How To Develop A Long-Term Plan For Practice Transition

When dealing with transition in a practice, one must take into account patient scheduling, practice marketing and the practice's financial operations. Using a review of one practice, this author details how one can improve daily operations and plan for the future.

By Steven Peltz, CHBC
Published in Podiatry Today July 2006
A detailed assessment of the day-to-day operations, billing and marketing of a podiatric practice can greatly enhance one's results while planning a personnel transition within the practice. With this in mind, I conducted an operational and revenue analysis for a doctor with the objective of helping him plan for the future of his practice and his location.

The analysis has three sections. The first section reviews the processes in the doctor's office such as scheduling, patient intake and patient flow. The second section reviews the practice's profit and loss statement. The third section describes the present marketing approach and reviews the findings. I also made recommendations that relate to each of these sections.

His practice includes a part-time physician. The office accommodates a busy one provider practice. When there are two or three providers, this impacts the ability of the physician to see patients at his own pace.

How Streamlining Scheduling Can Provide A Smooth Transition

When preparing for a practice transition, it is important to take a close look at the office scheduling. This will help prepare for a possible future when more than one doctor is working in the office and both time and office space are limited.

The full-time doctor's schedule allows for a patient every 15 minutes. With 28 office hours a week, he can see about 110-130 patients.

The part-time doctor's schedule accommodates a new patient for 30 minutes with some follow-up visits scheduled for 15 minutes. With five hours a week, she can see about 12-15 patients per week.

The office has three potential exam rooms. Using 40 hours per week that the office is open and doctors can see patients, 120 exam room hours are available or 360, 15 minute appointments. The practice uses about 155, 15 minute appointments, equating to a 43 percent utilization of the exam rooms.

Based on the above assumptions, the practice can see on average between 115 and 135 patients per week. If the office is open for 40 hours per week, there are three exam rooms and if the average patient visit is 30 minutes, then the practice

has the maximum potential of booking 240 patients per week. If doctors see 135 patients per week, the practice is operating on 56 percent of its allowable patient time. **However, this is still not efficient**.

Overhead depends on two factors: the actual costs paid for overhead expenses and the revenue collected. If the actual patient visit hours decrease, the overhead becomes higher. If the actual patient hours increase, the overhead becomes lower. These results take place without spending more or less on expenses.

When A Provider Rents Space In Your Practice

In planning for a transition, it can be important to determine how much rent a second practitioner would pay. A plastic surgeon rents space in the office on Tuesdays from 9 to 5. During that time he uses one exam room, one staff member and the conference room as his office. His rent for 2005 was $4,600 or $383 per month. The decision to rent to the plastic surgeon was more of an emotional decision than an analytical decision.

Therefore, on Tuesdays, the doctor cannot be double-booked due to there being only three usable rooms and three providers. In order to determine what the true rent should be, one would consult the following exercise.

Average reimbursement for an office visit = $50

The number of additional patients who could be seen if there were no physician renting space from the practice = 5

Additional collections above the current collections without a renter:

$50 per visit x five additional visits on Tuesday = $250 per Tuesday
$250 x 50 weeks = $12,500 – $4,600 (rent) = a loss of $7900.

How can the practice maximize the potential of office visit time? If the patient demand is present, increase the number of hours when doctors can see patients. Consider offering Saturday hours for one day every other week from 9 to 12. Consider either increasing the rent of the plastic surgeon to $1,400 per month or terminating the rental arrangement. You also may want to consider increasing the present provider's time in the office or recruit another provider for at least 15 hours per week.

Improving The Tracking Of Referrals For Diagnostic Tests

When planning a transition, it is also advisable to examine the operations of the other physicians in the office in order to determine how the office can run smoother in the future.

In this practice, the part-time physician works in the office and sees patients two mornings per week. She also assists the full-time doctor in surgery on some Thursdays. Due to family commitments, this is all the time she can devote to the office at this time. She notes that in the fall, when she can drop her children off at 8:15 a.m. on some Thursdays, she could see patients in the office starting at 8:45 a.m. Depending on how the schedules of the providers can be arranged with regard to available exam rooms, this may add additional office time to the practice.

