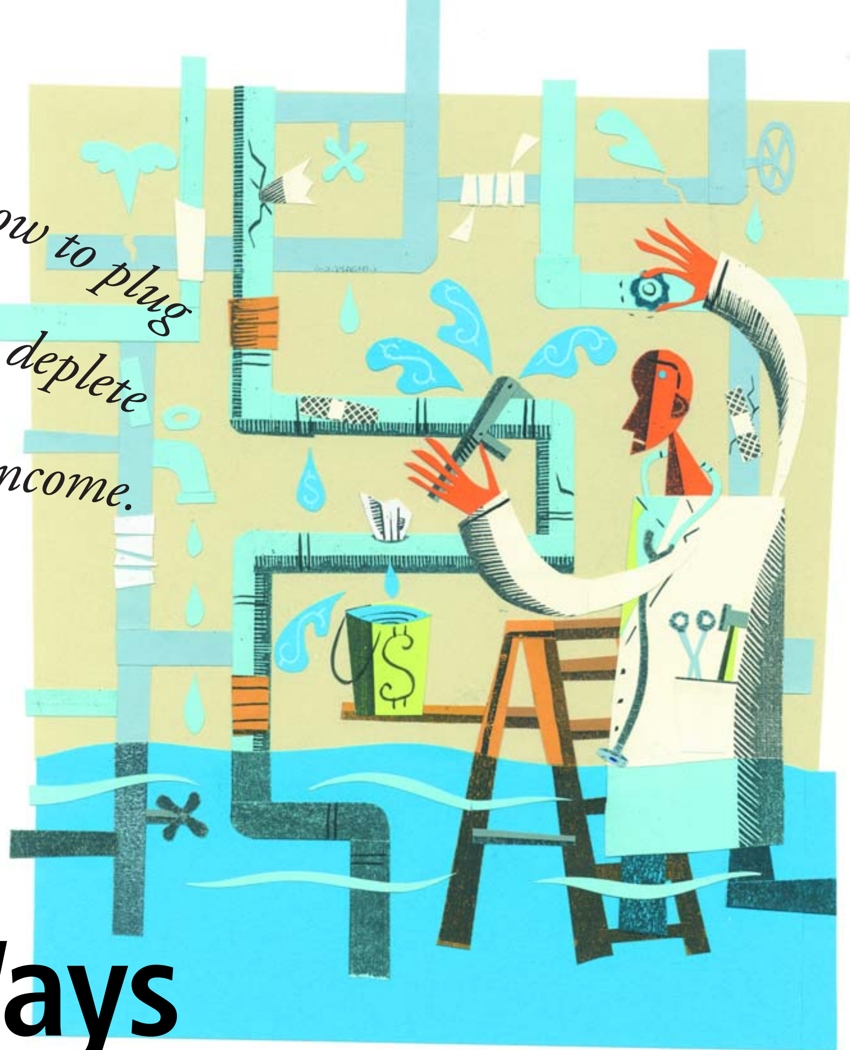
Learn how to plug the leaks that deplete your practice's income.



10 Ways Family Practices Lose Money

Keith Borglum

Covered in *FPM* Quiz

Rising costs, decreasing reimbursement and increased paperwork aren't the only factors causing financial problems for family physicians. In most practices, inefficiency and waste cut even deeper into profits and income. A certain amount of each is inherent in any practice, but an excess might be costing you much more than you think. For example, a practice with a typical 62-percent overhead and 38-percent profit margin that loses or wastes an extra 5 percent of collections actually loses approximately 13 percent of net income, since the losses come directly from the "last-dollar" profits that remain after overhead has been paid. That 13 percent represents approximately $19,000 for a practice with a profit of approximately $145,000, the median for a family practice without obstetrics.[1]

This article will help you identify ways your practice might be losing money and offers suggestions on how to stop your losses. Following these and other prevention tips can help you preserve the financial health of your practice.

1. Lost productivity

Family practices lose the most money through lost productivity, which occurs when physicians see fewer patients than optimum, provide fewer services per visit or have

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In addition to rising costs and decreasing reimbursement, inefficiency and waste cost family practices profits and income.

Family practices lose the most money through lost productivity.

One way to prevent lost productivity is to provide alternatives to unnecessary visits, such as by phone, e-mail or group visits.

