

Efficient practice management: a nine-point action plan

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They may seem like simple common sense, but the nine steps outlined here are often neglected by physicians, nurses, and their practice managers. In the past, it was easy to get complacent and accept that the amount of money coming into a practice was sufficient. However, in today's reimbursement climate, oncology practices can no longer afford such a lax attitude. Unless attention is paid to efficient business operations, you simply leave money on the table—money that could be in your pocket and in your practice.

There are many ways to make a practice more efficient and save money. Because all of us are so busy, we're wary of things that could take a lot of time. But in this article, I concentrate on nine ideas that produce the biggest rate of return in terms of dollars saved. The nine-point action plan detailed here was formulated out of my own frustration at seeing practices forfeit money owed them, simply because no one systematically attended to the workaday details that must be followed up. Putting this plan into place requires a team effort in order to be successful.

1. Take advantage of discounts given for early payment on drugs.

Most likely your largest expense is the cost of drugs. Distributors offer early payment discounts at varying rates that can exceed 3% of the cost of the drugs. Typically, there are no discounts for drugs purchased and paid for within 75–90 days. But depending on the distributor, you can choose from several tiered early payment discount rates offered for payment before 75 days. The deepest discounted rate is given for payment on the same day of purchase. Many practices take advantage of these types of discounts. But they don't re-evaluate the impact of purchasing drugs at a better discount rate. **Every 1% off of a million dollar purchase of drugs is equivalent to \$10,000.** When you are buying millions of dollars worth of drugs each year, this discount can add up to enormous savings.

Of course, all of this is predicated on your having a good cash flow. Many times there may not be good cash flow because the physicians are taking the money out of the practice too soon. By leaving enough money in the practice and taking advan-

tage of the early payment discounts, physicians can still take in all of the money they were going to get for that year *along with* the substantial savings from the early payment discount. Ask about and take advantage of these discounts. *Whatever happens, do not take out a line of credit. That can have a huge negative impact on your bottom line.*

2. Maximize your contracts on the supportive care and antiemetic drugs you purchase.

Pharmaceutical companies that compete in the marketplace with similar drugs such as Aranesp (darbepoetin alfa) and Procrit (epoetin alfa), for example, will vie for your business with lower prices and higher rebates. Many practices split their purchases between two contracts and receive two rebate checks. But these two checks total tens of thousands of dollars *below* the one check that could be had just by maximizing one of the contracts. If you believe that two drugs are equivalent in terms of treatment, then you need to figure out which one offers you the greatest savings.

To analyze this, calculate the reimbursement for each drug *less* the net cost of all rebates *times* your total utilization of that product. I have developed an Excel spreadsheet that performs this analysis for supportive care drug contracts. By plugging your numbers into this program, you can reach a rational and judicious purchasing decision. For a free copy of the software, please e-mail me at cancersp@erols.com.

3. At least once a month, make sure you are bill-

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ing out all your supportive care drugs (Procrit, Aranesp, Neupogen, Neulasta, and Leukine). This is perhaps the easiest type of item to miss when billing. One big reason is the following familiar scenario: A patient comes in for a follow-up visit. His red blood cell count is down and he needs a shot. The nurse is busy; she gives the shot but forgets to bill for it since the patient was not on her schedule and she did not have a billing ticket for him. And because there was no order, the billing department doesn't pick up on the fact that this drug was administered. The result is a missed opportunity and missed income. In this case what is needed is rigorous follow-through on

'The nurse is busy; she gives the shot but forgets to bill for it since the patient was not on her schedule and she did not have a billing ticket for him. The result: missed income.'

the part of the nurse. Here's a similar problem: I have heard many nurses—especially those who work part time—say that they do not like to use inventory control machines. They open the machine without documenting their removal of a particular drug and—as in the example above—they forget to bill for that drug.

With just a small bit of extra effort, use of these drugs could be easily tracked, making an enormous impact on revenue. I created an Excel spreadsheet that I use each month to determine whether I have billed out all of the supportive care drugs in my practice. If you would like a free copy of this tool, please e-mail me. I also created, in collaboration with the International Oncology Network (ION), AnalyzeIt software that allows me to analyze and track billing of all my drugs. Each month, I typically analyze only my top 13 most

expensive drugs; the software downloads my purchases and converts the vial sizes to the billing units. If you are interested in the software, you can go to www.iononline.com and click on "Health Care Providers," "Data Solutions" tab on the left side. Select the AnalyzeIt option.

4. Make the best and most creative use of codes. Because money has been pulled out of reimbursement for drugs, and restrictions have been placed on the use of drug administration codes, each practice needs to code properly and bill for everything it does. You also must bill the most effective code that reflects the actual service performed, at the highest level of reimbursement. One simple example is when a nurse performs a port flush on a patient during a visit, which is all that is done for the patient that day. In 2004, I would have billed a 99211. But as of 2005, I could still bill the 99211 (nurse office visit with physician supervision) or the G0363 (irrigation of implanted venous access device), which pays approximately \$7 more than 99211. This may not sound like much, but when your practice does this regularly for all patients during the year, it could add up to thousands of dollars.

Professional billers are better informed about these matters than are the clinicians doing the work. If I educate my nurses and clinical staff on how each code is used, anytime they flush a port or do a specific task, they know how to bill the best appropriate code without having to rely on the billing staff to make the choice.

