

IMPROVE YOUR NEUROLOGY PRACTICE: UNDERSTAND CASH FLOW, REVENUE CYCLE, KEY PERFORMANCE INDICATORS, WORKFLOW, AND BENCHMARKING

Gregory J. Esper, MD, MBA
Emory University
Atlanta, GA

Brad C Klein, MD, MBA
Abington Neurological Associates, Ltd.
Willow Grove, PA

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Introduction

Neurology practices continue to struggle for survival due to higher overhead and shrinking reimbursements for cognitive specialists. High malpractice premiums and office expenses, lower payments per patient, the rising cost of compliance with government regulations and cumbersome, time-consuming, insurance documentation requirements, are the trend. New models of reimbursement such as value based care have yet to be validated, though are being implemented across the country. Overlooking the true cost of services and procedures can result in financial drains to neurologic practice and unexpected losses. Running an efficient, productive practice is more important than ever. Whether in private practice, a large multi-specialty group, or an academic setting, neurologists face daily business decisions that affect income, practice viability, and professional satisfaction. Neurologists may risk economic losses and even bankruptcy if not involved in business management. Applying sound business principles to your practice can improve performance, maintain thorough services to a complicated patient base, and promote fiscal responsibility, especially in the new era of health reform.

It is our goal to provide an overview of basic financial principles and tools such that participants can apply sound business strategies to neurology practice issues. Participants should understand the process necessary to determine if expansion of services will result in establishing and sustaining financial growth. Relevant changes to the reimbursement schemes of the Centers of Medicare and Medicaid (CMS) will be discussed.

Upon completion of this course, participants should be able to understand practice revenues, expenses, and cash flow; identify revenue cycle problems; establish and use key performance indicators for their practices; enhance work flow to maintain fiscal health; utilize benchmarking to enhance their practice; determine whether a new service will result in sustainable practice growth; consider successful ways to try new ideas without risking financial losses; evaluate the economics of outsourcing versus providing in-house services; utilize financial analysis to determine if technology and other capital investments will provide a return on investment; know how to determine which payers are creating an administrative drain on their practices; negotiate payer contracts; and begin to understand what is involved to succeed in government, hospital, and commercial incentive/penalty programs such as accountable care organizations.

As with any business venture, successful neurology practices depend on the tracking of revenues and expenses feeding the bottom line. Monitoring all of the inputs that accrue to each line of the income statement can be difficult, especially in practices in which there are a large number of providers and/or multiple practice sites. The Revenue Cycle refers to the process by which all steps involved in generating revenue are captured. Expense management, or knowing what it costs to provide a service, is essential to realizing a practice profit. If the operational scheme of the practice is faulty, mishandling of steps in the revenue cycle occurs, expenses (including those per unit service) are miscalculated, the ensuing financial errors can be devastating.

Understanding how key performance indicators (KPIs) reflect the clinical operations involved in maintaining both a strong revenue cycle performance and a robust income statement creates a model that promotes the fiscal health of a practice.

Essential Points. The doctor needs to know these data every

- month: Charges
- Payments
- Total practice profits & expenses
- Changes in practice expenses
- Third next available appointment
- Days in accounts receivable

Then, the doctor also needs to evaluate every six months which potential payer should be dropped, and then ask the question, is Medicare profitable? Are other insurers profitable? This will be discussed within this syllabus.

Accounting

Different groups use different accounting systems, and it is important to understand which system is used in which setting. Most small practices use cash basis accounting, while larger groups and academic institutions often use accrual accounting. Cash basis accounting means that practices only count the income when it is actually received and put into the bank. It is not considered income when it is billed. When the check is received, the contracted payment is discounted. Write-offs for amounts not collected (either from insurance

companies or from patient copays) take place afterwards, if needed. Thus, one can imagine that in the first few months of a newly opened solo practice, there is no cash coming in because payments from insurers have not been received; the practice can only post deficits due to expenses which must be paid from other sources such as bank or private loans. Only when cash is received can it be posted to accounts as revenue that offsets expenses. See table 1 for an example.

Table 1. Cash basis accounting example, assuming that revenue is collected one month after it is billed.

	1/2017	2/2017	3/2017
Revenue Charged or	200	250	300
Revenue Posted	0	200	250
NPSR	0	100	130
GOM	N/A	50%	52%
Expenses	50	50	50
Income	(50)	50	80
Actual Cash	(50)	0	80

(Abbreviations: GOM: gross operating margin or revenue collected/revenue billed. NPSR: net patient service revenue or the amount actually collected)

The indirect method of accrual accounting allows income to be counted when billed as opposed to when received, with gross charges posted and the “net” charge received after insurance contracts. Patient non-payment of agreed amounts is later deducted as an adjustment. This is a system that is more difficult to employ because revenue is posted in advance of receipt, and it is subject to a collection rate that is historic but may change in the future, thus affecting revenue that has already been posted. In this course, we will analyze financial statements of a group using the accrual accounting method, though similar analysis is applicable for groups using cash basis accounting. See Table 2 for an example of accrual accounting.

Table 2. Indirect, “Accrual” accounting method, assuming that revenue is collected one month after it is billed.

	1/2017	2/2017	3/2017
Earned	200	250	300
Revenue posted	200	250	300
NPSR	100	130	156
GOM	50%	52%	52%
Expenses	50	50	50
Income	50	80	106
Expected Cash	50	130	236
Actual Cash	0	50	130

Budgets

The budget is a document that projects the revenue and expenses of the next fiscal year by evaluating the prior year performance, by assessing the possible revenue generation in the coming year based on provider number and provider effort, and by assessing the projected expenses for the coming fiscal year including the need for new staff, purchase of durable equipment or medications that the practice administers in-office (such as botulinum toxin), and projected changes in other items such as rent or utilities. Comparison of the current year’s

actual-to-expected numbers should inform next fiscal year’s budgeting. A quick example is the purchase and in-office use of botulinum toxin. The administrator may budget for an annual total medication expense; but, if the drug is shipped quarterly, the monthly statements do not reflect the cost. The expense must either be averaged or simply not posted for that month. Throughout the year, the practice can compare performance to budget, calculate variances, and identify trends that benefit or adversely affect the practice. This comparison is seen on the operating statements, which will be discussed below.

Understanding the Income Statement

The business manager uses the income statement to display all revenues and expenses that create the net operating income (NOI) on one spreadsheet. Positive NOI is good – this means that revenue has exceeded expenses and the practice made money; negative NOI is bad – expenses have exceeded revenue and the practice lost money. The spreadsheet rollup is typically reported to the group monthly or quarterly, but should be tracked daily by the practice manager in order to ensure that targets and goals, especially per clinical full-time equivalent (FTE) practitioner, are being met. Early identification of financial problems using these resources allows operational corrections through early intervention to prevent a bad fiscal performance.

Table 3. Sample MONTHLY Income Statement for Neurology Practice

	12/31/2016	1/31/2017	2/28/2017
Gross Billings per Clinical FTE	\$97,760	\$88,387	\$87,781
Gross billings	\$1,474,218	\$1,423,025	\$1,530,025
Deductions	(\$707,461)	(\$725,468)	(\$750,882)
Net Patient Service Revenue (NPSR)	\$766,757	\$697,557	\$779,143
Gross Operating Margin (Collection Rate)	52.0%	49.0%	50.9%
Other Revenue	\$57,020	\$50,564	\$72,775
Net Revenue	\$823,777	\$748,121	\$851,918
MD Salary Expense	\$262,440	\$261,262	\$258,170
Non-MD Salary Expense	\$194,242	\$193,697	\$180,213
Total Salary Expense	\$456,682	\$454,959	\$438,382
Physician Benefits	\$35,209	\$44,335	\$44,241
Non-physician Benefits	\$32,061	\$48,913	\$66,341
Total Benefits	\$67,270	\$93,248	\$110,582
Total non-labor expenses	\$221,136	\$237,928	\$291,504
Net expenses	\$745,088	\$786,135	\$840,468
Net Operating Income (NOI)	\$78,690	(\$38,014)	\$11,449
Net Operating Margin	9.55%	-5.08%	1.34%
Cash Balance	\$406,138	\$368,124	\$379,574

A sample income statement is provided in Table 3. In this income statement, gross billings total between \$1.4 and \$1.5 million per month. Deductions are the gross adjusted amount that was not collectable based on contract negotiations with third party payers. For instance, if a neurologist’s office submits a \$300 invoice to Medicare for a comprehensive initial visit (CPT code 99205), but CMS values the visit at \$203.66, then the practice is reimbursed only \$203.66. This is the “net patient service revenue” or NPSR for the visit. The “deduction” is \$300-\$203.66 = \$97.34. The gross operating margin is then calculated as NPSR/Gross Billings, which in the case of this practice, is between 49% and 52%. The gross operating margin varies based on the amount reimbursed by certain payers for certain CPT codes. The gross operating margin for actual procedures may be lower than that for evaluation/management (E/M) visits, but this could be more a function of how rates are set within the practice

rather than the actual reimbursement by an insurer.

