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Lessons For Ophthalmology From Enron

Scores of business and life lessons have emerged from the Enron scandal, many of which can be directly applied to your practice. Here are three:

Lesson One: You've got to know, and understand, the little details, numbers and protocols.

One senior Enron executive officer after another has now been trotted before various congressional committees, mostly to take the 5th Amendment. Most of those few current and former officers who have been bold enough to actually testify have said something to the effect of, "I wasn't involved with those decisions." Or, "I knew generally about that accounting procedure, and it worried me, but I didn't really understand it, and assumed the lawyers and accountants had signed off on it." It's essential that as a practice owner and as a manager you not only have access to the numbers, and the operational details, but that you understand them.

Lesson Two: It's essential to know the big picture.

This was one core Enron failing—or perhaps it was a success, since it kept the party going for just awhile longer. Numerous, now-famous off-balance sheet entities with romantic Star Wars names were used to veil Enron's corporate debt, and mask losses. The average ophthalmic practice owner may look at this and say, "Well, what does that have to do with me?" Interesting you should ask. I've run across a number of very successful doctors with very big Enron-like problems. You see, these doctors have been advised—and it's not bad advice, really—that they should subdivide their practices into various constituent parts to partition risk and shelter assets in the case of an adverse legal judgement. In these settings you typically see a core practice entity that basically owns nothing. It might in turn lease equipment from an equipment company, staff from a staffing company, a building from a real estate company, and so forth. The only problem is that this risk management advice is most often held out by attorneys without the benefit of corresponding accounting advice to unbraid the snarl of financial tracking entanglements that attend this approach.

Lesson Three: Bad enterprise models always fail, it's just a matter of time.

Each week thousands of fresh, new business ideas will noisily spring to life in America, rosy cheeked, fully funded, their CEOs charging hard toward dreams of wild success. In the very same week, about the same number of business will be smothered, voluntarily or otherwise. Obviously, the vast majority of you reading this book are working in enterprises that fall somewhere between these two benchmarks of nascence and demise. The happy truth is that eye care is an extremely difficult business to kill. You have to really, really work hard to go completely out of business as an eye surgeon. That doesn't keep some ophthalmologists from trying, however.

When you first scanned the headlines and saw the Enron news break years ago, you probably thought to yourself, "There's not much for me to learn from this." Think again. Business is business, and all businesses are fragile, living creatures. Somebody has to be their guardian, steward and watchdog. Your wee ophthalmology business, while less fragile than the weakest of Wall Street's wobbling giants, needs your daily care, vigilance and feeding.

2

The First Quarter Blahs

Novelist W. Somerset Maugham once wrote: “Money is like a sixth sense, without which you cannot make a complete use of the other five.” Most ophthalmologists are reminded of this in the first few months of every year. The first-quarter profits in the majority of practices tumble with a slew of seasonal adversities. With the onset of winter, and the departure of snowbirds from northern latitudes, about half of the country’s eye surgeons have a drop in elderly patient volume. (Of course, this is offset in southern practices, where the snowbirds roost.) Snow days can slaughter an entire week of patients in the toughest climates. Physician vacation time is often at a peak in the winter, not only for legal holidays, but for vacations south (for some) and to the ski slopes (for the rest.) Practice costs tick up a notch, with year-end lease escalations, cost of living staff raises, increased utility costs and vendor price hikes. Physician draws from the practice increase to catch up with under-funded tax deposits and holiday vacation spending. Medicare payments slow down as patients try to delay as long as possible the cost of the new year’s deductible. Optical sales are sluggish, as the buying public shakes off their holiday spending hangovers. None of these individual hits are all that traumatic. But taken together, they can shove weak practices over the cliff and nudge even the strongest practices into a short-term deficit. In the last decade, these oscillations into first quarter deficits have been getting just a little worse each year.