Family practices lose a lot of money through bad ICD-9 and CPT coding.

visits of less than optimum complexity. For example, missing one fee-for-service patient visit per day results in approximately $15,000 in annual losses (assuming 210 days of visits and a $72 average visit charge). Missing one capitated patient visit per day results in a reduction of the patient panel by approximately 87 patients, which is a loss of approximately $12,500 per year (assuming 210 days of visits, an average of 2.4 visits per year per patient and a $12 per-member-per-month (PMPM) capitation rate). Full practices can lose productivity by having an excessive number of unnecessary visits. This tends to minimize the services and complexity of each visit, which creates a loss of reimbursement per hour for time spent. Another cause of lost productivity is failing to provide services that patients want, forcing them to go to other specialists.

Prevention tips:

- Set, post and achieve daily productivity goals. For example, you might set your minimum daily goal for charges at $1,900 per day, which is the median for family practice without obstetrics.[2]
- Give staff bonuses for achieving productivity goals.
- Enhance physician/staff teamwork. For example, consider initiating a brief morning "huddle" of the physician, scheduler and medical assistant, with the goal of reviewing the day's schedule and deciding how you can optimize the patient flow for that day.
- Maximize delegation of clinical and administrative tasks.
- Acquire and use appropriate technologies, such as online referral authorization, phone-system automation with voice mail, or drug and formulary references on personal digital assistants.
- Maximize complexity and services per visit. For example, when patients call to schedule problem-oriented visits, have the scheduler ask them if there's anything else they'd like to discuss at the visit, such as prescription renewals, mammograms or lab tests for an upcoming physical.
- Provide alternatives to unnecessary patient visits, such as managing uncomplicated issues by phone, e-mail or group visits.

KEY POINTS

- Inefficiency and waste could be costing your practice more than you think.
- Missing one fee-for-service visit per day can result in approximately $15,000 in annual losses.
- The author estimates that most family physicians lose at least $10,000 per year from undercoding.

While these methods may not be directly reimbursable in the current system, they can provide indirect financial rewards by increasing the complexity of office visits. Greater reimbursement associated with the higher level office visits should offset the decreasing number of lower complexity visits.

- Provide elective cash services, such as osteoporosis testing, durable-medical-equipment dispensing, sclerotherapy and cryo-procedures.

2. Inadequate and inaccurate coding

The next most common way practices lose money is through inadequate or inaccurate ICD-9 and CPT coding. An extraordinary number of family physicians fail to keep their coding knowledge up-to-date, resulting in reduced reimbursement and delayed or denied claims. Many physicians purposefully undercode, fearing the penalties for overcoding or unbundling. Others leave coding to the support staff, which is virtually guaranteed to result in errors and undercoding since they don't know what actually occurred in the exam room. In capitated care, money is lost by failing to code for supplies reimbursement and miscoding elective services or carve-outs, which causes the services to be inappropriately bundled into the capitation rate. I know of one family physician group that had errors in 71 percent of codes one year, resulting in an estimated loss of $185,000. While the error rate for most physicians is not likely this high, I estimate that most family physicians lose at least $10,000 per year from undercoding alone. Physicians need to have enough coding expertise to be able to teach coding to a group of their peers. Since the codes, rules

> The next most common way practices lose money is through inadequate or inaccurate ICD-9 and CPT coding.

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and plan reimbursement protocols change regularly, this requires ongoing continuing education, among other things.

Prevention tips:

• Purchase new ICD-9 and CPT books annually. These are available from vendors such as www.medicalbookstore.com, www.amapress.com and www.codingbooks.com.

• Have a "cheat sheet" of the codes you use most available on paper or electronically in the exam room. For an example, see *FPM*'s annual short and long lists of ICD-9 codes for family physicians at www.aafp.org/x20096.xml.

• Take advantage of coding resources, such as the AAFP's online coding resources (www.aafp.org/x3309.xml) and coding courses (e.g., the AAFP's "Crash Course on Cash, Codes & Computers," www.aafp.org/ x10755.xml; the AMA's annual CPT Coding Symposium, www.ama-assn.org/ama/ pub/article/7353-6889.html, click on "coding and reimbursement"; and perennial offerings at the AAFP's Annual Scientific Assembly). In addition to the resources listed throughout this article, a number of relevant *FPM* articles, including some related to coding, appear in the reading list below.

> Leaving coding to support staff is virtually guaranteed to result in errors and undercoding.

