PERFORMANCE IMPROVEMENT INITIATIVES IN MEDICAL PRACTICES

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PERFORMANCE IMPROVEMENT INITIATIVES IN MEDICAL PRACTICES

The Five Levers For Medical Practice Improvement

1. **Reimbursement Systems**
2. **Billing and Collections Processes**
3. **Accounts Receivable Management**
4. **Operations Improvement**
5. **Practice Growth**

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1. Reimbursement Systems

A. Coding Compliance Program

B. Professional Fee Schedule Analysis

C. Fixed Fee Payor Impact Analysis

D. Managed Care Contracting

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OIG WORKPLAN FOR PHYSICIANS: 2015

- New inpatient admission criteria
- Medicare oversight of provider-based status
- Comparison of provider-based and free-standing clinics
- Outpatient evaluation and management services billed at the new-patient rate
- Diagnostic radiology – Medical necessity of high-cost tests
- Imaging services – Payments for practice expenses
- Selected independent clinical laboratory billing requirements (new)
- Physicians – Place-of-service coding errors
- Sleep disorder clinics – High use of sleep-testing procedures
- Enhanced enrollment screening process for Medicare providers
- Provider Self-Disclosure

"Physicians tend to overbill for what they document

and

Physicians tend to underbill for what they provide"

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Development and Implementation of Coding Compliance Program:

1. Evaluation and Management Coding Utilization Analysis by physician in order to ensure compliance against CMS Audit Standards and determine areas of potential undercoding or overcoding.
2. Performance of Documentation Chart Audits for each physician in order to ensure appropriate documentation and medical necessity vis-à-vis procedural coding.
3. Conduct Educational Sessions with each physician (individual and/or group) in order to review the outcome of our Assessment and establish a framework within which each physician may accomplish these tasks in order to satisfy compliance requirements.

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CMS ACTUAL USAGE DISTRIBUTION
EVALUATION & MANAGEMENT
FAMILY PRACTICE

NEW PATIENT VISITS

CODE	% DIST.
99201	2.65%
99202	20.47%
99203	42.90%
99204	27.11%
99205	6.87%
TOTAL	100%

ESTABLISHED PATIENT VISITS

CODE	% DIST.
99211	4.00%
99212	8.37%
99213	59.56%
99214	25.59%
99215	2.48%
TOTAL	100%

CONSULTATIONS

CODE	% DIST.
99241	3.44%
99242	19.35%
99243	41.63%
99244	28.04%
99245	7.54%
TOTAL	100%

HOSPITAL VISITS

CODE	% DIST.
99231	25.51%
99232	58.71%
99233	15.78%
TOTAL	100%

HOSPITAL ADMITS

CODE	% DIST.
99221	6.39%
99222	47.51%
99223	46.10%
TOTAL	100%

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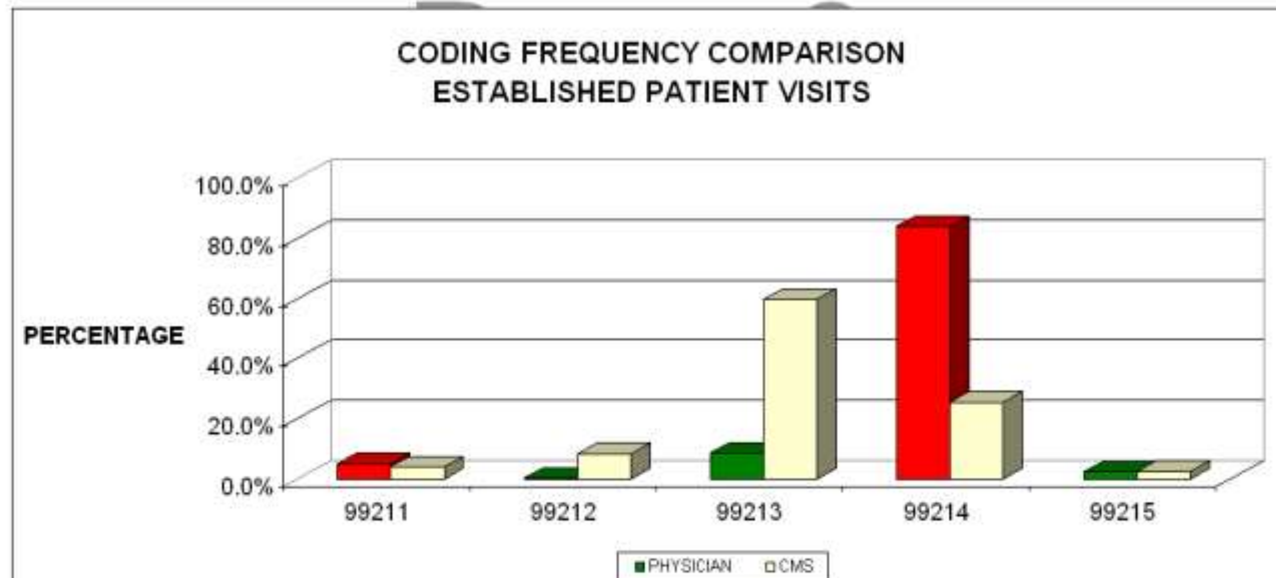
SAMPLE PERFORMANCE IMPROVEMENT CODING COMPLIANCE PROGRAM
FAMILY PRACTICE