The physician uses a log book to track her referrals for diagnostic tests and requests for laboratory work. She writes in the patient, date and test ordered and when the results come back in, she crosses it off in the book. The practice would be more efficient if it had a practice-wide testing and referral log book.

The full-time medical assistant and part-time medical assistant would enter into a test log binder the information in three columns. The first column is the date of the patient visit, the second column is the name of the patient and the third column has the requested tests. As the reports come back into the office, the medical assistant highlights the test. A quick glance to see what line is not highlighted gives her the knowledge of what test results have not been received.

She or the doctor then contacts the testing laboratory, radiological facility or physician to see if the test was complete. If the patient did not show up for the test, the office is obligated to contact the patient and enter into her chart the results of the follow-up call. This follow-up reduces a potential liability associated with not following up for a patient.

As the provider exits the exam room with the patient, the provider will inform the medical assistant of the requested test. The provider will enter it into the patient's chart. The assistant will enter it into her testing log binder. When the testing results come into the office, the assistant highlights the line, indicating the test was completed. It then becomes very easy to find the tests the patient was supposed to have, what results are still pending and what one needs to follow up on. The assistant would simply look for the line that is not highlighted.

The practice should establish a testing log for all tests requested outside the office. This will eliminate the liability and problem of when the doctor asks why did you not follow up on the test when you asked you patient to have it. Evaluate other tests that can be done in the office and whether you can justify the financial outlay before purchasing the equipment based on reimbursement.

Emphasizing The Continued Cultivation Of Referrals

Marketing a practice can be beneficial when a practice is shifting from one physician to another. Based on my discussions with the office manager and the

physician/practice owner, there were years when the physician would meet personally with current and potential referring sources. In 1999, the office sent out 50 holiday Godiva gifts. Last year, they sent 10 gifts. There are many good reasons why the number has decreased, **but they have in fact decreased.**

In order to stay viable and busy, all specialty practices engage in some type of marketing to their referral sources. A practice can accomplish this in different ways.

In establishing a practice, it is common for a physician to personally meet with a potential source of referrals, introduce him- or herself and deliver a quick "elevator" speech that discusses his or her training, specialty, area of expertise, common diagnoses that he or she treats and where his or her office is located. The doctor must do this within the 75 to 90 seconds allowed. If the referring doctor asks questions, it usually means he or she will remember you. At that time, it is important to introduce yourself to the office manager and head nurse/medical assistant and leave your card, Rolodex card and your manager's name.

Each year, there are new physicians going into competition with you. If the referring doctor has not seen you in years, and if a new, young, eager physician drops by to introduce him- or herself, you may have lost a referring physician.

If possible, it will earn a higher level of trust and recognition if you can put on a short, catered lunchtime presentation on a few simple diagnoses that the referring physicians will see. This will translate into remembering your name every time they come across that pathology.

When you get a patient referred to you, you should fax the thank you note along with your consultant letter within 24 hours and follow up with a hard copy. Remember that the patient's primary care physician may have spent 30 minutes with the patient, reviewed a 2-inch chart and received $38 for his or her time.

You may end up performing surgery and be reimbursed a few hundred dollars or more. Primary care physicians don't begrudge specialists. They just don't want to be taken for granted.

While doing these marketing activities are important, it is also important to remember that they require your time and not necessarily money. Setting aside an afternoon or morning every other week and setting a goal of seeing four physicians a month will do more than any advertisement in any newspaper. Seeing four potential referral sources per month means you will see almost 50 per year.

Every initiative done in a business must be evaluated for its value. When you begin any marketing campaign as part of your practice, establish a benchmark.

The practice should establish a monthly management report that indicates the amount of charges and collections for the month. The report should also have a chart that will quickly indicate where your patients are coming from and who you need to call for marketing purposes.

Set up times (and do not cancel them) when you can visit a group and bring them up to date on current procedures and technologies. They will appreciate your time and be better informed to help their patients when they present with a problem that you can resolve.

Secrets To Improving Billing And Collections

The practice uses an outside billing company as its billing department. The billing company uses a real time information system as its billing and practice management system as it relates to the billing for clients. However, there are methods the practice can take to make its financial practices more efficient.

