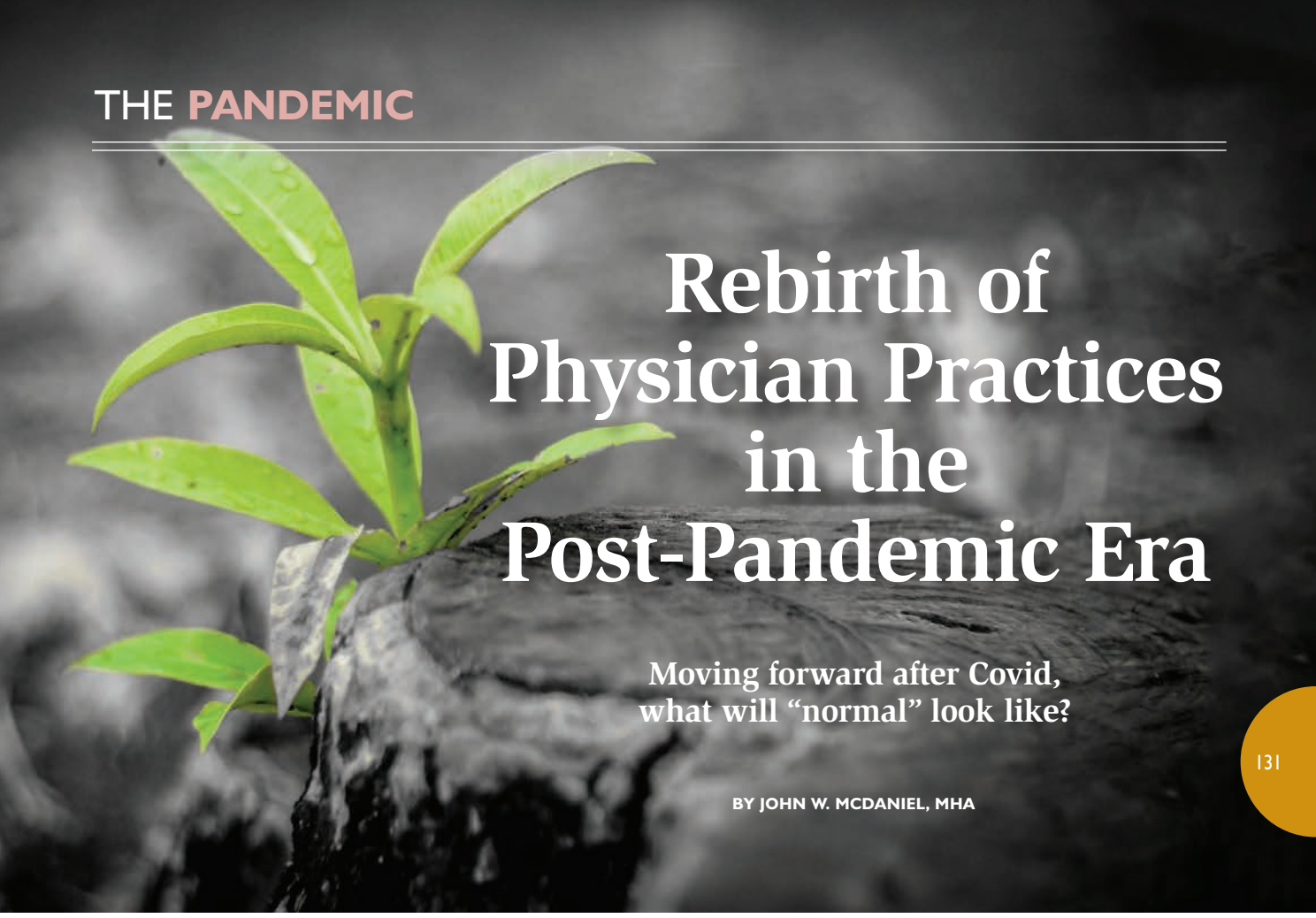

Rebirth of Physician Practices in the Post-Pandemic Era

Moving forward after Covid, what will "normal" look like?

