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Rx for Practice Management

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Quality vs. volume

How should physician compensation be determined?

Increasingly, hospitals, health systems and the federal government are pushing for "pay for quality" or "pay per performance" over the more traditional "pay for volume" as the underlying structure for physician compensation.

For instance

Recently, several medical groups and hospitals have shifted the payment emphasis to the quality model. For instance, Henry Ford Medical Group, located in the Detroit, Mich., area, is reportedly basing compensation for its 1,200 physicians more on how many patients choose them — a sort of popularity contest based on patient referrals and online reviews. Previously, 66% of physician pay was based on the volume of relative value units (RVUs). Now it has become a 50/50 split.

In addition, Geisinger Health System, a 12-hospital system headquartered in Danville, Pa., reportedly eliminated physician bonuses completely. In addition, it placed all 1,600 employed doctors on a straight salary at, or above, the national average in their areas of expertise. Previously, Geisinger paid doctors 80% straight salary, with possible performance bonuses of 20%.

Another physician group in Middletown, N.Y., links 15% of physician compensation to quality, cost and satisfaction measures, with that percentage expected to increase to 30% over the next three years.

Some issues

Quality and patient satisfaction are important and need to be weighed in physician compensation models. But decreasing the number of diagnostic tests performed, reducing the number of procedures performed and shrinking hospital stay

periods doesn't necessarily equate to improved quality or improved patient care. Such measures clearly decrease costs, but whether they amount to better patient care is less clear.

One of the basic tenets of productivity management is a reliance on RVUs, a system Medicare uses to determine how to reimburse physicians for the 9,000 or more services and procedures covered under its Physician Fee Schedule. The dollar amounts are linked to the Current Procedural Terminology (CPT) codes, and the three components of the dollar amount are calculated based on a physician's work, practice expenses and malpractice insurance. A physician's work is broken into four subcomponents:

1. The time needed to perform the service,
2. The technical skill and/or physical effort to perform the service,
3. The amount of mental effort and judgment involved, and
4. The stress related to potential risk to the patient.

But quality is a far more ephemeral issue. Some hospitals conduct patient surveys after every visit, with a link to the survey emailed to the patient. Like Henry Ford Medical Group, some pay is based on online reviews and patient referrals.

6 health care quality domains

The National Academy of Medicine (NAM) developed one of the most influential measures of quality in health care, citing six medical service aims related to quality:

1. Safety. Services shouldn't harm patients.

2. Effectiveness. Services should be based on scientific knowledge. Health care providers should avoid providing services to patients who aren't likely to benefit from the care.

3. Patient-centeredness. Care should be both respectful of and responsive to an individual patient's preferences, needs and values — and those values should guide all clinical decisions.

4. Timeliness. Wait times and delays for both patients and health care providers should be shortened.

5. Efficiency. Nothing should be wasted, whether it's time, equipment, supplies, energy or ideas.

6. Equity. Care should be the same for everyone, regardless of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.

Many of what are being called alternative payment models (APMs) are based on various metrics, such as the Medicare Access and CHIP Reauthorization Act (MACRA), which often take data from population data sets and then compare that data to individual physician and patient interactions.

Problems with that approach are fairly obvious — it's hard to compare large patient populations to small patient populations or individuals, data sources aren't comprehensive, and information systems aren't standardized. These are technical issues. Political issues can involve physician stakeholder wariness and a lack of consensus over the appropriate quality metrics and how to report them to and from consumers.

At heart, the issue is that, while methods for objectively evaluating the *amount* of care are straightforward and well documented, benchmarks for value aren't well documented — and are often fuzzy at best.

Data matters

The risk, of course, is that the patient will get lost in all the data-crunching, and/or that insurers and government agencies will be less interested in quality patient care than in driving down costs and reimbursements.

As health care systems experiment — and this is clearly an ongoing, long-term process — more data will become available about how these different models work, at least in terms of how much money they save and how they affect productivity. Until everyone agrees on what "value" is and how to measure it, the results are likely to be a constant topic of debate. Although patient surveys or referral rates don't seem to be entirely objective metrics for value, they probably indicate a portion of value.