• Periodically have a coding audit done by a consultant (which you can find through FP Assist at www.aafp.org/fpassist or the National Association of Healthcare Consultants (NAHC) at www.healthcon.org) and conduct self-audits.

3. Bad billing practices

Regardless of whether the above coding problems exist, bad billing practices can create unnecessary financial losses in your practice. These problems, which can occur within your practice or in any outside billing services you use, are caused more often by incompetence than by willful misbehavior. For example, receptionists may fail to update patient insurance coverage or verify that the insurance card being presented belongs to the person presenting it, claims may be sent late or to the wrong place, or patients may walk out with their encounter forms and not be billed.

Prevention tips:

• Familiarize yourself with proper billing practices (such as having standards for confirming insurance coverage, processing new claims and following up on past-due accounts), and enforce them in your practice. ➤

"Evaluating Health Plans: Finding the Keepers." Aymond R. April 2003:47.

"Coding Better for Better Reimbursement." Henley D. January 2003:29.

"How Many Staff Members Do You Need?" Reeves CS. September 2002:45

"11 Tips for More Productive Billing." Ciletti MV. March 2002:16.

"Making Your Balance Sheet Work for You." Arnow FM, Xakellis GC. June 2001:27.

"Using Peer Review for Self-Audits of Medical Record Documentation." Bradshaw RW. April 2000:28.

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"Monitoring Your Practice's Financial Data: 10 Vital Signs." Aymond R. July/August 1999:42.

"Improve Your ICD-9 Coding Accuracy." Hill E. July/August 1999:27.

"Use Random Audits to Find Payment Problems." Capko J. June 1998:16.

"Coping With Managed Care's Administrative Hassles." Spicer J. March 1998:66.

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"The 12-Step Way to Reduce Overhead: Operational Efficiencies." Tinsley R. February 1997:38.

"The 12-Step Way to Reduce Overhead: Staffing Efficiencies." Tinsley R. January 1997:22.

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Physicians should be good enough at coding to teach it to a group of their peers.

Bad billing practices – another source of inefficiency and waste – are caused more often by incompetence than by willful misbehavior.

One way to catch bad billing practices is to look through all the drawers in the billing office after hours.

Regardless of a practice's coding and billing practices, participation with an insurance plan or IPA that has poor reimbursement can also be costly.

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Fee schedules that are not based on the resource-based relative value scale (RBRVS) can result in fees that are set too high or too low.

Having a budget and comparing it to annual national surveys can help physicians identify whether a practice is spending too much on staffing, office supplies, etc.

A budget should be updated annually to address changes in specialty overhead trends.

Providing overtime compensation can cost practices thousands of dollars per year.

• Look at your practice's monthly charges, collections, adjustments and accounts receivable for unexplained changes or trends, such as increasing accounts receivables. One resource for doing this is my book, *Medical Practice Forms: Every Form You Need to Succeed* (available for purchase at 800-MED-SHOP or www.practicemgmt.com/forms_book_details.html), which includes a business summary sheet, an accounts receivable aging report and a collection agency account tracking sheet, among others.

• After hours, occasionally look through all the drawers in the billing office for checks or receipts that don't correspond to accounting records, unprocessed claims, appeals or letters from patients that haven't been handled, or thick files of any other type of unprocessed documents.

4. Poorly reimbursing insurance plans

Even if you code precisely and bill perfectly, you will still lose money if you do business with an insurance plan or IPA that has poor reimbursement. Some seem to willfully not reimburse what is due, others have very low reimbursement schedules, and some just fall further and further behind in payments until they go broke and stop paying altogether. If you choose to participate with a plan that reimburses at 25 percent less than normal, you may have to see 40 percent more patients from that plan to make up the loss, since the reimbursement on the additional patients seen is also 25 percent less than normal (and you may have additional costs involved in seeing more patients, such as the cost of supplies, the additional labor and administrative costs of processing the extra claims, and perhaps extra administrative review of the contract).

Prevention tips:

• Evaluate any health plans or IPAs that you are currently participating with or considering participating with to determine how well they reimburse.

• Resign from poorly reimbursing plans or IPAs to allow time to see patients from better plans and to encourage patients to switch to better plans.

• Post a sign in your reception area that recommends the best plans.