BY JOHN W. MCDANIEL, MHA

Editor's Note: *This article was written in July of 2020, pre-vaccine and in the throes of some of the worst days of the Pandemic; thus the author's emphasis is on a sometime-in-the-future period post-Covid-19. At this point, 14 months later, the nation is still not back to "normal" (among other issues, we're dealing with the Delta and the Lambda variants, as well as misinformation about vaccination), but in any case, the author's points are totally relevant, whether your practice is back to near-full capacity or still in the midst of struggling to "return" to some sort of normalcy.*

Let me tell you a story about how resilience can help us overcome tragedy in the face of life during and after the coronavirus pandemic.

As you may recall, New Orleans was the epicenter of destruction during and after Hurricane Katrina in 2005. This epic storm devastated property and life as it had been known, and it fractured personal and family relationships as tens of thousands had to relocate to various cities since they had no homes, no jobs, and needed to enroll their children in new schools. Through sheer determination and the will to return to their beloved city, however, the majority of New Orleanians have returned and developed a stronger and more progressive city.

When we are able to return to operating medical practices toward the end of this pandemic, what will "normal" look like?

The sentinel event that captured the spirit of New Orleans and the return to some sense of normalcy occurred on September 25, 2006, when the New Orleans Saints returned to the Mercedes Benz Superdome for the first time in over a year on Monday Night Football to face their division nemesis, the Atlanta Falcons. The Saints have always represented the soul of New Orleans, and this setting could not have been more perfectly scripted.

After the Falcons received the kickoff and went three and out, only 90 seconds into the game, Steve Gleason (#37), a special teams stalwart, blocked the punt, and teammate Curtis Deloatch returned it for a touchdown! To this day, those in attendance, including the announcers, said they have never heard a collective chorus of sheer joy any louder than on that September night.

Although the Saints won the game, this was more than a football game. It signified the rebirth of a city. In fact, a statue entitled "Rebirth" near the southeast corner of the Mercedes Benz

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Superdome memorializes this iconic play. Sadly, approximately five years after this game, Steve Gleason was diagnosed with amyotrophic lateral sclerosis (Lou Gehrig's disease). During his nine years of battling this devastating disease, Steve has become a champion in the fight for a cure and epitomizes the type of person we all aspire to be through his love of life and gifts of encouragement and hope.

Analogous to the aftermath of Hurricane Katrina, when we are able to return to operating medical practices toward the end of this pandemic, what will "normal" look like? We must return to the fundamentals of operating practices and focus on improving and reinventing certain areas for operational improvement:

- Reimbursement systems;
- Billing and collection processes;
- Accounts receivable management;
- Operations improvement; and
- Practice growth.

Let's examine how we can use these five levers for performance improvement to increase practice profitability in the days ahead.

The process for implementing sustainable change in medical practices in the post-pandemic future involves the following:

I. Reimbursement Systems

1. Implementation of telemedicine services

A. The silver lining of the pandemic has been the rapid proliferation of telemedicine visits and consults. Over a matter of weeks, we have seen a transformation in the future of healthcare delivery, out of necessity in being sequestered from human interaction, and the public has quickly accepted the benefits of telemedicine. Although telemedicine is thought to be mostly used by primary care providers, specialists can provide certain services via telemedicine, such as follow-up of various disorders (e.g., postoperative or post-procedures), pre-visit consultations, and so on. As medical practices' use of telemedicine becomes more sophisticated, they may want to explore formalizing their telemedicine programs (e.g., using video conferencing products, free video chat apps, or electronic signature software for patient forms and consents). Physicians also must be mindful that there is competition in the telemedicine arena among proprietary companies (e.g., TeleDoc) as well as various local physicians and corporate medical practices.

B. Medical practices have begun to realize the benefits of performing patient assessments (within limits) through telehealth visits, online digital visits, remote patient monitoring, and telephonic E/M services. In addition, practices have begun providing other telemedicine services, including Medicare annual wellness visits (AWV) and chronic care management (CCM), for example.

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2. Development of coding compliance program

A. Conduct evaluation and management coding utilization analysis (including telemedicine codes) to determine compliance with CMS Audit Standards and determine areas of potential under- or over-coding.

B. Perform documentation chart audits to ensure appropriate documentation and medical necessity vis-a-vis procedural coding.

C. Conduct and document educational sessions to review the outcome of this assessment process to satisfy compliance requirements and establish an action plan for improvement.