Out of a misguided fear of an audit, I've observed doctors "downcoding" their office visit services. Instead of billing 99215—the highest level office visit, which is paid at approximately \$120—these physicians code 99214, which is paid at approximately \$83. Also, I have observed that 99214 downcoded to a 99213, which pays at approximately \$53. I say their audit phobia is misguided because

they have done the work, their documentation supports billing for more services, and yet they are willing to forfeit thousands of dollars. If an oncologist can't bill for a comprehensive office visit (99215), what specialist can? Unlike the rest of the medical community, oncologists have been willing to discount their work to the government. That should stop.

5. Analyze your chemotherapy regimens and assess the net profitability of each one. You need to examine the *full* cost versus reimbursement for all services, drugs, and labs. You also need to compare the same data but exclude from the services provided the costs all of the physicians' salaries and benefits. This allows you to make sure that if an insurance company is paying you less than all of the costs, excluding the physician's costs, then you know your patient needs to be treated in the hospital outpatient setting. Otherwise, you are working for free and subsidizing the insurance company for that treatment.

It's also important to do this analysis to determine how much of the patient's responsibility must be collected up front in order to cover the hard costs of the practice. In 2006, most of the 20% of the Medicare allowable must be paid by the patient in order for a practice to at least break even. And if you are not breaking even, you are subsidizing treatment of patients by taking money from one part of the practice to pay the expenses for another part. I also use my AnalyzeIt software to calculate all of my costs versus all of the reimbursement amounts from Medicare and my third party carriers for the regimens we use to treat patients in our practice.

6. Collect co-payments up front. Make patients aware of their responsibilities. There is nothing more frustrating than spending lots of time and money on postage and statements to collect a \$1 co-pay from a Medicaid patient. Have the billing staff make staff members at the front desk aware

of every patient's co-pay responsibility. Place your credit card machine at the front desk and train the staff to make credit available if patients have no other form of payment. If staff members at the front desk have a problem asking for the co-pay from a patient because they are too sensitive, have them contact the billing staff to back them up and ask for the money. Dentists, veterinarians, and even pharmacists have trained patients well: they don't receive the service until they have paid their co-pay. Unless you set a clear policy with patients, you will be spending precious time and money chasing them later.

7. When a patient cannot afford his or her co-payment, use "tough love" and shift the care of that person to the hospital. In the past, it was very difficult for small practices to feel comfortable sending patients to the outpatient unit in the hospital when they could not pay, but now it is something you may *have* to do in order to keep your practice financially viable, for the good of all your patients. Treating patients in the hospital moves the financial responsibility to the hospital and out of the practice.

Many physicians feel guilty about shifting patients to the hospital and instead choose to eat the loss. In our practice, we explain the numbers to the patients so that they can understand why they are paying their balance and why, if they cannot pay it, they have to be moved to the hospital setting. It also helps us to encourage patients to become politically active. We show them how Medicare reimbursement has declined and how critical it is to collect every dollar of their co-pay, which does not even guarantee that we will break even. We tell them how to contact their member of Congress. We advise them to call 1-800-MEDICARE and demand fair changes in reimbursement and to let officials know how their care has changed with Medicare cuts.

8. Work hard at collecting what is owed to you by insurance companies. I see many practices that are so focused on billing out services today and trying to collect what they can on the current accounts receivable, they miss all of the insurance claims that have aged over 90 days. They know that these balances exist, but they don't have the time and energy to aggressively work those accounts because they are too busy chasing patients for small dollar amounts and insurance companies for current balances. Typically, I see about 15% to 23% of insurance receivables age over 60 days. This can equal several hundred thousand dollars. We all work so hard to get preauthorization and many bill electronically to insurance carriers, but then many practices don't fight aggressively to get what is owed them on a timely basis because it really does consume a lot of time. But it is money you have earned and deserve to be paid.

Insurance companies drag their feet with all kinds of excuses hoping you will forget about it or that you will adjust it off because they said that they would not pay for those services. Hold them to the contract and fight to get what is legally yours. You should not have to wait for months to receive payment on clean claims. Most of the time, 90% of the accounts receivable is made up of insurance claims. If this is so, have your billing staff spend that much time collecting and fighting insurance companies to get the low hanging fruit. The older a bill gets, the more difficult it is to collect; sometimes it becomes impossible to collect.

If more than 20% of your insurance accounts receivable are more than 60 days old, then you could devote someone's time to follow up on these claims daily until they are cleared up. This would allow your other billing staff to concentrate on current balances less than 60 days old. Your practice would see a windfall of

tens of thousands of dollars.

9. Renegotiate. Don't be afraid to say no to a third party payer because you are worried that your competition will end up with that contract. When you say no to an unfair contract, in all likelihood the insurance company *will* go to your competition—and will run that practice into the ground. You have to stand up and refuse to work for contracts that pay you below costs. Know what you are willing to accept above break-even. If the insurance company chooses to pay you below that level and you acquiesce, then you are subsidizing the treatment of patients. We are all tired of being treated this way.

'You've got to fight aggressively to get what is owed to you by insurance companies. Typically, up to 23% of receivables have aged more than 60 days. That's thousands of dollars.'

In the past, many practices accepted contracts no matter how unfair they were because other insurers subsidized the losses. This is not true in 2006 with all of the Medicare cuts and the third party payers who have followed with the same cuts.

Once again I utilize my AnalyzeIt software to create the reports needed so I can negotiate contracts with my third party payers. The reports show what my utilization is with that payer and how much they are reimbursing me versus how much it costs. This tool then allows me to know at a minimum what I need to be asking in order to cover my true costs.

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