Please note that the gross operating margin is different from the net operating margin (Net Operating Margin = NOI / NPSR), which is a sign of the financial health of the practice that reflects how well a practice converts revenue from core operations into actual profit. Net operating margin is also a barometer of cost control and efficiency within a practice. The practice developed problems in January and February of 2016, which we will study below.

It is imperative to understand the amount each insurance company reimburses for each CPT code for which the practice bills. Insurance companies individually set their amounts of reimbursement for each clinical procedure. Companies will reimburse different amounts for the same procedures; some insurers can reimburse at rates higher than CMS, and others may reimburse similar amounts to CMS or lower. Each neurology practice should have a table that identifies insurers and CPT code reimbursements, similar to that which is shown in Table 4. Using this tool, the practice can identify which payers are reimbursing well for certain procedures and which are not. The practice should set its charges above the highest rate of reimbursement, which may be upwards of 180% of what CMS will pay. This will identify whether or not the charges for the practice are set high enough to ensure that no matter which company receives the invoice, the entire amount that can be collected from an insurer is received. The signed contract between the payer and practice will typically require the payer to only pay the lower of the negotiated rate or the charge rate. Gross charges may be skewed if practices set their charges much higher than the negotiated rates. Note that in the example below, Aetna will pay more than the fee charged by the practice for both 95819 (EEG, awake and asleep) and 62270 (LP); therefore, for each billed Awake and Asleep EEG and LP, the practice leaves \$10 on the table. This may seem minimal, but if a practice does 100 LPs per year and 200 Awake and asleep EEGs per year, then \$3000 of income is not collected. Magnify this over the entire fee schedule, and the practice could lose thousands of dollars per year.

Table 4. Sample reimbursement table per insurer for common procedural codes*						
Code	Description	FFS	MC	BCBS	United	Aetna
95819	Awake/asleep EEG	\$420 per unit	\$421 per unit	\$410 per unit	\$415 per unit	\$430 per unit
62270	Lumbar Puncture	\$200 per LP	\$162/LP	\$190/LP	\$185/LP	\$210/LP
Bolded amounts represent insurance reimbursement higher than neurologist fee schedule						
FFS-Practice's fee for service; MC-Medicare; BCBS-Blue Cross Blue Shield						
*values listed in this table are arbitrary except for Medicare reimbursement (2017 fee schedule, CF \$35.8887 *						

A line that encompasses "other revenue" is also listed on the income statement. This revenue can be from medical directorships in hospitals, legal consultation fees, speakers' fees, research, and a number of other activities that are not directly tied to patient care and insurance reimbursement. Practices may choose to put incentive monies from CMS into this line item, though this should probably be tracked separately as its own line item. The total amount of "other revenue" can be significant and should not be overlooked; in our example it represents about 7.3% of revenue to the practice. This line item can be the difference between a positive NOI and a negative NOI, and it certainly represents an opportunity to explore alternative sources of revenue for a practice that is struggling.

Expenses can financially drain a neurology practice if not closely monitored. Generally, the largest expense to a practice should be the physician salaries. The Non-MD salary expenses are comprised of salaries for mid-level practitioners, nurses, medical assistants, secretaries, and other office staff. Benefits including various types of insurance for practitioners and staff are generally a certain percentage of salary; non-labor expenses are those expenses that include drug purchasing (i.e. botulinum toxin), medical supplies (i.e. electrodes for electromyography (EMG) or electroencephalography (EEG)), office supplies, and other items such as rent and interest expenses.

The ending cash balance from the prior year is \$406,138. This is how much actual gross cash is present from month to month, and the NOI is added monthly to the previous month's cash balance to generate the new monthly cash balance. In our example, expenses are rising each month (between 5-7%), and in January 2017,

NOI was negative, reducing the cash balance by 9% in one month. A quick look shows that gross billings per clinical FTE were down by almost \$10,000 though gross billings declined by about \$50,000. Two questions that immediately come to mind are: Did the practice add another FTE who did not have a full clinical load? Was there improper coding? Another reason for the decline is that the gross operating margin was 3% less than the prior month. Expenses also rose because of a 25% increase in physician and non-physician benefits though the MD and non-MD salary expenses remained about the same. The practice rebounded in February despite the higher expenses, largely due to a higher NPSR. In order to really understand a deeper level why the cash flow fluctuated so greatly from month to month, a look at more detailed statements is necessary.

Understanding the Operating Statement

The income statement is meant to track large changes in a practice; deep dives into revenue and expense data are necessary after a problem is identified on the income statement, such as an increase in practice expenses, a decrease in revenue, or both. A line item operating statement (Appendix I) is necessary for an in-depth internal look at the practice as it breaks out in detail revenues earned and expenses incurred by the practice. Rent/mortgage, depreciation, interest expenses, insurance expenses, recruitment expenses, and other various items are tracked against budget and the previous year, and a variance report is generated. The variance report, or the percentage change from period-to-period, is a highly valuable tool that can immediately identify areas that requires investigation.

Table 5A. OPERATING STATEMENT 12/31/2016	ACTUAL	BUDGET	VARIANCE	VAR %	PRIOR YEAR
OPERATING REVENUES					
GROSS BILLING	1,474,218	1,369,606	104,612	8%	1,228,476
CAPITATION REVENUE	0	0	0	-	0
PATIENT REVENUE	1,474,218	1,369,606	104,612	8%	1,228,476
DEDUCTIONS FROM REVENUE	(707,461)	(652,595)	(54,866)	(8%)	(562,279)
NET PATIENT SERVICE REVENUE	766,757	717,011	49,746	7%	666,197
GROSS OPERATING MARGIN	52.0%	52.4%	-0.3%	(1%)	54.2%
VARIABLE MOU REVENUE	0	0	0	-	0
OTHER REVENUE	57,020	76,879	(19,859)	(26%)	39,939
NET REVENUE	823,777	793,890	29,887	4%	706,136
OPERATING EXPENSES:					
MD INCENTIVE PAY	6,605	6,605	0	0%	0
OTHER MD SALARIES	255,835	211,911	(43,923)	(21%)	189,569
MD SALARIES	262,440	218,516	(43,923)	(20%)	189,569
NON-MD SALARIES	194,242	163,200	(31,042)	(19%)	145,356
SALARIES	456,682	381,717	(74,965)	(20%)	334,925
MD BENEFITS	35,209	38,549	3,340	9%	23,028
NON-MD BENEFITS	32,061	50,027	17,966	36%	43,564
EMPLOYEE BENEFITS	67,270	88,576	21,306	24%	66,592
MEDICAL SUPPLIES	15,617	70,711	55,094	78%	101,201
OFFICE SUPPLIES	7,722	3,578	(4,144)	(116%)	4,269
SUPPLIES & OTHER	23,339	74,289	50,950	69%	105,470
PURCHASED SERVICES	2,080	8,720	6,640	76%	203
RENT	42,598	40,787	(1,812)	(4%)	35,348
UTILITIES	8,669	9,487	818	9%	8,152
MAINTENANCE	373	1,407	1,034	73%	0
RENT, LEASE, & UTILITIES	51,640	51,680	40	0%	43,500
INTEREST EXPENSE	646	646	0	0%	670
INSURANCE EXPENSE	46,680	46,680	(0)	(0%)	42,955
DEPRECIATION	3,631	4,945	1,314	27%	4,310
OTHER EXPENSES -PHYSICIAN	250	1,680	1,430	85%	155
OTHER EXPENSES -NON PHYSICIAN	407	174	(233)	(134%)	0
SECTION ADMIN ALLOCATION	0	(1,027)	(1,027)	(100%)	0
RECRUITMENT & EDUCATION	0	42	42	100%	0
SHARED SERVICES	85,808	85,810	2	0%	82,676
OTHER EXPENSES	6,655	5,299	(1,355)	(26%)	9,870
TOTAL OTHER OPERATING EXPENSE	93,120	91,978	(1,142)	(1%)	92,701
NET EXPENSES	745,087	749,230	4,143	1%	691,325
NET OPERATING INCOME/(LOSS)	78,690	44,659	34,031	76%	14,812
NET OPERATING MARGIN	9.55%	5.63%	3.93%		2.1%