3

The Practice Treasury

Most countries have a treasury department, and keep significant reserves—real treasure, as in gold bars—to back their currency and as a store of national wealth. Most corporations of any stature also follow a strict treasury protocol, keeping an appropriate portion of their capital locked up as a reserve against future calamity and future opportunity. In a round-about fashion, mature eye surgery practices have a kind of “treasury.” It’s not gold bars kept in a vault, but the personal wealth of the constituent surgeons. If the practice hits a lull, the doctors can simply forego their salaries for a few months. How much in reserves is enough? This is a complex question, with several inter-connecting parts:

- How fast is the practice growing and what are your profit margins? If profit margins are low, you have less cushion for error or a general economic slide, than if your margins are high.
- How old are you? If you are 40, and have 25 years to recover from a business miscalculation, you don’t need the reserves or caution of a 60-year-old.
- How vulnerable is your retirement portfolio? If you’re nearing retirement age, and financially secure, there’s nothing wrong with taking one last, dicey business fling. The converse is also obviously true.
- How vulnerable is your payer mix? If you have a typical geriatric practice, the majority of your payments are as secure as the U.S. government. If you have an elective LASIK practice in a company town vulnerable to massive layoffs, or depend on a single, large year-to-year capitated contract, your cash flow is far less secure.

As a general guideline, I like to see clients have at least three to six months of overhead expenses readily-accessible. That’s to say, if it costs \$45,000 per month to run your practice—pay staff, rent, utilities, etc., but not your salary—you should have at least \$135,000 to \$270,000 in reserve.

4

Make Vendor Reviews Part of Your Practice’s Annual Spring Cleaning

The typical mid-sized practice writes about 200 checks a month to a wide range of vendors. Over the course of a year, there may have been 500 different parties who sold you their services or

products. You may believe that some of these vendors have an unadjustable steel claw on your practice bank account, but even seemingly expenses may be subject to negotiation.

Here's an easy exercise. Assemble the practice's most senior staff. Get out your checkbook or general ledger. For every vendor fill out the following simple form:

Vendor Name	Cost Per Year	Current Rating (<u>S</u>uperior, <u>A</u>cceptable, <u>P</u>robatinary or <u>T</u>erminable)	Our Ability to Eliminate or Substitute	Agreed Action
<i>Mike's Office Cleaning Service</i>	<i>\$6000</i>	<i>Superior—always exceed our expectations, and no rate increase in 5 years</i>	<i>Lot's of options, but no need to replace</i>	<i>Letter of thanks for another great year of service</i>
<i>First Federal Bank & Loan</i>	<i>\$800</i>	<i>Terminable—refused to increase our credit line, and lots of statement errors</i>	<i>Three other banks available within one mile; all have agreed to waive account fees</i>	<i>Interview branch managers and change banks by July 1st</i>
<i>McLauren Advertising</i>	<i>\$225000</i>	<i>Acceptable—This vendor is sufficient for our immediate needs, but may not have the creativity if we expand our LASIK program</i>	<i>The best ad agency in town is already serving our competitor; we've gotten too big for most freelancers; the next step may be to create an in- house department</i>	<i>Meet with our account executive and tell them we're expecting more this year or we will commence a formal agency review in the 4th quarter; review bills closely.</i>

5

Cost Containment Pearls

Here are some cost-containment or service enhancement opportunities you may have overlooked. It's a useful list to bring out from time to time to remind you to work more effectively with your vendors.

- Ask companies with a discount policy for prompt payment (eg: 2% off for payment within 10 days) to extend that same discount if you pay at the 30-day mark.
- Ask your cleaning service what discount they would provide if you had each staff member take a moment to bag their own paper waste at the end of the day, or if they cleaned the office just three times a week instead of five times during the slow winter months.
- Ask ongoing, reliable vendors (eg: radio stations you advertise on and similar small, flexible businesses) if they can provide you with an additional discount for a longer-term contract, or for pre-paying for a year of service. If your practice has sufficient cash or borrowing power, at current interest rates, a 10-15% discount for pre-payment may be strongly in your favor.
- Ask the painter what discount they could provide on the total job if they not only painted the office, but the homes of five staff members and doctors who have been wanting to redecorate their residences.
- Ask your optical frame vendors what further discount you would enjoy if you bought just four frame lines instead of the current 12, and could push more business to a smaller number of companies.