Practice: Family Medicine
Physician:

Specialty: Family Practice
Locality: MS

Privileged and Confidential

CPT CODE	FEES	Actual Frequency	Total Charges	Redistributed Frequency	Redistributed Charges	Net Change	Physician Percentage	CMS Percentage
99211	$47.00	153	$7,191.00	121	$5,687.00	$1,504.00	5.1%	4.00%
99212	$67.00	9	$603.00	253	$16,951.00	($16,348.00)	0.3%	8.37%
99213	$85.00	258	$21,930.00	1,800	$153,000.00	($131,070.00)	8.5%	59.56%
99214	$124.00	2,536	$314,464.00	774	$95,976.00	$218,488.00	83.9%	25.59%
99215	$198.00	67	$13,266.00	75	$14,850.00	($1,584.00)	2.2%	2.48%
		3,023	$357,454.00	3,023	$286,464.00	$70,990.00	100%	100.00%



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SAMPLE PERFORMANCE IMPROVEMENT CODING COMPLIANCE PROGRAM
FAMILY PRACTICE

Practice:Family Medicine
Physician:

Specialty: Family Practice
Locality: LA

Privileged and Confidential

CPT CODE	FEES	Actual Frequency	Total Charges	Redistributed Frequency	Redistributed Charges	Net Change	Physician Percentage	CMS Percentage
99211	$27.00	9	$243.00	146	$3,942.00	($3,699.00)	0.2%	3.6%
99212	$50.00	1,778	$88,900.00	660	$33,000.00	$55,900.00	43.9%	16.3%
99213	$70.00	2,164	$151,480.00	2,478	$173,460.00	($21,980.00)	53.4%	61.2%
99214	$88.00	98	$8,624.00	664	$58,432.00	($49,808.00)	2.4%	16.4%
99215	$105.00	0	$0.00	101	$10,605.00	($10,605.00)	0.0%	2.5%
		4,049	$249,247.00	4,049	$279,439.00	($30,192.00)	100%	100%