When patients arrive at the office for the initial visit, they complete an intake form that collects most of their demographic information. The real time billing program collects the patient's insurance information and checks the patient's eligibility. However, the patient is usually not asked if his or her spouse has his or her own insurance. In today's economy, there are fewer times when both spouses will have their own health insurance through their employer. However, there are times when it does occur.

If a claim is submitted for a patient and there is no information on the claim form regarding the spouse's coverage, the claim goes into the "pending" bucket. It stays there because the insurance company you billed for your service may have information that there are two health insurance policies for the family and the insurance company you billed wants to know if the other insurance company should be billed first or wants to find out if the patient is withholding information.

This is referred to as a coordination of benefits (COB) problem. The claim you submitted will not be processed. The insurance company will send a letter to the patient requesting information on any other health insurance policy the family might have.

At this point, the insurance company denies the claim and the billing staff receives an internal note of a COB problem. The assistant should call the patient immediately. The patient will receive an information request from the insurance company about additional coverage through his or her spouse. If the patient does not complete and return the form within a specific time period, the claim will be cancelled and the patient then becomes the responsible party for payment rather than the insurance company.

The billing company also confirmed that at the present time the practice has no collection agency. As a result, when a claim has been processed as much as the billing company can, the unpaid portion defaults into the patient's account. The billing company sends out a series of bills and, after 90 days, sends a final letter stating the patient may be sent to collection. If there is no attempt at either calling the patient or using a collection agency the account may be inadvertently adjusted off. If the account is not closed or adjusted off the amount stays in the over 90 days account and stays there forever, thereby skewing the accounts receivable report.

In the past, many physicians have been hesitant to send a patient to a collection agency because of a personal relationship or their knowledge that the patient has no available funds. They also may be hesitant sending a patient to collections as he or she may then go and complain to the referring doctor. However, in most cases if a patient has not paid the practice's bill, he or she probably has similar issues at the referring doctor's office. In addition, the referring doctor will be somewhat embarrassed that a patient he or she sent to you has not paid you what is owed.

The collections process can eliminate most of these concerns. The billing staff can print out the "collections pending" list each month. The doctor and staff can go over the list and determine which patients owe too small an amount to be sent to collections, which ones have no funds and which ones should not go to collections for other reasons. The billing staff can then send that message to the billing company and they will adjust those balances. At the same time, the doctor and assistant will determine which patients are to be sent to collections.

The billing company stated that most practices write off balances below $25 and send the rest after screening them to a collection agency. The agency sends a report and funds collected to the billing company on a monthly basis.

Consider discussing with the medical assistant the potential of an additional step in the intake process. In addition to what the practice is presently doing, ask the patient if his or her spouse also has coverage. If the spouse does, the receptionist can indicate it on the form to the billing company. This will eliminate denials and charges pending based on the patient not responding to the insurance companies' request for more information. You will accordingly increase your collections.

In Conclusion

The financial health of the practice is dependent on the owner to continually market his or her practice to established referring physicians and new ones who can become referring physicians. In the past, the practice in question did this on a more consistent basis. If the practice is to continue and thrive, the doctor must

be able to market his or her skills and services to those who can refer patients to him or her.

When a patient enters the office, it is incumbent upon the staff to glean all the information that the insurance company wants in order to be paid for your services. The objective is not only to submit a clean claim but submit a claim that will pass all the insurance company's edits. Failure to complete all parts of the process costs the practice in denied claims.

What further exacerbates the dollars falling through the cracks is the office's non-collection policy. Do your patients have to pay for their gasoline and groceries? They will also pay for your services if you manage the information flow from the patient entering the office to the claim for the patient paying for uncovered services.

Consider the following factors for bolstering your practice and facilitating smoother transitions. Perhaps you can market the practice to a wider scope of providers than the ones who are currently referring to you. What about increasing the utilization of the exam rooms? What about thoroughly collecting all billing information from the patient and following up on collection accounts? Another consideration is referring out procedures that the insurance companies will not reimburse you for performing. These measures can potentially result in an increase for the practice of $20,000 to $60,000 per year.