• Monitor the health of the plans or IPAs you participate with. One way to do this is to purchase solvency reports (e.g., Insurance Solvency Reports, www.insurancesolvency.com) or credit reports (e.g., Dun & Bradstreet, www.dnb.com).

5. Infrequently and improperly updated fee schedules

Many physicians think that fee schedules no longer matter in this age of discounted medicine, but even in a capitated environment, you can't calculate a fee-for-service equivalent to evaluate a plan's PMPM reimbursement without an accurate, up-to-date fee schedule. Some practices base their fees on a whim or on Medicare reimbursement. Others base their fees according to the results of a survey of what nearby physicians charge, which tends to result in localized, informal fee freezes, since the same groups just keep comparing fees with each other year after year. Fee schedules that are not based on the resource-based relative value scale (RBRVS) often result in fees that are set too high or too low. And just one underpriced service could cost your practice thousands of dollars each year.

Just one underpriced service could cost your practice thousands of dollars each year.

Prevention tips:

• Become familiar with the RBRVS methodology. A good place to start is the AMA's *Medicare RBRVS: The Physicians' Guide* (which is available for purchase by calling 800-621-8335 or at www.ama-assn.org/ama/pub/category/7495.html).

• Update your fees annually on your own or with the help of a consultant. One way to do it yourself is to subscribe to a service such as FeeAnalyzer.com or purchase a report from Custom Physician Fees (store.yahoo. com/pmiconline/cufe20onesp.html), both of which provide annual physician charge data for a particular geographic area and specialty.

6. Lack of a budget

Many physicians don't know what their costs of doing business are, much less what those costs should be by expense category. Having a budget and comparing it to annual national surveys can help you identify whether you're spending too much on staffing, office

supplies, medical supplies, etc. Think of a budget as one of your practice's financial vital signs. It can help you diagnose the reason for lost profits so that a proper treatment plan can be prescribed.

Prevention tips:

• Prepare monthly income and expense reports for your practice. This can be done easily from your practice's accounts payable software.

• Compare your practice's income and expenses to those of other family practices nationally. These statistics are available from health care consultants and from sources such as the Medical Group Management Association's (MGMA) *Cost Survey* (www.mgma.com) and the NAHC/Society of Medical-Dental Management Consultants' *Joint Statistics* report (www.healthcon.org/statistics.html).

• Establish a baseline budget based on national statistics. You may need to make adjustments based on your particular situation. For example, if you choose to be in a high-rent office, your baseline rent might be 8 percent of collections rather than the national median of 6.8 percent.[1] Update your budget annually to address changes in specialty overhead trends. For example, if staffing costs have been continually increasing as a percentage of collections nationally, yours should probably also increase unless there are other mitigating factors.

7. Excessive overtime and overstaffing

Providing overtime compensation can cost practices thousands of dollars per year. While overtime is a fact of life for most family practices, it can and should be tightly controlled. At time-and-a-half pay, every hour of overtime could have been replaced by 1.5 hours of work at regular pay by another person or by an alternate schedule. Often, staff will work overtime unnecessarily, such as when loyal staff members all stay late while the last patient is seen.

Since work expands when staff are available to do it, overstaffing may result from employees being added during periods of high demand (e.g., during flu season or when converting to open-access scheduling) and then permanently retained even after work patterns change and short-term projects are completed.

Prevention tips:

• Adjust staff schedules to minimize overtime, such as with the use of split shifts or 10-hour days.

• Have only one staff person stay to assist in exiting the last patient.

• Insist on pre-approving all overtime.

• Develop a staffing budget and stick to it.

8. Inefficient supply purchasing

Maintaining the necessary supplies in your practice costs more than you think. Those friendly supply vendors who come to your office and stock your shelves are not inexpensive. How do you think they can afford to bring all those doughnuts and pizzas for the staff? And while your office manager might consider the weekly trip to the office-supply store a nice respite from the stresses of the office, paying his or her hourly wage for the trip may exceed any savings on the supplies.

Prevention tips:

• Set up a good inventory management system. This can save hundreds or thousands of dollars per year in supply and labor costs.

• Join a purchasing group to negotiate discounts (e.g., AAFP's discount office supply program, www.aafp.org/x15354.xml).

• Buy from discounters rather than retailers.

• Have your staff buy online (e.g., www.henryschein.com) rather than spending time visiting stores.