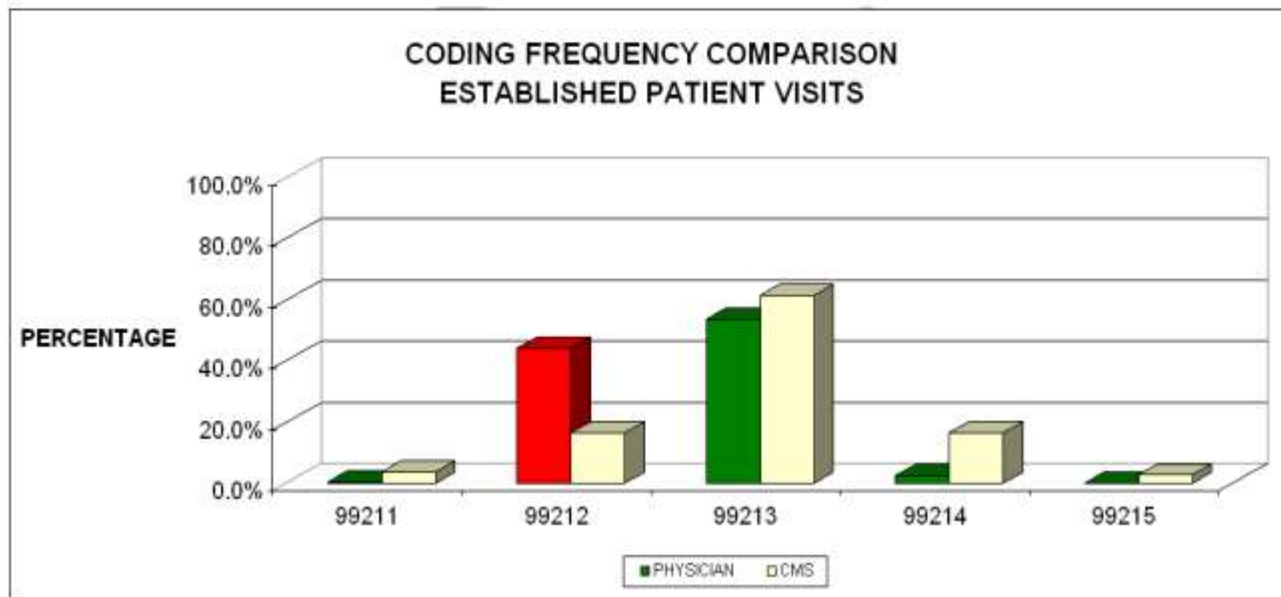

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CHART AUDIT FINDINGS

The following table represents a review of evaluation and management service documentation provided by the specialty of Internal Medicine. The information provided was used to determine appropriate code assignment, but internal policies and forms not included in assessment may affect level of service. The results of this audit should be reviewed by the provider. Once final code assignment is determined, if a discrepancy exists that indicates the service billed was inconsistent with that documented, appropriate actions should be taken to ensure accurate billing. Federal law requires refunding any amount overbilled for care provided to federally insured beneficiaries.

Patient #	DOS	Billed	Due	HPI	Exam	MDM	Comments
141628	1/15/03	99213	99214	EPF	D	MC	One new problem and one established worsening with Rx med given
141628	12/9/02	99204	99204	C	C	MC	
141029	12/19/02	99213	99214	EPF	D	MC	Difficult to read history information
141029	1/16/03	99214	99214	EPF	D	MC	
141447	*6/11/02*	*99203*	*99202*	*EPF*	*C*	*MC*	*Need one more descriptor of chief complaint in order to code level 3*
14150	12/18/02	99213	99214	EPF	D	MC	When have multiple Dx need to number order of importance to ensure that diagnoses most responsible for visit being coded

DOS- Date of Service Billed- E/M Billed Doc- E/M service level documented HPI- History of Present Illness component Exam- Examination component MDM- Medical Decision Making component PF- Problem Focused EPF- Expanded Problem Focused D- Detailed	C- Comprehensive SF- Straight Forward LC- Low Complexity MC- Moderate Complexity HC- High Complexity **Potential Undercoding** *Potential Overcoding*

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Sample Recommendations from Practice Assessment

1. Reimbursement Systems

- Conduct Annual Professional Fee Schedule Review
- Conduct Charge Validation Study to ensure accurate Managed Care Contract reimbursement
- Conduct quarterly coding in-service training with all physicians and appropriate Clinic staff
- Establish Chart Audit Committee to perform random sampling audits on a quarterly basis from a compliance standpoint as well as to ensure the capturing of all appropriate charges
- Consideration should be given to developing a Coding Compliance Program, particularly focusing on Coding, Documentation and Medical Necessity

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2. Billing And Collections Processes

A. Up-Front Collections
B. Initial Billing
C. Rebilling Frequency
D. Claim Denial Follow up
E. EOB Review
    - Coding Optimization
    - Fee Schedule Comparisons
F. Credit Balances

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REVENUE CYCLE MANAGEMENT

I. FRONT OFFICE OPERATIONS:

- Patient scheduling and registration
- Insurance verification and eligibility
- Over the Counter collections of co-payments, deductibles and outstanding balances
- Coding validation
- Charge entry
- Referral Management

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REVENUE CYCLE MANAGEMENT

II. BUSINESS OFFICE OPERATIONS:

1. **Initial Billing**
   - Pre-billing edits
   - Electronic claim submission/validation
   - Claim review procedure
   - Electronic
   - Hardcopy

2. **Rebilling**
   - Account follow-up
   - Secondary insurance
   - Rejections
   - Denials

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REVENUE CYCLE MANAGEMENT

II. Business Office Operations (cont'd):

3. Payment Posting
   - Tracking by insurance company

4. Claims denial and rejection monitoring and management

5. Payor contract compliance

6. Transfer patient balances to self pay accounts
   - Management of self pay accounts and patient payment plans

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REVENUE CYCLE MANAGEMENT

II. Business Office Operations (cont'd):

7. Accounts Receivable Management
   - Collection agency performance monitoring
   - Charity write-off
   - Physician requested write-off
   - Administrative write-off
   - Untimely and improper insurance filing
   - Aged accounts receivable reconciliation write-off

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Sample Recommendations from Practice Assessment