- Ask your techs if some of them would be willing to job-share and take 15 hours of work off each week during the slowest times of the year.
- Ask your staff if they would be willing to launder their own uniforms, saving \$3500 in cleaning service fees each year.
- Ask you patients if they would be willing to use the office's courtesy telephone to call their own insurance company for approvals, or to call for a taxi cab at the end of an appointment, thus saving the practice valuable staff time.
- If you have a fallback position, ask the director of the open access LASIK center you use if you can perform your low number of cases at their "high volume discount rate," thus preserving their relationship with you.
- If you use a hospital's outpatient department to perform cataract surgery, ask the PR department to help you with a publicity project for free, saving you the cost of hiring a local freelance publicist.
- If you haven't checked your carrier's long-distance phone rates against the competition in the last year, check them now—they're still falling like a rock. At the very least, ask your current carrier if they have a less-costly plan for a customer like you.
- Ask the sandwich shop that caters your staff lunch every week if they can throw in dessert for free since you're such a great customer.
- Ask your local postmaster if there's a less costly (or less time-consuming) way you could be mailing out your present volume of patient statements than with a first class stamp.
- Ask your doctors if they could be a little less wordy in their dictation to save transcription costs.
- Ask yourself if you really need to send eight staff members across the country to a meeting, or could the same training goal be accomplished by sending the most deserving two staff members, and having them be the in-house trainers for the other six.
- Ask yourself if an off-the-shelf accounting software package and three extra hours a month of your office manager's time could eliminate half of the \$8000 annual bill you get from your accountant...and get you more timely financial reports in the bargain.
- Ask if annual dues paid to umpteen local, state and national professional societies is still necessary at this point in your life, or do you no longer have a need to pad your CV?

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Should I Become or Remain a LASIK Surgeon?

For every economically viable refractive surgeon, experience shows there are several LASIK providers who have no real economic driver to remain in this subspecialty, even if they do love this area of care as an interesting sidelight of their practice. Here's a typical call I receive from such lower-volume surgeons: "I got into Lasik with everyone else, thinking that the pasture was greener on the far side of the cataract fence. I was wrong. After nearly a million dollars invested over the last three years, I still just do 15 cases a month. Meanwhile, the other local ophthalmologists—who stuck with senior eye care and left refractive surgery to me—have cut my cataract numbers in half...All while I've been distracted. I need help getting back to cataracts. That's where the grass is definitely greener." In truth, aside from the highest-volume LASIK surgeons, the cataract pasture has probably been the greenest all along...at least if you see your practice as a long-term, annuity enterprise, with the value of a patient being counted as revenue and profits over decade-long spans of time. With current economics, Lasik doesn't even stack up all that favorably against traditional contact lens and spectacle correction, and ongoing care. Here's an extremely simple comparison. At typical \$1800 average per-eye fees, and today's realistic marketing, technology and general overhead costs, the net profit from a bilateral Lasik case is about \$750. And while that patient may be a raving fan for the first few months, chances

are good they will not be an ongoing patient, and alumni referral will taper significantly in the following years. By comparison, a myopic patient kept in the practice for 10 years and treated non-surgically may yield as much as much or more in net profits, and be responsible for generating considerably more derivative referrals. I'm not making an argument for abandoning your low-volume LASIK practice if you relish this dimension of practice, but want you to realize that the profitability of this sub-specialty has shouldered off by lower fees, rising competition, and elevated technology costs. The considerable exposure to spurious malpractice lawsuits only tilts the arrow to "No" unless you are fully committed.

7

Check Your Bank Statements For Daily Deposit Postings

Here's a simple cross-check to make sure that funds coming into the practice are being rapidly deposited. Pull out your most recent monthly bank account statement. Go to the deposits section. In a large clinic, you should be bank deposits being made daily. In smaller practices, you should have at least a deposit every other day. It's not unusual to examine the bank statements of otherwise well-run practices and see just one large deposit every week or two. This hold-up in cash flow is easy to overcome—simply establish rules for how often you run to the bank.