• Specify the types or brands of items you need to prevent staff from purchasing expensive elective items, such as $5 pens when 15-cent pens would do.

9. Petty theft and embezzlement

Petty theft of office supplies or pharmaceutical samples will likely occur at some time in your practice. Often, staff just don't think that taking home a box of pens, a ream of copy paper or a handful of floppy disks is theft. It might not be a big deal if it's done once, but in a year's time and with a large staff it can add up.

About half of all practices will also face a more serious kind of theft that involves thousands of dollars and often continues for years. Embezzlement usually happens in practices that don't pay careful attention to practice data and cash flow or don't have financial-control policies in place. You can't identify embezzlers from the way they look, act or dress. In fact, successful ones are often otherwise ideal employees. One such staff person in a solo practice increased the

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Since work expands when staff are available to do it, costly overstaffing may result from employees being added during periods of high demand (e.g., flu season) and then permanently retained.

Setting up a good inventory management system can save hundreds or thousands of dollars per year in supply and labor costs.

Petty theft will occur in most practices and embezzlement will occur in half of all practices.

Some ways to prevent these problems include checking employees' credit reports and paying attention to detail in the practice's finances.

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Unmanaged risk can also cost practices money; the margin of error is smaller and the consequences greater than many physicians realize.

You can manage your risk by reading and understanding your managed care contracts before signing them.

It's also helpful to become an expert on carve-outs, formularies, etc., and to know your costs per contract, per month and per patient encounter.

Prevention is the key to your practice's financial well-being.

physician's fee schedule without his knowledge by $10 per visit and pocketed the difference for more than a year before being caught. Most embezzlers of physicians are merely fired and not reported to law-enforcement authorities, so they just get another job with another physician who doesn't check references. Unfortunately, there are dozens of ways to embezzle, and embezzlement can only be discouraged, not entirely prevented.

Prevention tips:

• Check employment references, credit reports and court and police records when hiring employees who will be handling your money.

• Obtain a "fidelity bond" insurance policy on staff who handle money. This is often available at a discount from your professional liability insurer.

• Establish a formal office policy that says that taking supplies or drug samples without permission is considered theft.

• Rotate or divide financial duties among staff.

• Review your practice finances monthly, investigate irregularities and discuss them with staff.

• Verify that vendors to whom you write checks are valid, and spot-check invoices and signatures on checks.

• Pay attention to detail, and use the basic financial controls installed by your CPA or practice management consultant. Examples of financial controls include requirements that receipts are issued for cash payments, employees who handle cash are bonded, deposits are prepared daily, a running balance of petty cash is kept and write-offs and adjustments are reviewed by the physician monthly.

• Don't set a bad example by "dipping into the till" yourself.

• Investigate suspected embezzlement discreetly, and involve law enforcement after your CPA or consultant verifies it. This is important since embezzlers sometimes become arsonists to cover their tracks when they suspect they are being investigated.

10. Unmanaged risk

Taking capitated contracts or discounted fee-for-service contracts with risk-withholds involves risk. Don't take on risk if you can't manage it or survive its failure. The margin of error is smaller and consequences greater than many physicians realize. For example, if you charge $100 for a visit, your plan pays $75 and your overhead is $65, then your profit is $10. Even just a 5-percent miscalculation ($5 in this case) can cost you half your profit.

Prevention tips:

• Read and understand your managed care contracts before signing them.

Prevention is the key to preserving the financial health of your practice.

• Be an expert on carve-outs, formularies, pre-authorizations, admissions, specialist panels, co-pays, coding, noncovered services, cost reimbursements, etc. A good resource for this is *The Managed Care Handbook* (available for purchase at 800-MEDSHOP or pmiconline.site.yahoo.net/noname10.html).

• Know your costs per contract, per month and per patient encounter, and know how they compare to others in family practice. A helpful tool for gathering this information is the "Managed care data tracking worksheet," available from *FPM* at www.aafp.org/fpm/971000fm/cover_1.html.

• When measuring productivity, aim for at least the 65th percentile for the number of ambulatory encounters your practice provides compared to national family practice statistics.

Prevention, prevention, prevention

Prevention is the key to preserving the financial health of your practice. Regardless of whether your practice currently has any or all of the financial leaks described above, following these and other prevention tips can help to ensure that your practice brings in and retains the money it earns. FPM

Send comments to fpmedit@aafp.org.

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