Table 5B. OPERATING STATEMENT					
1/31/2017					
	ACTUAL	BUDGET	VARIANCE	VAR %	PRIOR YEAR
OPERATING REVENUES:					
GROSS BILLING	1,423,025	1,412,343	10,682	1%	1,263,226
CAPITATION REVENUE	0	0	0	-	0
PATIENT REVENUE	1,423,025	1,412,343	10,682	1%	1,263,226
DEDUCTIONS FROM REVENUE	(725,468)	(673,631)	(51,837)	(8%)	(603,341)
NET PATIENT SERVICE REVENUE	697,557	738,712	(41,155)	(6%)	659,885
GROSS OPERATING MARGIN	49.0%	52.3%	(3.3%)	(6%)	52.2%
VARIABLE MOU REVENUE	0	0	0	-	0
OTHER REVENUE	50,564	54,379	(3,814)	(7%)	61,936
NET REVENUE	748,121	793,091	(44,969)	(6%)	721,821
OPERATING EXPENSES					
MD INCENTIVE PAY	6,605	6,605	0	0%	0
OTHER MD SALARIES	254,657	211,911	(42,746)	(20%)	195,119
MD SALARIES	261,262	218,516	(42,746)	(20%)	195,119
NON-MD SALARIES	193,697	169,318	(24,379)	(14%)	145,525
SALARIES	454,959	387,834	(67,125)	(17%)	340,645
MD BENEFITS	44,335	38,549	(5,786)	(15%)	55,466
NON-MD BENEFITS	48,913	51,740	2,828	5%	37,539
EMPLOYEE BENEFITS	93,248	90,289	(2,959)	(3%)	93,005
MEDICAL SUPPLIES	42,595	79,865	37,270	47%	11,620
OFFICE SUPPLIES	2,874	3,578	704	20%	2,356
SUPPLIES & OTHER	45,469	83,443	37,974	46%	13,976
PURCHASED SERVICES	2,136	9,035	6,899	76%	33,754
RENT	42,598	40,787	(1,812)	(4%)	35,372
UTILITIES	8,227	9,487	1,260	13%	9,073
MAINTENANCE	740	1,407	667	47%	6,583
RENT, LEASE, & UTILITIES	51,566	51,680	114	0%	51,027
INTEREST EXPENSE	646	646	0	0%	670
INSURANCE EXPENSE	46,680	46,680	(0)	(0%)	42,955
DEPRECIATION	3,749	4,945	1,195	24%	4,189
OTHER EXPENSES - PHYSICIAN	250	1,680	1,430	85%	706
OTHER EXPENSES - NON PHYSICIAN	0	174	174	100%	557
SECTION ADMIN ALLOCATION	0	(1,027)	(1,027)	(100%)	0
RECRUITMENT & EDUCATION	0	42	42	100%	0
SHARED SERVICES	85,808	85,810	2	0%	82,676
OTHER EXPENSES	1,624	5,299	3,676	69%	1,444
TOTAL OTHER OPERATING EXPENSE	87,682	91,978	4,296	5%	85,383
NET EXPENSES	786,135	766,530	(19,605)	(3%)	665,604
NET OPERATING INCOME/(LOSS)	(38,014)	26,560	(64,574)	(243%)	56,217
NET OPERATING MARGIN	(5.1%)	3.3%	(8.4%)		7.8%

Table 5C. OPERATING STATEMENT 2/28/2017					PRIOR YEAR
	ACTUAL	BUDGET	VARIANCE	VAR %	
OPERATING REVENUES:					
GROSS BILLING	1,530,025	1,430,174	99,850	7%	1,430,725
CAPITATION REVENUE	0	0	0	-	0
PATIENT REVENUE	1,530,025	1,430,174	99,850	7%	1,430,725
DEDUCTIONS FROM REVENUE	(750,882)	(682,447)	(68,435)	(10%)	(704,681)
NET PATIENT SERVICE REVENUE	779,143	747,728	31,415	4%	726,045
GROSS OPERATING MARGIN	50.9%	52.3%	(1.4%)	(3%)	50.7%
VARIABLE MOU REVENUE	0	0	0	-	0
OTHER REVENUE	72,775	59,379	13,397	23%	46,246
NET REVENUE	851,918	807,106	44,811	6%	772,291
OPERATING EXPENSES:					
MD INCENTIVE PAY	6,605	6,605	0	0%	0
OTHER MD SALARIES	251,565	211,911	(39,653)	(19%)	204,721
MD SALARIES	258,170	218,516	(39,653)	(18%)	204,721
NON-MD SALARIES	180,213	151,942	(28,271)	(19%)	139,432
SALARIES	438,382	370,459	(67,924)	(18%)	344,153
MD BENEFITS	44,241	38,549	(5,692)	(15%)	40,833
NON-MD BENEFITS	66,341	46,875	(19,466)	(42%)	61,619
EMPLOYEE BENEFITS	110,582	85,424	(25,158)	(29%)	102,452
MEDICAL SUPPLIES	90,662	80,862	(9,800)	(12%)	161,736
OFFICE SUPPLIES	4,184	3,578	(606)	(17%)	3,275
SUPPLIES & OTHER	94,846	84,440	(10,406)	(12%)	165,012
PURCHASED SERVICES	3,834	9,072	5,238	58%	23,222
RENT	40,352	40,787	434	1%	35,372
UTILITIES	8,485	9,487	1,002	11%	8,633
MAINTENANCE	919	1,407	488	35%	0
RENT, LEASE, & UTILITIES	49,756	51,680	1,924	4%	44,005
INTEREST EXPENSE	646	646	0	0%	670
INSURANCE EXPENSE	46,680	46,680	(0)	(0%)	42,955
DEPRECIATION	3,799	4,945	1,145	23%	4,201
OTHER EXPENSES - PHYSICIAN	861	1,680	819	49%	465
OTHER EXPENSES - NON PHYSICIAN	428	174	(253)	(145%)	0
SECTION ADMIN ALLOCATION	0	(1,027)	(1,027)	(100%)	0
RECRUITMENT & EDUCATION	0	42	42	100%	0
SHARED SERVICES	85,808	85,810	2	0%	82,676
OTHER EXPENSES	4,846	5,299	453	9%	15,243
TOTAL OTHER OPERATING EXPENSE	91,943	91,978	35	0%	98,384
NET EXPENSES	840,468	745,322	(95,146)	(13%)	825,054
NET OPERATING INCOME/(LOSS)	11,449	61,784	(50,334)	(81%)	(52,763)
NET OPERATING MARGIN	1.3%	7.7%	(6.3%)		(6.8%)

The operating statements for the three months tell an interesting story (tables 5A, 5B, and 5C). Net revenue for the positive NOI months was ahead of budget by 3-6%; in the month in which there was a negative NOI, revenue was 5% behind budget. In all three months, there are certain expenses that far exceed budget: salaries and benefits. In all three months, MD salaries were 20-25% above that which was budgeted for the year. This could have been because of raises in salary, but more likely was secondary to the hiring of a new recruit(s) that were not included in the original budget. The practice administrator or medical director must follow up on this to determine the exact reason for the variance. The MD and non-MD salary burden reduces the NOI by approximately \$60,000.