2. Billing and Collection Procedures

- Develop claim denial follow up reporting on a monthly basis
- Develop monthly targets for over the counter collections for the practice
- Develop system for tracking compliance with patient payment plans
- Ensure consistent performance by front end personnel with respect to insurance verification and pre-authorization processes
- Implement formal training programs for front office clinic personnel to decrease error rates for claim rejections and denials

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Sample Recommendations from Practice Assessment

2. Billing and Collection Procedures (Cont'd)

- Monitor credit balances on a monthly basis to ensure prompt refunding of patient overpayments
- Monitor reasons for rejections and denials due to inaccurate information
- Review, revise and implement written financial policies and procedures

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3. Accounts Receivable Management

A. Utilize 80/20 Analysis
B. Strategy: Segregate Aged Trial Balances by Insurance Company
C. Approach for Collection of Patient Balances
D. Strategy: Aging Analysis Reports
   - By Insurance/Payor
   - By Patient
   - By Physician
   - By Practice Site
E. Monitoring Reports/Guidelines

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PERFORMANCE AND PRACTICES OF SUCCESSFUL MEDICAL GROUPS

Strategic Priorities (1=Very Low; 5=Very High)		
Accounts Receivable	4.28	4.35
Physician Compensation	4.20	4.13
Human Resources	3.88	3.79
Information Technology	3.82	3.70
Physician-Administrative Management Team	3.60	3.57
Physician Recruitment	3.53	3.40
Governance	3.30	3.24

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Consider Utilizing IRS 1099-C Form

In order to report income to an individual regarding the cancellation of debt, the following conditions must be met:

- The account must be at least $600.00
- The accounts must be cancelled and returned from any collection agency
- You must have determined the account to be uncollectable during the current year
- You are giving up trying to collect the account
- You are writing the account off or removing it from your books

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Sample Recommendations from Practice Assessment

3. Accounts Receivable Management

- Consider utilizing IRS Form 1099-C for uncollectable accounts over $600.00
- Consider utilizing the credit bureau and small claims court for excessive delinquent account balances
- Develop monthly audit of accounts receivable and claim denial follow up and review notes on each particular account in order to ensure each account is properly worked on a monthly basis
- Develop segregated aged trial balances by major payors in order to facilitate follow up with outstanding account balances in excess of thirty (30) days by major insurers

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Sample Recommendations from Practice Assessment

3. Accounts Receivable Management (Cont'd)

- Increased surveillance as to the charge/collection/ adjustment ratios by payor should occur in order to detect areas of low reimbursement and/or delayed payments from major managed care companies
- Quarterly monitoring of collection agency performance
- Utilize Prompt Payment Laws

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4. Operations Improvement

A. Economies of Scale

- Outsourcing Opportunities
- Purchasing Contracts
- Change Mix of Personnel
- Centralized Scheduling
- Ancillary Service Opportunities
- Practice Compliance and Integrity Programs
  - Coding Compliance Program
  - Medical Practice Compliance Program
  - HIPAA Compliance Plan
  - OSHA
  - CLIA
  - ADA
  - etc.
- Other Opportunities (i.e., Customer Service)

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4. Operations Improvement (Cont'd)

B. Operational Improvements

- Human Resource Investments
- Physician Compensation Plans
- Cost Analyses
- Return on Investment Strategies
- Patient Flow Models
- Information Technologies Solutions

C. Financial/Operational Reporting Process

- Productivity
- Capacity
- Staffing Indicators

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Sample Recommendations from Practice Assessment

4. Operations Improvement

- Develop effective patient recall system for practice
- Develop monitoring systems for the practice with respect to no show patients and cancellations
- Develop performance monitoring Benchmarks
- Encourage practice to utilize information system for appointment scheduling
- Implement Medical Practice Compliance and Integrity Program
- Explore opportunities for additional ancillary services

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5. Practice Growth

A. Frequency by CPT-4 Codes

B. Frequency by ICD-9-CM Codes

C. Physician Referral Analysis

D. Patient Origin Analysis

E. Ancillary Services

F. E-Business Strategy

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5. Practice Growth

G. Surveys

- Patients
- Employees
- Physicians

H. Market Research

I. SWOT Analysis

J. Develop/Implementation of Strategic Plan

K. Monitoring Reports/Guidelines

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Productivity Improvement Program

- **Patient Scheduling**
- **Physician Productivity**
- **Physician Incentive Compensation Structure**
- **Establish Physician Productivity Goals and Monitoring Reports**

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SUMMARY

High Performance Physicians Invest In Areas With Greatest Return On Investment

- Reimbursement Systems
- Billing and Collection Processes
- Accounts Receivable Management
- Ancillary Services
- Human Resource Investments

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