3. Conduct professional fee schedule review to determine reimbursement by the top CPT-4 codes by frequency for the top 10 payers.

A. Identify opportunities for fee schedule adjustments and/or negotiation with managed care companies

B. Consider opting out of specific contracts depending on revenue value to practice.

4. Conduct reimbursement validation analysis to determine contract compliance by insurers and document payment at contracted rates.

5. Consider outsourcing Medicare AWVs and CCM if practice lacks internal resources to provide these services.

6. Perform charge/collection/adjustment analysis by payer to determine gross collection rate (GCR) and net collection rate (NCR).

A. Target payers for renegotiation.

7. Focus on risk-stratified care management (value-based care) programs, such as accountable care organizations (ACOs), managed security service providers (Medicare Shared Savings Programs), and the Merit-Based Incentive Payment System.

A. Cautiously approach these programs regarding qualifying criteria pertaining to the determination of incentive payments versus payback requirements.

II. Billing and Collection Processes

1. Monitor upfront collections regarding copayments, deductibles, outstanding balances, and non-covered services.

A. Set monthly targets.

2. Establish acceptable turnaround regarding submission of initial claims and rebilling of denied or rejected claims.

3. Develop claim denial and rejection

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follow-up processes.

A. Monitor weekly;

B. Track reasons;

C. Provide ongoing education to reduce frequency; and

D. Assess the impact of delayed cash flow.

4. Monitor credit balances to ensure prompt repayment of Medicare and Medicaid overpayments within 60 days.

A. Failure to refund overpayments will result in false claim penalties.

5. Assess cost/benefit of in-house versus outsourcing of revenue cycle management activities.

A. Must examine both costs to provide services against effectiveness of performance metrics

6. Develop a system for tracking compliance with patient payment plans.

7. Ensure consistent performance by responsible staff members regarding insurance verification and patient eligibility and pre-authorization processes.

A. Maximize information system capabilities.

8. Formalize or standardize financial policies and procedures.

III. Accounts Receivable Management

1. Utilize the 80/20 analysis in managing the accounts receivable aged trial balance (A/R ATB) by payer.

A. Approximately 20% of insurers will represent 80% of total A/R dollars.

B. Focus on the A/R ATB for that 20% to gain the greatest impact in the shortest amount of time.

2. Adopt strategies for collection of patient balance accounts:

A. Patient payment plans;

B. Utilization of third parties (e.g., collection agencies, credit bureaus, small claims court); or

C. Early Out Program (where a provider contracts with a third party, such as a collection agency, and the third party bills and collects for all outstanding patient balances from Day 1)

D. Outsource all patient balance accounts.

3. Develop monthly audit of A/R ATB regarding insured accounts at 60+ days.

A. Review notes for each claim and information needed to complete claim or reason for nonpayment if claim is complete.

4. Review charge/collection/adjustment ratios by payer to detect areas of low reimbursement or delayed payments.

5. Institute quarterly monitoring of collection agency performance regarding patient balance accounts and determine acceptable performance metrics.

6. Explore feasibility of outsourcing 90+ insurance accounts.

7. Determine feasibility of outsourcing all patient balance accounts through Early Out Program.

IV. Operations Improvement

1. Develop a business continuity plan to prepare for recovery from losses in patient revenue, ongoing labor costs, and supply expense.

A. Continue to explore federal and state financial assistance programs.

2. Manage supply inventory on hand to meet patient demand. Monitor usage and assurance from vendors about reasonable turnaround time for supplies and pharmaceuticals to avoid excessive inventory and supply expense.

A. Ensure availability of personal protective equipment.

3. Embrace digital healthcare solutions in every feasible aspect of the practice to increase efficiency.

4. Assess office space requirements and lease needs as the practice increases its use of telemedicine and other off-site services (e.g., business office operations).

5. Develop operating/cash flow budgets to reflect changes in patient care delivery (e.g., telemedicine) and support services (e.g., off-site coding, business office operations, scheduling).

6. Assess cost/benefit of remote patient monitoring via telehealth.

7. Develop asset management plan:

A. Repay Small Business Administration loans (if applicable);

B. Consider bank line of credit; and

C. Establish capital reserve account

8. Consider joining a national group purchasing organization through professional societies.

9. Review mix of personnel: full-time, part-time, contract labor, RN/LPN versus medical assistant, and so on.

10. Assess possibility of integrating telemedicine software with current management information system/EMR versus a standalone system.