8

What's an Appropriate Line of Credit?

A line of credit is a pre-negotiated credit facility signed with your bank to provide working and other capital for foreseen needs. Think of it as another kind of insurance policy, which should be "taken out" in the context of your practice's unique needs, and the other kind of conventional insurance you already have. You obviously don't need a line of credit if you are independently wealthy and don't mind putting your own capital into the business. You may also not need a line of credit if you have a small practice and lots of business continuation insurance (in the event of your temporary disability) or have an extremely large practice, with many hands covering the monthly bills in case your personal production is knocked out for a time. But for the average practice, to get through times of normal stress (payer hiccups, unexpected absences from the practice, expected bubbles of expenditure on new projects), it's appropriate to negotiate one or more lines of credit equaling not less than three-month's expenses. Obviously, like a home equity loan on your house, this should be negotiated well before you need it, tapped sparingly, and used only when other resources are unavailable.

9

Aging Report Accuracy

Aging, or "aged trial balance" (ATB) reports should be run based on the date of service, not the date of charge posting. A billing department that generates the latter kind of ATB report unwittingly makes it appear that cash flow is better than it actually is. Also, in many systems, refiling a claim will set the aging clock back. We've been to offices where the billing managers (with some guile) have rigged the reports so that the office appears to be very current in its accounts receivable management. You'll never know about how polished your billing department is until you ask the right question: "Do you age by date of service or charge posting?"

10

An Annual Amnesty Program

When a patient owes the doctor a little bit of money, the patient is in trouble—when the patient owes a lot of money, it's the doctor who's in trouble. The pearl that follows may not sit right with

every practice, but it may be helpful in your setting. Some clinics have a soft heart, and as a result, every year they gather patients who still haven't paid their bills despite multiple demand letters, and they have not yet sent these patients to collections (which they probably should have much earlier.) Before sending these patients to collections (or in lieu of that if you're really a softie) you can send a last letter out describing that if patients in arrears pay just X% of their bill by December 31st, the balance of their bill will be waived in the spirit of the holiday season.

11

Should We Add Cosmetic Surgery?

On the face of it, intuitively, providing cosmetic surgery should be a great way to augment cash flow for a practice. Experience shows it's very difficult for the typical ophthalmologist to add elective plastic surgery to his practice, for a variety of reasons. First and foremost, most surgeons are uncomfortable being as "pushy" as it takes to help a patient who has come in to see better understand that there are other services that you provide. Vision care deals largely with *objective*, measurable improvements. Both the doctor and the patient are convinced that there's been a great operative outcome. Cosmetic surgery depends on the patient's *subjective* impression that the operation has been a success. If you are not currently providing cosmetic surgery and think you might be good at the promotional aspects, start first with botox injections. The barrier to entry is low, and you'll learn quickly if you can deal with three patients a morning who say, "I think we're a-l-m-o-s-t there...could we try some more?"

12

Examine Your Cataract Operative Criteria

Pull up charts of the last few dozen cataract surgeries you've performed. Write down the best-corrected pre-operative visual acuity for each eye. Now average the resulting numbers, omitting the eyes that are 20/400 or worse. If you're an aggressive surgeon, your average figure may come out somewhere in the 20/50-20/60 range. If you're much more conservative, your average figure may fall well over 20/70. Obviously, the cash flow and profits of cataract surgeons with the lower average number is going to be more favorable...to a point. Get too aggressive, and you may one day find yourself working backwards in the cash flow department, refunding fees and more to payers for unnecessary surgery. If you feel you're too conservative, due to practice stage or skill deficits, it may be time to link up with a more accomplished surgeon for the benefit of both your patients and your pocketbook.