Benefits show a similar percentage variance, but account for much less of a negative expense. Because of the salary issue that is identified, it would then be appropriate to identify the month that the new salaries were added to the practice expenses, and to track whether an increase in NPSR was driven by the new and higher expense (assumed to be a new provider and the staff required to support him/her). Financial ratios, which we will review below, will also be helpful in making this determination.

Notice in December that funds spent on office supplies was double what was budgeted; this was partially alleviated in the next month. Medical supplies include medications such as botulinum toxin, EMG needles and electrodes, and EEG electrodes. While in this example the funds budgeted for medical supplies exceed expenses, practices can easily take a loss if they don't adequately account for expensive medications given out in their practice. The fact that the medical supplies vary so greatly from the budget is either due to inappropriate budgeting, a decrease in the demand for procedural services, a charge that has not hit the books yet, or hopefully less likely, an error in accounting. One cannot make the conclusion that if the expenses had not varied from budget that the NOI would have been much less; theoretically these would have been costs associated with medical care that would have generated revenue and increased NPSR.

Financial practice indicators, ratios, and benchmarking

There are a number of financial indicators and ratios that allow a business manager and medical director of a practice to track the performance of a practice; they are the key performance indicators (KPIs). A few of these are:

- Work relative value units (RVUs) per encounter
- Work RVUs (wRVUs) per clinical FTE
- Encounters per clinical FTE
- Clinical Physician FTE to Total Physician FTE ratio (important in large group practices)
- NPSR per total RVU
- NPSR per total Physician FTE Paid
- Staff per total Physician FTE Net
- Expense per total Physician FTE

Work RVUs are a very helpful shortcut, to the extent they are relative and correct. If RVUs change for a procedure as they did for EMG and nerve conduction studies in 2013 - RVU ratios may change significantly. It is a system artifact with important ramifications for the practice as a whole and for the individual doctors; the administrator must keep up with changes so that "work" can be measured appropriately. The Medical Group Management Association (MGMA) lists many other financial and operational/productivity indicators that can be tracked (see appendix II and III). However, those listed above are the indicators and ratios that allow a greater understanding regarding the financial strength of the practice. These should be combined with revenue cycle data (discussed below) to develop a refined picture of the practice that can be tracked, shared with, and understood by all physicians within the practice. They can also be benchmarked against local, regional, or national practice management data. Returning to our practice example, Table 6 summarizes these ratios.

Table 6. Key Performance Indicators for SAMPLE Neurology Practice.			
	12/31/2016	1/31/2017	2/28/2017
WORK RVUS	8,718	8,540	8,946
CLINICAL FTE	15.1	16.1	17.4
TOTAL MD FTE	17.5	18.6	19.0
CLINICAL FTE : TOTAL FTE RATIO	0.86	0.87	0.92
TOTAL ENCOUNTERS	3,425	3,430	3,426
DAYS IN ACCOUNTS RECEIVABLE	34	38	38
wRVU PER ENCOUNTER	2.55	2.49	2.61
wRVU PER CLINICAL FTE	578	530	513
ENCOUNTERS PER CLINICAL FTE	227	213	197
NPSR	\$766,757	\$697,557	\$779,143
TOTAL RVUS	15,165	14,911	15,777
NPSR PER TOTAL RVU	\$51	\$47	\$49
NPSR PER TOTAL FTE	\$43,740	\$37,503	\$40,943
PAID NON-MD FTES	57.5	58.0	58.2
PAID STAFF PER TOTAL MD FTE	3.28	3.12	3.06
NET EXPENSE	\$745,087	\$786,135	\$840,468
TOTAL MD FTE	17.5	18.6	19.0
NET EXPENSE PER TOTAL MD FTE	\$42,504	\$42,265	\$44,165

The number of wRVUs tracks appropriately with the numbers that we see for NPSR – there is a dip in January compared with December, but a recovery in February. Productivity clearly fell in January, evidenced by the fact that the number of clinical FTE went up by 0.5, though wRVUs and NPSR dropped while expenses climbed. One reason is that patients are more inclined to go to physicians late in the year when their deductible is already paid off, rather than in January when they may be paying more out of pocket until they meet their deductible. As a result, practices will often see a dip in revenue in the early months of the year. Practices may adjust clinic schedules accordingly to keep revenue stable. However, this is also a classic scenario in which a physician joins the practice, but the schedule is being ramped up and is not yet full. Non-MD FTEs are required to staff the new physician's practice burden, but the NPSR is not maximized. While wRVUs and NPSR are up in February, they are still not enough to cover the net expense per total MD FTE, so for the second straight month, the practice would have lost money. Why didn't it? The income statement has this information – other revenue was up over \$22,000 from the previous month.

Academic practices use Faculty Practice Solutions Center data to benchmark work RVUs. 2016-2017 values for various sub-specialties are listed below in annual and monthly values in table 7a:

Table 7a. Faculty Practice Solutions Center data for neurology subspecialty work RVUs.							
<u>Annual per FTE</u>	Specialty	N	25th Percentile	50th Percentile	65th Percentile	75th Percentile	90th Percentile
Neurohospitalist	Hospitalists	326	2,904	3,850	4,409	4,855	6,149
Epilepsy_EEG	Neurology: Epilepsy / EEG	77	5,387	7,117	8,629	9,775	13,207
General	Neurology: General	251	3,391	4,330	5,013	5,693	7,273
FPSC_Neurmsclr	Neurology: Neuromuscular	47	3,912	4,789	5,586	6,023	7,237
Psychology	Psychology	20	1,321	1,920	2,195	2,742	4,316
Monthly per FTE							
Neurohospitalist			242	321	367	405	512
Epilepsy_EEG			449	593	719	815	1,101
General			283	361	418	474	606
FPSC_Neurmsclr			326	399	466	502	603
Psychology			110	160	183	229	360

Let's benchmark this practice to national data from MGMA (Table 7b), just to understand whether or not the performance of this practice is below, on par, or above the performance of other practices. First, it is important to note that MGMA data is largely derived from surveys submitted to practice managers who are members; we will use 2011 numbers reported in 2012 that are derived from responses by between 10 and 35 practices (some did not report on various metrics). While the data is "old," it provides the reader an appreciation of benchmark data available and its use within a practice. Also, the type of practices may differ. Some may be practices with only a few providers; others may be large groups. Academic practice groups are less well represented. National data from the American Academy of Neurology: Neurology Compensation and Productivity Report for 2016 data will provide additional metrics over more neurology practices.

Table 7b. Adapted from 2012 MGMA Financial Survey Data for Neurology Practices in 2011

	Count	10th %tile	25th %tile	Median	75th %tile	90th %tile
Total AR/physician	10	\$60,308	\$81,283	\$140,980	\$218,821	\$293,272
Total support staff FTE	33	.97	1.48	2.25	2.93	4.64
Physician work RVUs	13	2,198	4,860	5,318	6,372	9,201
Total gross charges	27	\$497,054	\$626,752	\$804,377	\$1,108,581	\$1,612,383
Total medical revenue	35	\$184,954	\$289,858	\$416,321	\$575,416	\$816,756
Total general operating cost	32	\$66,807	\$107,196	\$169,353	\$221,591	\$288,223
Total operating cost	35	\$139,945	\$208,927	\$318,359	\$397,737	\$536,400
Total medical revenue after operating cost	33	-\$79,980	\$18,152	\$162,974	\$225,859	\$344,158
FTE (full time equivalent), AR (accounts receivable), RVU (relative value unit)						
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This neurology practice has approximately 3.15 paid staff per total MD FTE. Benchmarking this against MGMA data suggests that this is above the median (2.25). Our sample neurology practice ranks somewhere above the 75th percentile for this ratio. In this practice, expenses are already high; the question is whether adding more clinical support staff could improve revenue, and more importantly, NPSR through higher collections. Of note, in the sample practice, one might expect a lower staff FTE: physician FTE ratio because of economies of scale in larger practices.

