any sooner than 30 days prior to the provider’s start date.
- Applications take 60-180 days to process.

Medicare Enrollment

- Prior to January 1, 2009 you could see Medicare patients and hold claims until application was processed.
- As of January 1, 2010, the effective date of billing can only be 30 days retroactive from: the later of the “date of filing” or the date you first started furnishing services at the practice.

Medicare Enrollment Example

- April 1 is the effective date.
- Down side = You will be holding claims until June 28.
- No way to complete an application and have your provider enrolled before they start in your practice.

Internet Enrollment

- Provider Enrollment, Chain and Ownership System (PECOS)
- All states are enrolled
- You have the option of internet or paper applications
- Username and password are your NPPES username and password
- https://pecos.cms.hhs.gov/
New Locations

- Decisions
  - # of Providers
  - Office square footage
  - Lease vs Purchase

- Use benchmarking for data driven decision-making
  - VERY important!

New Locations-Benchmarking

- Assess Local Population to Provider Ratio
  - There are about 10,000 active ophthalmologists in America, serving a population of about 315 million...that's 20,000 people per ophthalmologist
  - Divide your local health care service area population by the number of ophthalmologists practicing in this area
  - Target: You operate in a favorable market if there are more than 20,000 people per ophthalmologist in your service area, and vice-versa

- Take this into account when considering professional staff additions, succession planning, M&A work, satellite development, etc.

New Locations-Benchmarking

- Calculate current facility usage:
  - Annual patient visits (including post-op visits) divided by total exam rooms times 2080 typical annual work hours
  - Current room capacity norms are +/- 1 patient visit per room per hour

Mergers and Acquisitions

- Another method of practice growth
- Develop a multi-year proforma to assess financial viability
- Combining practice cultures can be challenging

New Locations

- Must be added to your profile with all payers
- Complete CMS-855B for Medicare
- Recognize different Medicare fee schedules in different locales

Increasing Staff

- More Benchmarks:
  - Tech hours per visit
    - Norms in ant seg/glau are 0.9-1.0
    - This is 1.1 in pure refractive sx and 1.3 in retina

- Billing Staff hours per transaction
  - 0.3 norm
  - Billing staff norms of 18 minutes per patient transaction
  - May be appropriate in any one practice with special conditions (inexperienced staff, difficult payors, etc.)
Respect the Growing Process

“In times of change we must remember . . . mistakes will be made. We must remember that people will be people.”

Source: Change is Good . . . You Go First by Mac Anderson and Tom Feltman

Case Study

- Billing office receives call from technician / MD
- Provides “list” of covered diagnosis codes for a particular test
- Technician / MD append one of the “covered” diagnoses to ensure payment
- Billing office works only from list of approved codes and never checks the chart to confirm condition exists

Avoiding Diagnosis Code Errors

- Physician and staff training on assigning correct diagnosis codes
- Physicians should “link” diagnosis codes
- Patient inquiries require chart review of chief complaint and finding
- Establish policies regarding changing diagnosis codes

Case Study

Well-Intentioned Employee

- Submitted claims based on CPT codes circled on superbill
- Noticed combination of FA / FP / OCT
- Checked NCCI edits and determined FP / OCT are mutually exclusive
- Added modifier -59 to all FP claims with OCT
- Did not ask about medical necessity or clinical support to unbundle
- Substantial overpayment to Medicare owed

Internal Auditing of Billing Office

- Track staff’s accuracy
- Identify denial causes
- Identify denial trends
- Determine if appeal is warranted
- Monitor electronic remittances closely

Know When to Expect Payment

- Cash patients - the day of the service
- Medicare 16 days
- Blues about 20 days
- Medical Groups / IPAs 60 days
Conduct Chart Review
- Verification of credentials
- Validate medical necessity
- Certify correct coding
- Assess documentation
- Confirm compliance with statutes and regulations

Source: DHHS OIG report on Medicare fee-for-service payments

Case Study – Dr. I. M. Troubled
- 1 MD, 1 OD
- 5 Full time staff (2 tech, 3 office staff)
- 70% Overhead
- 60% of A/R > 60 days
- Wants go add new physicians ASAP
- Being audited by Medicare
- Staff coded and filed all encounters w/minimal physician input

Case Study – Dr. I. M. Troubled
- Implemented a compliance program
- Trained all staff and Physicians on documenting and coding
- Quarterly utilization reports
- Quarterly internal chart reviews
- Physicians accountable for coding
- Staff held accountable for their documentation, claim filing, and collections
- Annual external chart review/training program

Case Study – Dr. I. M. Troubled
- 3 MDs, 3 ODs, 3 locations, ASC
- 30+ staff
- 60% Overhead
- 20% of A/R > 60 days
- Passes audits when audited
- Physicians actively involved in compliance
- Utilize EMR
- Successful with MU and PQRS

Inhibit Embezzlement
- Screen and inform employees
- Diversify duties
- Outsource payroll function
- Proper cash handling
- Prompt banking
- Efficient software
- Patient billing documentation
- Careful inventory tracking
- Professional advisors
- Knowledgeable physician partners

Government Mandates and Scrutiny
- Quality programs
- Data mining by CMS
- CBR Reports
- Claim’s payment data
Health and Human Services Timeline

- 85% Medicare fee-for-service payments in categories 2 - 4 by 2016
- 90% Medicare fee-for-service payments in categories 2 - 4 by 2018


The future of PQRS?

- Not going away!
- Important part of PPACA
- Integration into VBM penalty/bonus
- The new MIPS will also use “quality” data in some form
- Another possible step towards P4P

Responding to Data Mining

- Review your data
- Don’t act defensive
- Don’t play the blame game
- Point out the limitations of the data
- Describe your geographic service area
- Demonstrate expertise about the procedures you perform

Potential Compliance Issues

1. HIPAA enforcement activities and litigation will increase.
2. The ICD-10 conversion will create new compliance risks.
3. Whistleblower activity will increase.
4. The Affordable Care Act will create billing compliance headaches.
5. Meaningful use audits will increase.
6. Provider integration and realignment will trigger compliance concerns.

Source: Medical Practice Compliance Alert 1/6/14

“To change any culture, in any company, the people at the top have to show it! Because words without deeds mean nothing!”

Source: Change is Good . . . You Go First by Mac Anderson and Tom Peters

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