13

Prepare For the Cash Flow Consequences of Any Proposed Action Before You Act

If such analysis indicates you may be treading financial water for awhile, you must assure in advance your access to any needed capital. Here's a common example. A two-surgeon practice hires a new subspecialist. There are immediate costs for marketing, equipment and generally setting up a new nest for the doctor. Then problems hit. There's a clerical snafu or a holdup in securing a Medicare provider number. Or credentialing for managed care contracts is slow in coming. In situations like this, especially in a low profit margin practice, carrying a new associate can make it hard to make payroll for the existing doctors. The time to go to your banker to negotiate a bridge loan or line of credit is before you need the money.

14

What's an Accretive Decision?

Every practice initiative should, within an acceptable timeframe, be accretive to the net earnings of every owner. That's just a fancy way of saying that your business decisions should be made with the aim of eventually resulting in more profit per hour per owner doctor. Let's take an example. In a five-surgeon practice, Dr. Smith's pod is going to be built out with two more exam rooms at a cost of \$75,000, charged evenly to the partnership. On the face of it, seems like Smith is getting a great deal and his partners are hosed, right? Wrong. If in the next year, Dr. Smith uses these rooms to produce another \$300,000 in collections, both Smith and his partners will get a pay raise; Smith gets the money directly as a producer, of course, but he and his partners also get an indirect benefit by having more of their fixed overhead covered. Following this rule doesn't promise that every doctor will get an *equal* benefit from every development decision, but that every doctor will be better off at the end of the day.

15

Remember: Healthcare is a Local Business.

Don't over-extend your supply lines to distant operations unless you have abundant capital and proven operational competence. For most surgeons, staking out satellite operations more than 25 miles away without planting a homeroom doctor in the subject market is becoming a very diseconomic business model as fees continue to erode and practice costs continue to rise. Try to have the discipline to keep remembering that success should be measured in profit per surgeon-hour (including travel time), not cases per month.

16

It's Not Case Volumes But Profits That Count

Many surgeons with the highest case volumes aren't taking home the largest pay checks. And while they may be among the most driven doctors, they certainly aren't always the happiest. By the time you back out optometric comanagement fees and the marketing costs needed to drive a top-tier practice, the annual income hero in your town may be someone you least suspect, especially when calculated on a profit-per-hour basis.

17

Filling the Seats

Here's a great pearl for doctors who still can't quite seem to get their staff to fully book out the appointment template—they have patients booked out a month, but tomorrow's calendar has 48 slots and only 43 are filled. It's deceptively simple. For every day that the template is filled 100% with appointments (before no-shows peel this back) every staff member (in a small office) or selected staff (in a larger practice) get a \$5-10 bonus. That may seem excessive. But do the math. Let's say it's a small 12-staff office. Five patients are gained in this case. The average ticket might be \$150. That's \$750. And almost all of it is profit, since it's incremental revenue and generates no additional fixed overhead. The cost? Twelve staff times let's say \$8...just \$96. And the resulting morale boost is worth the cost alone. Doing this is probably the only way in the world you'll ever have techs going to the front desk and pestering your clerks in the afternoon, saying, "Are you sure we can't a few more patients on the schedule for the morning?"

18

Choices Enhance Profits

Mediocre administrators will give their managers or their boards ultimatums: "We must do this!" Exceptional managers give the people they supervise, and those to whom they are subordinate,

two or more equally acceptable alternatives: “I’ve brought three alternate plans for us to consider today. I believe that any one of these that you choose can solve the problem we’ve been wrestling. If, as a manager, you force yourself to come up with at least two or three viable solutions to problems that land on your desk, chances are you’ll at least double the odds of finding the best and most profitable solution.

19

Health Insurance Factsheets

Patients show up at the front desk daily with questions about their insurance. They’re often confused about what benefits they enjoy and the process they must undergo to take full advantage of these benefits. Like as not, they blame you and your practice for oversights or coverage gaps, instead of their carriers. It all takes a toll on staff time, efficiency and morale. Here’s a partial solution. Make up simple fact sheets on the most common payers in your service area, and perhaps one generic sheet to cover all the rest. Taking pains in writing to explain what co-pays and deductibles and refraction fees are all about will have several positive benefits. It will educate patients and hopefully make them a little more understanding of your role. It increases consistency and reduces the chance that an uninformed staffer will misguide a patient. It will save staff time and hassle factor—they can handle the more elaborate or customized questions. And it will likely lead to less resistance to cover their patient-responsible amounts at checkout.