Days in accounts receivable (AR) is a measure of how many days it takes for money owed to a practice on credit to become cash received by the practice. The higher the number of days, the longer it will be for an intangible monetary amount owed on credit to become tangible cash that the practice can value as an asset. Increasing days in receivables means that the practice is not using current assets effectively, and it also increases the chance that the amount owed will default to bad debt that is not collectible.¹ This simply means that the practice is not paid for the services that it rendered. Various strategies are possible for reducing AR, and if practice billing is done in house and not through an outside agency, it is imperative to break down AR by payer and set goals to decrease the number of days per payer. Prompt submission of clean claims is necessary, as is an effective claims management process that encompasses both proper initial submission and aggressive claims denial tracking and resolution. Practice managers and medical directors should ensure that physicians understand that appropriate, same-day documentation is essential to reducing days in AR, and they should educate staff how to handle claims using a thorough, efficient management process that recognizes the intricacies of different payers. Setting goals for employees and rewarding productivity are ways to keep staff engaged in claims management. Also, improving 10-day charge lag compliance is key to reducing days in AR. The greater the delay in charge entry, the greater chance that the service will not be reimbursed. Our sample neurology practice displays average performance among its peers, as days in AR is between 34 and 38 for the months that we are evaluating, and an opportunity to improve this is seen as 10 day charge lag compliance was reported to be 88%, 89%, and 93% in each consecutive month.

Similarly, this neurology practice also has a collection rate (49-52%) in the mean/median range as compared to MGMA standards. This is based on the actual income received compared to the charge rate. While this rate is important, a more important measure of the success of a practice is whether or not they collect 100% of the allowable amount, or whether the practice leaves money on the table. The collection of the allowable amount

would be reduced if there are denials, bad debt, inappropriate billing codes, provider related adjustments, inability to access the medical records for the billed procedure, inappropriate registration, poor collection of co-pays, or insurance adjustments (i.e. “not medically necessary”). The total of these amounts may be termed “write offs” and in most successful practices, write offs should approach less than 1%.

Collection rate, days in AR, and FTE ratios are surrogate markers for practice efficiency. Similarly, other benchmarking items such as total operating cost, total physician cost per FTE, etc. are important to know and track. But, if we look at the three months, the practice manager should be very concerned. The annualized data, taken as the average of the first three months multiplied by 12, suggests that NPSR per total FTE will be \$488,744 but net expenses per total FTE are \$515,736. Each MD FTE is on track to lose \$26,992 for the year, and the practice is projected to lose over \$500,000 unless an intervention is made promptly. This requires investigation and modification to revenue cycle processes.

Revenue Cycle

The steps of the revenue cycle are:

- a. Scheduling
- b. Patient registration
- c. Patient intake process (Eligibility, demographics, credit management, initial payment)
 - Medicare: LMRP Inquiry □ produce Advance Beneficiary Notice (ABN)
 - Commercial insurers: Referral inquiry or request
 - Medicaid: Referral inquiry or request
- d. Patient examination, documentation
- e. Coding
- f. Coding review and edit
- g. Charge processing, claims submission, and tracking
- h. Payment Processing Resubmission and Appeals
- i. Secondary Claims/Guarantor billing AR follow up
- j. Bad Debt follow up/processing

Scheduling. Scheduling of patients greatly impacts the revenue cycle. The objective of appointment scheduling is trading off the interests of physicians and patients: the patients prefer short waiting times, and doctors prefer little to no idle time while finishing on time.² There is often a tradeoff between whether or not to overbook patients, whether to book patients for procedures and evaluation and management (E/M) visits on the same day, and whether or not to have level scheduling (scheduling based on room availability and room utilization rather than on physician preference). While value based reimbursement may play a larger role in the future, volume based reimbursement still drives the revenue for most practices, such that a greater patient volume generates more billable encounters that can potentially improve NPSR; however, this is only if the revenue generated by the service exceeds the cost per service. It is therefore imperative to understand which encounters generate the most revenue per unit time and to design a patient flow that maximizes income while achieving high patient and physician satisfaction. Scheduling is also in part driven by variable costs and should be examined regularly. The types of visits are also key in determining the cost benefit of which patients to schedule when, e.g. return visits with NPs instead of MDs.

In small practices, it is best to have a small team of people (at least two) who perform a number of functions including patient registration, transcription (if necessary), and invoice submission to insurance companies. This not only maximizes utility of paid employees, it ensures cross-training for multiple functions allowing continuation of office functions in the event of employee absence.

In larger practices, there tend to be teams of people performing various functions independently. While complexity and volume necessitate this, there is a tendency for a silo mentality to develop within each group. It is thus important to have frequent meetings that address problems that arise between the various departments. Problems in scheduling on the front end may cause errors in billing and coding. Simple, correctable errors may go unnoticed for a period of time, which may result in the loss of thousands of dollars. Frequent, in-office communication should be the rule.

Neurologists should be savvy in how their schedules are constructed. If the neurology group has a heavy inpatient presence (and therefore generates the majority of their revenue by hospital-based billing), outpatient schedules should reflect this. Either a dedicated physician FTE should be in the hospital, or the group should agree on arrangements for sharing hospital consults, with appropriate scheduling adjustments to the neurology practice's hospital consultant for the day. Arrangements starting later in the morning (i.e. 10 am) and finishing earlier (4 pm) can be helpful in facilitating more time for the inpatient activity.

If a considerable number of new patient visits are scheduled within a week's time, leaving blocked slots available is a good practice. For instance, various groups may leave 7:30 am (or earlier) appointment times open for ER follow-ups, hospital discharges, or urgent outpatient consultation requests. Other frozen slot times can be built into the schedule for similar appointments, and these slots can be programmed to "thaw," such that if a slot isn't filled by 12 hours in advance (i.e. end of the prior work day), schedulers may fill the slot with a patient from a waiting list. Creating open slots and decreasing the third next available appointment time should have a very positive impact on revenue; however, it is imperative that the physician and practice manager should stay directly involved in this process to ensure that the slots do not remain empty. Monitor daily schedules at least 24-48 hours in advance to proactively populate empty patient visit slots. Patients should receive reminder calls to keep them abreast of appointment day and time. An empty appointment slot is certainly revenue lost, but more importantly, a lost opportunity to help someone who may need to see a neurologist urgently.

Patient Registration. The billing process continues with patient registration, and it is imperative to ensure collection of accurate demographic and insurance information. Reasons for denials include ineligibility for service under current insurance plan, billing errors, improper documentation, and lack of medical necessity for the procedure, among others.³ In general, most practices have information technology (IT) that is able to capture registration information. This may or may not be integrated with other technology systems within the office including those that allow the generation, tracking, and resolution of an invoice. It is best if there is one IT system that integrates all the functions of an office. If this is present, errors resulting from the need to access multiple different systems (i.e. the demographic database, the documentation database, and the billing/coding database) are reduced, and one resource is available for all parties involved in a patient's care. Business managers must be aware of state specific rules for Medicaid patients as well as insurance contract details to incorporate these facts into registration and thereby avoid denials

The patient's demographics and insurance can change from the time that they are registered to the time of the visit, between visits, or after a visit but before an invoice has been paid. In periods where job turnover and unemployment are high, patients who originally had insurance may have no current coverage, thus rendering them a self-pay patient. The practice must verify demographics and insurance coverage not only when the patient is scheduled but immediately before the visit. This way, the practice can account for interim changes in patient coverage. If insurance coverage changes after the visit but before an invoice has been paid, it is imperative for the office to maintain records including precertification, referrals, dates of service, and procedures provided such that if and when an insurance denial occurs based on current coverage, the office can immediately appeal the denial with the appropriate information that shows that service was rendered at the time that the patient was insured. Given an increasing number of high deductible plans, it is imperative that practices have a system in place to ensure patients are aware of their potential financial obligations ahead of the visit and that practices receive timely payment by patients for services provided.