Going forward

Experiments in physician compensation based on value are likely to always have critics. They may be meaningful for some types of care and not for others. Patient noncompliance and other factors beyond the control of a physician, such as emergencies that throw off scheduling, can have a negative impact on patient surveys. Perhaps the search for "value metrics" is really a Holy Grail — and the experiments will only continue.

Surviving — and thriving — in a changing practice landscape

More physicians are currently employed by hospitals or medical practices than ever before, while fewer are in private practice. Since 2000, physicians as a group have shifted from private practice to being employed, according to a 2016 Medscape report. And the rate of employed physicians has grown by more than 30% from 2000 through 2016.

One reason for this shift is that health care reform and declining reimbursements in many specialties have created greater stress and uncertainty for physicians in private practice. Another reason is that many physicians today want to focus on treating patients — rather than jumping through the many hoops that running a medical practice involves. Here are some tips for surviving — and thriving — in the current complex medical world.

Hospital and practice employment strategies

Physicians who work for a hospital or medical practice usually get paid, so they have more financial security. In addition, they obviously don't have to worry about human resources, billing, collections, rent, overhead and day-to-day operations.

Here are some tips for achieving success in employment:

- Be aware of the tradeoffs and be prepared for them — in other words, know what you're getting into.
- Conduct due diligence on the hospital or medical group you're considering and make sure your goals are aligned with the institution's mission.
- Connect with physicians already employed at the hospital and discuss their work environment.

- Decide if the tradeoff of less control for fewer business and operational responsibilities will work for you.

If any of these issues raise flags, you might want to explore involvement in any of the hospital's business-related committees (such as compensation) or management-related positions.

Private practice strategies

Physicians in private practice don't have to abide by policies, procedures and pay set by someone else. They can use the electronic health record systems and practice models they've determined are best for them.

If private practice seems a better fit for you, consider these strategies to help ensure success:

- Learn more about good business practices, so you can leverage profits and minimize overhead.
- Explore merging with another practice, partnering or forming an independent physician association (IPA).
- Look into becoming a micropractice (sometimes just a physician with no administrative or clinical support), which could enable you to keep overhead costs down as low as 35%, compared to the more typical 60% at small primary-care practices.

- Investigate developing a concierge practice to cut back on the patient load by having patients pay an additional fee for more individualized services.
- Look for high-impact areas of savings and emphasize best practices in billing and collections.

Reap the rewards

Being a physician is a rewarding career, but all too often the business, regulatory or administrative aspects of it lead to high stress and career burnout. Some physicians thrive in private practice, while others prefer employment. Make an educated decision to ensure you'll be the best doctor you can be.

Steps to take to improve claim acceptance

The financial health and stability of a medical practice greatly depends on having claims accepted and paid. A claim denial is an avoidable error that disrupts the billing process and slows down cash inflows.

How to avoid denials

The goal should be for your practice to have its claims accepted on the first submission. But this requires taking steps much earlier in the revenue cycle.

To begin the process, identify and record the exact reason for every claim denial. Use a denial management module built into your overall practice management system to do this quickly and easily. A variety of reasons for denial will come up. For example:

- The payer may insist that the stated diagnosis doesn't support the medical necessity of the services.
- There may be missing paperwork in the documentation for the claim.
- The patient may not be a covered beneficiary of the payer to whom the claim was submitted.

The various reasons that emerge should guide your practice to take two types of actions: 1) Make immediate efforts to correct the errors and reverse the denial, and 2) modify your practice processes to prevent the errors from occurring in the future.

How to respond

There are several possible responses to a claim denial. For instance, once the root cause of the denial is established, try to correct and resubmit the claim. Make sure you locate any missing paperwork and then add it to the claim. You can change inaccurate codes to the right ones, or determine the patient's correct insurer and submit the claim to it.