20

Great Billing Advice May Be Just Down the Street

One of the least expensive and most effective sources for help with billing problems are staff in regional eye care practices just like yours. You and Dr. Jones may compete vigorously, and it would not be likely to find your marketing departments collaborating—but it’s very useful to develop relationships between patient accounts departments. It may even be helpful to formalize this with periodic group meetings to share ideas related to local carrier challenges. It’s especially useful if you can network with practices that have your same computer system. One caveat, however. Just because Mary Jane from the neighboring practice says that something is correct, does not necessarily make it so. The higher the stakes, the more you should cross-check multiple sources.

21

Computer Conversion Tip

When making a conversion to a new computer system, it’s intelligent to keep the old system up and running...and not just to collect old accounts. Run a few trial electronic claims on the new system first. Work out the bugs. Depending on your vendor selection, these may be minimal, and you can immediately plow ahead after the test runs and leave the old system far behind. But on the off chance that you have major conversion difficulties, this backup could save a lot of headaches. This may seem like common sense advice, but many practices have ditched their old systems before their new system was properly tested and had to scramble instead of solving their conversion problems in leisure. Remember, it’s not your computer...it’s your cash flow.

22

It’s Not “Worth” if Its Not Put to “Work”

Billing and coding consulting firms take pains to research your practice’s patterns, and write up their findings. But as the Chinese proverb says, “To know, and not to do, is not to know.” Make sure that such reports don’t just sit on the administrator’s desk, but that the principle findings get

shared with all relevant parties on a need-to-know basis. Note that sometime the contents of these reports is highly sensitive, so the entire report should not simply be parsed around to all hands. However, make sure that any reasonable suggestions for policy changes are the basis for re-writing your protocols, and scheduling appropriate auditing and training sessions.

23

“Do We Have ALL of Your Insurance Information?”

A significant amount of re-work is done in every insurance department, chasing down blind alleys for payment. You can eliminate some of this by making sure that the front desk always inquires of patients about their co-payer status, makes copies of all insurance card changes. It’s frustrating to bill the incorrect secondary payer, and then have to start all over again with a new payer. This points out, once again, the value of having the patient accounts and front desk staff under a single department head, so that problems in one area can be smoothly resolved in a contributing area.

24

Inspect What You Expect

It makes anyone nervous to have a supervisor hovering around ready to pounce on errors. That’s why it’s not only more effective, but more humane, to let your staff know—in writing—what kind of performance you’re expecting. Make it clear that charges for the day’s services should be posted by the end of the same service day, or by noon the following day, or whatever your policy calls out. It’s not fair to hold people accountable for occult policies and procedures. Write it down...train to what’s written...then inspect at will.

25

Are You a Fast or Slow Technology Adopter?

Every practice likes to think of itself as leading edge, up on the latest knowledge and at the ready to provide the latest services to patients, right? Well, like every other part of your practice, it’s a question of balance. Unless you work in a setting supported by unlimited grant monies, you have to pick and choose as new technologies and techniques arrive. Too liberal a policy, and you could spend hundreds of thousands of dollars a year on gadgets, many with doubtful clinical application or financial rationale in your setting. We’ve seen practices (an increasing number, unfortunately) sink under the weight of too rapid an adoption curve. But the opposite, using the same old rattle-trap equipment year after year, is just as damaging to a practice, and to the quality of patient care. Ask yourself and trusted colleagues, “Are we too fast, too slow, or just right in our technology adoption pace?” In general, most ophthalmologists are weighted toward the former, and their administrators have to put their foot down around the time of the national meetings.