It is a good idea to always require a referral from a primary care doctor even if not required by an insurer. This is especially important if there are treatment implications outside the scope of the neurologist's expertise (i.e. diabetes management) or if the neurologist is not available for urgent calls and the patient has a medication side effect or other untoward event.

Patient intake process. For patients who arrive with Medicare insurance, it is important to determine through the local medical review policy (LMRP) how local carriers will review claims to ensure that they meet Medicare coverage and coding requirements. LMRPs specify under what clinical circumstances a service is covered and correctly coded. An LMRP includes a description of the service, specific procedure codes, and for each of these procedures, a list of covered and non-covered diagnostic codes with a goal of prevention of overutilization of clinical services paid by CMS.⁴ If it is suspected that Medicare will not cover a service, then it is appropriate to have the patient fill out an Advance Beneficiary Notice (ABN). This form explains to the beneficiary what service

may not be paid, what the reason for expected denial is, and what options the beneficiary has. This instrument also protects the provider, by explicitly accounting for the payment responsibility of the beneficiary should they still elect to have the service rendered.

Similarly, ensure that front desk staff members verify whether a commercial insurance company requires a referral from a PCP in order to pay the claim for the neurology visit. Obtaining the referral, documenting it, and having it readily available may make the difference between whether the practice is paid for a service or not. If in-office procedures are required, especially same day procedures, injections, or electrophysiology studies, the staff should have the appropriate insurance company phone and fax numbers for timely submission readily available. Electronic faxing greatly assists in this regard, and if the office is automated with an electronic health record, documentation is easily stored for future reference. These principles are also required to process Medicaid claims.

The collection of copays should always be performed at the time of a visit. It is the point at which the patient's motivation to pay is greatest and the cost of collection is the lowest. Commercial insurances require copay collection as it is an expected patient and physician responsibility. Delay in the copay collection will inevitably result in lost revenue. Credit card or cash payments should be the main method of payment; accepting checks for payment increases risk for bad debt in the event of default. Patients should also be required to make payments on balances owed to the practice; if the full amount cannot be paid at one time, a payment plan should be set up for the patient to increase the chance that the full amount owed may be collected. Payment plans should be processed through a patient's credit card. Practices should expect copayment rates as close to 100% as possible, as it is very expensive to bill repeatedly for a \$10 or \$20 copayment that was missed at the time of a visit. New staff must be monitored because inexperience at the front desk can result in a decrease in copay collection and increase in bad debt.

It has become commonplace for practices to charge a certain fee for no-show patients; often, credit card information should be collected at the time the appointment is scheduled to ensure that payment can be collected in the event of a cancellation. This reduces risk of cancellation and offsets the cost of a lost appointment. Many practices also separate from patients who regularly no-show. This information can and should be shared in the practice welcome packet/pamphlet.

Patient examination, documentation, and coding. Hopefully, the neurologist is able to provide timely access to patients. Classically, a physician's reported access is referred to as the "third-next available" appointment. As the third next available appointment time increases, the chance that the patient will not show for the appointment also increases. Patients will often seek a sooner appointment from a different provider, or their complaint may resolve by the time of the appointment. If the third-next available appointment is consistently longer than 30-40 days for both new patient visits and return patient visits, the practice should consider hiring another neurologist or reorganizing to improve the efficiency and type of physician extenders, provided that the cost-benefit ratio is favorable. Another way to decrease the third-next available appointment time is to cancel contracts with the lowest payers.

Accurate documentation and coding is absolutely critical for appropriate reimbursement for services rendered. The elimination of consultation codes by CMS that started on Jan 1, 2010 reduces the complexity of coding (and reimbursement) somewhat, though other payers to this date have not followed suit. Documentation of consult requests needs to be a part of the medical record in the form of the actual request by the referring physician and language documenting performance of a consultation in the neurologist's note. Appropriate use of the correct CPT codes and modifiers is essential, as is documentation to support the use of those codes. ICD9 codes delineating the most accurate diagnosis should be used rather than more generic ICD9 codes (i.e. use the code 346.00 for classical migraine, non-intractable rather than simply to code as a "headache", 784.0). ICD10 codes will increase the specificity of one's diagnosis considerably.

Appropriate documentation for supplies and drugs using the healthcare common procedure coding system (HCPCS) code sets should also be routinely and accurately performed.

With rapidly changing coding rules and governmental regulations, use of certified professional coders is a must. Physician Quality Reporting System (Physician Quality Reporting or PQR), established pay-for-performance metrics and created an extra layer of difficulty. However, this has since been rolled up into the Merit-based

Incentive Payment System (MIPS). Given that incentives and penalties will be a part of revenue cycle management for neurologists, learning how to document, code, and track outcomes for the various initiatives that are neurology specific is necessary.

Charge processing, claims submission and tracking. The neurologist may enter all necessary codes onto a superbill that is then processed by a biller/coder. Alternatively, use of electronic medical records may reduce this step into an electronic transfer that is performed by the biller/coder into claims manager software that can clean entries for correctness and generate a charge from a code. Charges should be entered the same day as the service, or by the beginning of the next business day at the latest. The 10-day cumulative charge lag is a measure of the timeliness of submission, and all practices should strive for 100% of charges to be submitted within 10 days. As mentioned above, the later the submission, the less chance that it will be paid.

Most payers will pay clean claims quickly. Medicare defines a clean claim as one that does not contain a defect requiring the Medicare contractor to investigate or develop prior to adjudication. Simply put, a clean claim is the appropriate code for the appropriate service, thoroughly and correctly documented and submitted with no errors. Claims should be edited to ensure that they are complete and correct and then should be sent out as soon as possible. Electronic claims submission is by far more efficient, and often results in a more immediate resolution of claims. Use of a claims clearinghouse may ensure appropriate formatting of claims to meet regulations before forwarding to third parties. Self-pay invoices should be routinely sent to patients and tracked for resolution.

The billing/coding team must have an internal automated tracking system to document both pending and resolved claims; this may be the most important link in the revenue cycle value chain as it directly results in lower days in AR, increased cash flow and higher NPSR. More automation will reduce costs (human resources, office supplies); in the event that documentation needs to be submitted, identify if it can be done electronically. The coders should use denials as a means of educating physicians and other clinic staff.

Payment processing. Remittances are payments, denials, or adjustments, and these must be handled as soon as they are received. Preferably, all remittances should be processed within 24 hours of receipt, though industry standard is to process remittances in an average of 48 hours. Often, remittances may be accompanied by an explanation of benefits that defines payment amounts, contractual allowances, co-payment/deductible amounts, and rejection codes. From this information, the practice directs the unpaid amount of the invoice to either the secondary insurance or a self-pay balance.

Resubmission and appeals. It is no secret that the primary goal of third party payers is to complicate the system to reduce cash payments to physicians. The neurologist's office has to be set up to manage the resubmission process aggressively and acutely. The reasons for resubmission and appeals are often invalid registration, poor medical documentation, coding or charge corrections, and missing referrals or preauthorizations. Office goals must include reprocessing of payment rejections within one week through the use of standard appeals forms and letters. Also, learning about the process directly from representatives in the insurance company (such as through conversations with the medical director) is very helpful in understanding what gets paid and what does not.

Secondary claims/guarantor billing. This process goes after the dollars not paid by the primary insurance company. A defect in this process can greatly reduce cash flow as well, and the practice needs to identify all possible coverage that a patient has to ensure payment of the medical bill. Medigap plans fall under this category, as do other supplemental insurance plans that pick up the remaining 20-30% of a medical bill that the primary insurance does not pay for. Secondary claims should be submitted within 2 days of primary payment receipt, and follow-up on self-balances should occur within 5-7 days of statement submission. Unpaid claims will post to bad debt write-offs; a final pass at unpaid claims should be made at the 120 mark before transferring the debt to a write-off.