If the practice can't fix the reason for the denial, or the payer refuses to accept the correction, it may make sense to drop the matter and write off the charge. A write-off is necessary if the practice can't locate the documentation to support the claimed service or if it turns out that the service was really part of a bundle that already has been paid separately and never should have been claimed in the first place. Nonetheless, a write-off should be the last resort to a denial.

But you might want to appeal the claim first. In the event that your practice makes what it believes to be appropriate corrections, but the payer still rejects them, the best option may be to file an appeal. You'll need to contact the payer to learn its reasoning on the matter. Then, you must prepare persuasive arguments in support of the claim. As appropriate, gather additional relevant documentation, or obtain more expansive statements of medical necessity from your clinicians. Finally, file the appeal and follow up with the payer every two weeks until the matter is resolved.

How to change your system

Of course, you want to avoid claim denials, so you may need to make systemic changes for the future. You might encounter problems with incomplete documentation or improper coding that may require retraining staff and clinicians. The people may be fine, but the processes they perform may need to be re-engineered. In that case, your focus should be on getting all the right patient information before or during registration, capturing and entering the correct charge codes in a timely manner and correcting preadjudication edits returned by the claims clearinghouse on a daily basis.

How to get on track

By following these steps, your practice will be well on its way to clean claims. It's important to fully understand the causes of claim denials. This starts with reporting denials at the claim level and on a line-item basis, and then projecting trends over time. Your health care advisor or coding professional can help you implement best practices and get on the right track.

How to handle a Medicare audit

Generally speaking, the question isn't *if* you get a Medicare audit, it's *when*. Every Medicare claim undergoes statistical analysis, and Medicare compares individual claims data to all other data submitted. In addition, it now does so in real time. It's important to understand how a Medicare audit works, so that you can handle it successfully.

The two types

Medicare audits fall loosely into two types: a prepayment review and an analysis of claims

after payment. Prepayment claims are the most common type, and are typically random reviews by carriers that look at just one or two of each physician's claims. The primary purpose of such a focused review is to educate a physician about a coding problem. It could lead to a refund of a single overpayment.

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On the other hand, in a comprehensive review, a carrier reviews a small sample of claims and uses the data culled to project overpayment for a period of months or years. In that context, the physician has three options:

- Pay the assessment.
- Waive appeal and provide evidence that the assessment is incorrect.
- Retain the right to appeal, but have the carrier review a larger sample of charts (usually the best option).

How to deal with it

Given that some level of Medicare audit is generally inevitable, here are some suggestions on how to deal with one:

Contact your attorney immediately. Your attorney can advise you on the audit's level of seriousness and how best to respond to it. Don't assume that it's routine — treat all requests for information seriously.

Read the audit letter carefully. Make sure to provide all of the requested information when responding.

Submit a copy of the complete record. This includes not just records from the date of service in the audit letter, but chart information as well.

Ensure all medical records and copies are legible. If the records aren't clearly readable, have the illegible record transcribed and included with the copies of the original records. Make sure no information has been cut off.

Include related X-rays or other diagnostic studies. It's important to include everything that's part of the patient's records.

Don't alter the medical records after receiving the audit notice. But, if there are orders, consults or other materials that haven't yet been filed, file them as you normally would.

Place a brief summary of the patient's care with each record. This doesn't replace the record, but helps any auditors not familiar with your specialty.

Insert an explanatory note or supporting guidelines. These may involve local coverage determinations or medical literature to support unusual procedures or billings.

Don't delay. Submit the materials before the deadline.

Follow up. If you communicate with the auditor via telephone, follow up with a letter confirming the communication.

Send all communications by certified or express mail. Request return receipt. In addition, make complete, legible copies of all correspondence and documents you submit. It has been suggested that you maintain one copy for yourself, one for the auditor, one for legal counsel, and two for your future expert witnesses (if necessary).

Label accurately. Label each copy of the medical record you submit, including page numbers.

Know the steps to take

In most cases, a Medicare audit is routine and minor. At worst — especially if delivered by an FBI agent or government official — the audit could lead to charges of fraud and hundreds of thousands of dollars of repayment. The key is to stay cool, document everything — and immediately consult with your attorney and financial expert.