11. Implement a formal Medical Practice Compliance Program.

A. Increased federal/regulatory scrutiny regarding HIPAA privacy and security standards with telemedicine

12. Develop a "Disaster Recovery Plan":

A. Notify patients when it is safe to return to practice and conditions under which patients will be seen on site.

B. Notification process:

i. Social and print media;
ii. Patients (e-mails);
iii. Referring physicians;
iv. Hospitals;
v. Community agencies; and
vi. Critical vendors.

13. Consider adding extended hours for access to routine and urgent care via telemedicine.

14. Explore all options for outsourcing nonclinical services.

15. Assess feasibility of continuing current ancillary services versus developing new modalities.

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16. Review physician/provider compensation program.

A. Adjustments will be necessary in base salary, incentive compensation (quantitative v. qualitative), and so forth.

17. Develop actionable monthly financial/operational reports.

18. Develop effective patient recall system, particularly for patients not seen within the last 12 months.

19. Follow up with no-show patients to attempt to rebook appointments.

20. Explore ways to improve patient volume capacity through improved scheduling.

21. Establish benchmarks for physician/provider productivity and share through individual monthly reports.

22. Conduct provider compensation/productivity analyses to ensure fair market value compensation for hospital-affiliated physicians and providers

23. Track charges, collections, expenses and net profit/loss by patient and by Work Relative Value Units.

24. Review personnel policies and procedures to determine areas of potential savings (e.g., employee benefits such as paid time off).

A. Address policies related to furloughs and deferral of compensation in times of emergency.

25. Assess cost/benefit of IT support.

26. Review patient flow/patient process redesign options to promote efficiency.

27. Conduct internal training and education regarding areas for regulatory compliance.

V. Practice Growth

1. Consider practice mergers regarding development of larger single specialty or multispecialty group.

A. Assess economies of scale.

B. Evaluate benefits of standardization/centralization.

2. Explore sale of practice to hospitals, federally qualified health centers, or private equity companies.

3. Address differences between primary care and specialty care in terms of target markets.

A. Marketing plan/budget;

B. Use of social media; and

C. Website development/enhancement (e.g., use of patient portal).

4. Review frequency of CPT-4 and ICD-10 codes to determine types of patients currently being seen in practice.

A. How can the practice redesign benefit-targeted procedure and/or diagnosis codes (patients)?

5. For specialty practices, conduct Physician Referral Analysis to determine number of referrals by physician by total charges and payer mix.

6. Conduct patient origin analysis to determine the geographic distribution of patients and potential areas for office expansion.

7. Develop e-business strategy for practice (e.g., telemedicine, increased use of IT resources, social media).

8. Develop practice strategic plan:

A. Conduct SWOT analysis (strengths, weaknesses, opportunities and threats);

B. Determine future areas of focus/development; and

C. Determine what to stop doing/offering.

9. Assess benefits of participating with a management services organization.

A. Cost/benefit of providing various services in-house versus outsourcing

10. Review payer contracting organizations to determine the benefits of continuing certain arrangements.

11. Assess benefits of participating with various physician networks (e.g., ACOs, clinical integration networks).

12. Explore opportunities for contracting with hospitals to provide specific services, such as call pay, medical directorships, and clinical co-management arrangements.

13. Consider feasibility of concierge model for primary care physicians and certain specialties that treat patients with chronic disease (e.g., cardiology, endocrinology, pulmonology, nephrology).

We should all learn the lessons from this tragedy and apply them toward providing healthcare in a much smarter and more convenient manner while improving the quality of life of both patients and those dedicated to healing them.

The practice of medicine in the aftermath of the coronavirus pandemic will allow practices to reinvent themselves. Although most of us live in a comfort zone and are unwilling to change, "necessity is the mother of invention," and true innovation takes place outside of our comfort zone. In life, real growth usually results from difficult times. We should all learn the lessons from this tragedy and apply them toward providing healthcare in a much smarter and more convenient manner while improving the quality of life of both patients and those dedicated to healing them. **PM**

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