Accounts receivable management. Correct insurance information, refile claims, and identify tracking inefficiencies. Is one insurance company continuously making accounts management difficult, and are there payments worth maintaining acceptance of that plan? Is the patient not paying their owed balance? Does the patient understand what is expected of them in regard to payment for services rendered? Often this latter type of education should be done on the front end; but if not, it should be handled by an experienced member of the neurology office staff so as

not to alienate the patient. Managing write offs is the key. The medical director should meet with the manager monthly or so to determine which accounts to write off. There is no sense in spending \$5 per month to collect \$10, particularly after three months of trying. Get the cost off the books and to a collections agent if it is a significant amount.

Fraud

This topic can be especially troublesome for many groups, especially because staff colleagues often hold one another in high esteem. However, fraud is not uncommon especially in medical practices. Ways to avoid internal theft and fraud include verification of bank deposits against a day's receipts, checking receipts at the end of a day against documents from each patient, and evaluating checks against source documents (which can only be done on a sample basis). In larger groups, there can be separation of duties, such that no one person handles all the billing. One employee should count the cash at the end of the day, and a second should add up receipts for the day; a third can then do the actual deposit. Authority for write-offs or bill pay should be given only if absolutely necessary; many physicians will turn over everything to the practice administrator without a system of checks and balances. Anyone handling money in the practice should be subject to both credit checks and background checks. This can be financially devastating to a practice.

Government Effects and Medicare Changes

Medicare Fee Schedule updates for the following year are typically finalized and published around the end of October. When CMS released its CY 2013 Medicare Physician Fee Schedule final rule, it included severe and drastic cuts to nerve conduction studies (NCS) and electromyography (EMG) studies. It was unexpected and abrupt, leaving less than 2 months' time for national organizations, hospitals, and providers to analyze and facilitate practice management adjustments. As a result of advocacy from a number of provider organizations, including the American Academy of Neurology, Medicare will now provide a public notice period prior to official rule announcements yearly. CMS has launched, as of this year, a new value based care over volume based care program under the Medicare Access and CHIP Reauthorization Act of 2015 (a.k.a. MACRA). Under MACRA, physicians' compensation will now be adjusted by the quality, cost, involvement in practice improvement activities, and use of electronic medical record technology; this plan is called the Quality Payment Program. Practices must be aware of national changes due to the potential effects it can have on one's income and management of a practice. Understanding the resources available, such as the American Academy of Neurology, to learn of policy and regulatory changes is imperative. Detail on MACRA is covered in other courses at the AAN annual meeting, webinars, and the website itself. See <https://qpp.cms.gov> as well as <https://www.aan.com/practice/MACRA/> for more information.

Retaining your colleagues and recruiting talent

While the number of neurologists is stagnant, the number of patients requiring neurological care is increasing. Practices can see their third-next available appointment extending from weeks to months, and it is difficult to attract and retain the best talent. The first order of business is to define the potential costs and revenue associated with bringing on a new employee. Costs will include salary, benefits, rent, medical and office supplies, and possibly more support staff to handle the extra administrative work. With declining net operating income, neurologists may not be able to afford extra staff and may even need to reduce staff. However, if the demand in the community exists, there is unused office space, and the practice would not need to hire more than one secretary, the practice may find hiring another physician to be lucrative. In this case, the additional provider may help support some of the existing fixed costs of the practice, thus each current provider would need to pay less overall to cover the overhead.

Another important consideration is the culture of the practice. Ensure that neurologists within the practice are happy in the current environment. Content partners create a higher probability of landing top recruits, and they will create a working environment that is hard to resist. Frequent and effective communication with partners is highly important. Ask questions to garner information, and listen to the responses. Make changes if suggestions make personal and financial sense. Honoring promises and agreements is also essential. Most of all, be open – don't conceal information from your associates or partners or this will lead to rapid and frequent attrition.

Neurologists and administrators should identify the type of neurologist needed: subspecialist or generalist, procedure-trained or not, one with clinical trials experience, etc. While advertisement via direct mail may work, more economical and farther-reaching strategies are probably better. Social networking sites including YouTube (www.youtube.com), Facebook (www.facebook.com), Twitter (www.twitter.com), and Linked-In (www.linkedin.com) are some of the best electronic ways to advertise positions and other content, but filtering will be important. Conversations with potential candidates before actual interviews are a key to identifying a potential partner, and it helps minimize recruitment costs.

Consider means other than fiscal promise to attract good candidates; in the end, salary is often a negative motivator, especially after the doctor arrives and begins working. Candidates may care more about lifestyle and environment than earning extra money. Returning to an area they once lived or where there is family can be an attraction for candidates, and making the move irresistible for a spouse or children can be a major force in landing a good candidate.

There is a definite way to interview candidates, and it must encompass a way to ensure that the candidate has both the knowledge and emotional intelligence to succeed in your practice. In addition to interviews assessing knowledge base, behavioral based interviews are an ideal option capturing both real life experiences and future plans while allowing the interviewer to better understand the individual's passion and skill set. Practice members must understand the following three things about potential candidates: 1. Will they fit into practice, 2. Can they do the job, and 3. Will they do the job. Fitness for the practice is measured by assessing the candidate's motivation for practicing, how well the candidate handles criticism, whether the candidate prefers to work alone or in a team, and how the candidate handles pressure or manages staff. Ensuring that the candidate has relevant skills and qualifications includes an assessment of both strengths and weaknesses, including personal accounts of achievements and/or difficult situations from which the candidate has learned. Business acumen in a candidate is a plus. Loyalty and future goals are key to assessing whether or not the candidate will do the job. It is not unreasonable to ask why the candidate wants the specific job you are offering. Understand what motivates the candidate and define their professionalism by asking them what a "good job" means. Understand why they left prior positions, and explore where they see themselves in three, five, or ten years. Then, grade each candidate based on with a scorecard that the practice develops, encompassing what the minimal acceptable rating is and what the candidate's actual rating is.⁸

During contract discussions, ensure openness and honesty. Don't state things that must be retracted later. Ensure a positive environment based on trust from the beginning.⁹ Be fair with financial offers, but ensure good performance by requiring the candidate to reach productivity goals that are similar for other partners. Define the time period for reaching productivity targets and share productivity categories. Signing bonuses and relocation packages should be reasonable; high asking prices by the candidate may be a warning signal of future problems, but low estimates by the practice can turn off a candidate sharply.

Before the contract offer, make sure that the entire group is willing to go ahead with the plan. It is easier to find another candidate than it is to replace a colleague. After making the contract offer, define a finite period of time during which an answer must be received.

Appendix I. Operating Statement Spreadsheet for Sample Neurology Practice

MONTH/YEAR	CURRENT PERIOD					YEAR-TO-DATE				
	ACTUAL	BUDGET	VARIANCE	VAR %	PRIOR YEAR	ACTUAL	BUDGET	VARIANCE	VAR %	PRIOR YEAR
<i>OPERATING REVENUES:</i>										
GROSS BILLING										
CAPITATION REVENUE										
PATIENT REVENUE										
DEDUCTIONS FROM REVENUE										
NET PATIENT SERVICE REVENUE										
GROSS OPERATING MARGIN										
VARIABLE REVENUE										
OTHER REVENUE										
OTHER REVENUE										
NET REVENUE										
<i>OPERATING EXPENSES:</i>										
MD INCENTIVE PAY										
OTHER MD SALARIES										
MD SALARIES										
NON-MD SALARIES										
SALARIES										
MD BENEFITS										
NON-MD BENEFITS										
EMPLOYEE BENEFITS										
MEDICAL SUPPLIES										
OFFICE SUPPLIES										
SUPPLIES & OTHER PURCHASED SERVICES										
RENT										
UTILITIES										
MAINTENANCE										
RENT, LEASE, & UTILITIES										
INTEREST EXPENSE										
INSURANCE EXPENSE										
DEPRECIATION										
OTHER EXPENSES - PHYSICIAN										
OTHER EXPENSES - NON PHYSICIAN										
RECRUITMENT										
SHARED SERVICES										
OTHER EXPENSES										
TOTAL OTHER OPERATING EXPENSE										
REIMBURSEMENTS & RECHARGES										
NET EXPENSES										
NET OPERATING INCOME/(LOSS)										
NET OPERATING MARGIN										
TOTAL NON-OPERATING REVENUE										
EXCESS REV OVER EXPENSE										

Staffing and Practice Data

Total provider FTE

Total physician FTE

Total non-physician provider FTE

Total support staff FTE

Number of branch clinics

Square footage of all facilities

Accounts Receivable Data, Collection Percentages and Financial Ratios

Total AR/physician

Total AR/provider

0-30 days in AR

31-80 days in AR

61-90 days in AR

90-120 days in AR

120+ days in AR

Months gross fee-for-service (FFS) charges in AR

Days gross FFS charges in AR

Gross FFS collection %

Adjusted FFS collection %

Net capitated revenue % of gross capitated charges

Current ratio

Total asset turnover ratio

Debt ratio

Return on total assets

Return on equity

Breakout of Total Gross Charges by Type of Payer

Medicare fee-for-service Medicaid

fee-for-service Commercial FFS

(no withhold) Commercial FFS

(with a withhold) Capitation

Workers' compensation

Charity and professional courtesy

Self-pay

Staffing, RVUs, Patients, Procedures and Sq. Footage (per FTE physician or per FTE provider)

Total provider FTE/physician

Neurologist/physician

Other MD specialty/physician

Total Non-physician practitioner/physician

Total support staff FTE/physician

Total employee support staff FTE

General administrative

Patient accounting

General accounting

Managed care administrative

Information technology

Housekeeping, maintenance, security

Medical receptionists

Medical secretaries, transcriptionists

Medical records

Other administrative support

Nurses
Medical assistants
Clinical laboratory
Radiology and imaging
Other medical support service
Total contracted support staff

Total RVU/physician

Physician work RVU/physician

Patients/physician

Total procedures/physician

Square foot/physician

Charges and Revenue (per FTE physician or as % of total medical revenue)

Net fee-for-service revenue

Gross FFS charges
Adjustments to FFS charges
Adjusted FFS charges
Bad debt due to FFS activity

Net capitation revenue

Gross capitation charges
Capitation revenue

Net other medical revenue

Gross medical revenue from other activity
Other medical revenue
Revenue from sale of goods/services
Cost of sales

Total gross charges

Total medical revenue

Operating Cost (per FTE physician or as % of total medical revenue)

Total support staff cost/physician

Total employee support staff cost/physician
General administrative
Patient accounting
General accounting
Managed care administrative
Information technology
Housekeeping, maintenance and security
Medical receptionists
Medical secretaries and transcribers
Medical records
Other administrative support
Registered Nurses
Licensed Practical Nurses
Medical assistants/aides
Clinical laboratory
Radiology and imaging
Other medical support services
Total employee staff support services
Total employee support staff benefits
Total contracted support staff

Total general operating cost

Information technology
Medical and surgical supply
Building and occupancy

Furniture and equipment Administrative
supplies and services Professional liability
insurance
Other insurance premiums
Outside professional fees
Promotion and marketing Clinical
laboratory Radiology and
imaging Other ancillary services
Billing purchased services
Management less paid to MSO
Miscellaneous operating cost

Total operating cost

**Provider Cost (per FTE physician or as % of total medical revenue) Total
medical revenue after operating cost**

Total provider cost/physician

Total NPP cost/physician
Non-physician provider compensation Non-
physician provider benefit cost Provider
consultant cost
Total physician cost/physician
Total physician compensation
Total physician benefit cost

**Net Income or Loss (per FTE physician or as % of total medical revenue) Total
cost**

Net non-medical revenue

Non-medical revenue
Financial support for operating cost
Goodwill amortization
Non-medical cost

Net income practice with financial support

Net income practice without financial support

Net income excluding financial support (all practice)

**Assets and Liabilities (per FTE physician or as % of total medical revenue) Total
assets**

Current assets
Non-current assets

Total liabilities

Current liabilities
Non-current liabilities

Working capital

Total net worth

**Charges, Revenues and Cost (per FTE provider) Total
gross charges**

Total medical revenue

Net fee-for-service revenue
Net capitation revenue
Net other medical revenue **Total**

support staff cost/provider Total

**general operating cost Total operating
cost**

Total medical revenue after operating cost

**Total provider cost/provider Total
NPP cost/provider Provider
consultant cost
Total physician cost/provider
Total physician compensation
Total physician benefit cost
Net non-medical revenue
Net income practice with financial support
Net income practice without financial support
Net income excluding financial support (all practice) Total
support staff FTE/physician**

Appendix III. Examples of practice operations and productivity measures¹⁰:

Patient Encounters

New patients
Referral source/patient origin tracking
Encounters per doctor/FTE Encounters per
location/satellite Patient encounters per
provider Encounters per hour
Encounters per procedure
Patient base per provider
Scheduled patient hours per provider week
Number of new patients per year per provider

CPT Analysis

E&M code frequency/distribution
Procedures as percentage of charges CPT
procedural code frequency Accuracy of CPT
coding
Accuracy of E&M coding

Operational Assessments

Earliest available comprehensive examination
Earliest available routine appointment
Patient time in waiting room
Patient arrival to exit time
Patient time on hold on telephone Rate
of patient turnover Examination rooms
per provider Procedure rooms per
provider

Staff Performance

Numbers of calls answered per hour
Number of call backs per hour
Number of appointments made per hour
Numbers of medical records pulled per hour

Managed Care

Fee schedule by CPT code
Payer by CPT code Payer by gross
charges Payer by actual payments
Payer by down-codings
Payer by total accounts receivables Payer by days in accounts
receivables Payer by delays for additional information

Payer by time on telephone for referral management
Payer by time on telephone for pre-authorization of tests
Payer by number of appeals

Appendix IV: Practice Data Reporting Frequency

Daily

- Insurance eligibility verification
- Total schedule patients
- Daily Sheets

Monthly

Billings & Claims Management

- Copayments collected/ Copayments due
- % point-of-service collections/scheduled patient-responsible balances
- # Encounters without claims
- Payments without claims
- Avg days b/w receipt of payment & payment posted
- Unposted Refunds
- Aging Summary Analysis Report
- Charge lag time
- Claims denial %
- Claims successfully appealed vs total rejections
- Avg # unpaid claims resolved by day per collector
- Write Offs
- Contractual allowances

Provider analysis

- Charges, Payments, total encounters & RVU per provider

Staff analysis

- # Telephone calls with message taken/staff
- # appt scheduled vs. available visit
- # Patient Office check-in with registration & verification/staff
- # Patient Inquiries/staff
- Overtime Hours/Salary Expense
- Non-salary expenses

Quarterly

Financial

- Gross Collection Ratio
- Net Collection Ratio
- Individual expenses/total collections
- Average Adjusted Charges/ # business days in last 3 months
- Average Cost per patient
- Lab (Ancillary) expense ratio
- Insurance pre-authorizations/ total required for services rendered

Clinical

- Third next new patient evaluation
- Days to next follow-up visit appt
- Appt no show rate
- Appt "bump" rate
- Canceled appt
- Patient Satisfaction survey
- Avg wait time in reception area

Biannual

Payer Evaluations

- Master Fee Schedule
- Payer Mix
- Charges by Payor

Practice Overall Evaluation

Overhead (expense) ratio

Patient Volume

Physician referrals

Miscellaneous Ratios

Office Square foot/ FTE physician

Administration staff/ FTE physician

Information Technology Cost/ FTE physician

Promotion & marketing/ FTE physician

Coding audit

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