26

It’s Not Your Phone, It’s Your Business

In the voicemail world we’ve all gritted our teeth and become accustomed to, and with rising staff costs, it’s not unusual for practices succumb to the cash flow trap of having a skeleton phone staff and resorting to messages on hold for callers. Don’t do it. Ophthalmology is best and most profitably performed with as much of the human touch as possible. For example, resorting to the false economy of automated appointment reminder calls is similarly ineffective. Our experience in the field is that practices using automated calling for appointment reminders have their no-show rates increase 50% to 100%. Norms are a 5% no-show rate in most general/suburban practices. In a practice seeing 50 patients a day, that’s two or three patients a day. The loss of an

extra two or three patients, by using a computer rather than even a very junior clerk to call, results in a +/- \$350 in lost revenue for the day. A clerk can rescue this by getting the calling job done in an 60-80 minutes at a cost about \$20, including phone charges and floor space. Not a bad return on investment.

27

Read Provider Contracts Before Signing... Then Keep Checking

Don't assume you have to accept every contract that comes across your desk just as it's written. If you have any kind of negotiating position (you don't really need the patients, the payment level is borderline, or the payer is notoriously late in paying) consider coming back with suggested changes to speed or increase payments, or reduce paperwork. And do make sure, to the extent possible, that every contract has a fee schedule attached, even if this can be changed at a whim by most payers. Periodically, ask for updated fee schedules and compare your actual payments per the EOB with this fee schedule to assure that you are still being paid per the contracted allowable.

28

Spread Payables Duties Around to Ward Off Diversion

It's not unusual, especially in smaller practices, to have one office manager or bookkeeper review vendor invoices, write the checks (even sign or stamp them!), prepare the general ledger and profit and loss statements, and *also* reconcile the bank statements each month. This clearly leaves open many opportunities for embezzlement. A doctor (the same one each month for consistency) should sign all checks above trivial amounts (let's say \$250-500) which can be signed by the office manager. Checks ready for signature should be attached to the relevant invoice, and the purchase agent or other person who can verify the bill should have signed off the invoice. The monthly general ledger (showing all checks as a separate line item, arranged according to your chart of account...e.g. "utilities") should be reviewed by the doctor/s. Any unusual-sounding vendors should be asked about. Reconciliation of the bank statement to the general ledger should typically be performed by the practice's outside accountant, as another safeguard against diversion.

29

When Should I Pay This Bill?

The answer is, "It depends." You should certainly pay it no earlier than it is due. And you may want to stretch out payment as long as possible if your practice is in a cash flow bind (as increasingly happens in the first quarter of the year, even in well-run practices.) On the other hand, you want to secure every possible discount by paying early. Any "2% net 10 day" accounts (where you subtract 2% from the bill for paying early) should obviously be paid within the 10-day window.

30

Aging Your Payables

We're all familiar with the concept of aging your receivables to have some sense of where the practice stands on collecting outstanding accounts. It's much less common in a service sector business like ophthalmology, where most trade payables are paid within 10-45 days, to age your payables. But this is exactly what you should start doing if and when you find yourself in any financial tight spot, to the point of having to start stretching out vendor payments. Don't be like the administrator who hid a sheaf of invoices from her doctor just to make the books look good and hit her bonus figure.

31

Should My Practice Be Audited By Our Accountant?

Periodic deep or even shallow auditing of the practice's books by an outside accountant is an often-overlooked area of good practice management hygiene. This need not include the full green eye shades treatment, but just a half day snooping around once or twice a year. The key value that emerges from this review is physician peace of mind. The secondary gains include a) staff know that someone will be looking over their shoulders periodically, so their work tends to be a bit neater and any thoughts of larceny are dampened, and b) as you grow, your accountant—by orbiting more closely—will be in a position to suggest improvements in funds flow through the organization.

32

Every Financial Tool Should Agree

Your practice has a number of financial tools to measure volume performance, collections and cash flow. You likely have an appointment module and can cross-correlate this to any missing fee slips/superbills for the day, which should in turn tie to posted charges and patient-responsible amounts received on that day, charges, collections, bank statements (and their reconciliation)...all of which should eventually tie with the profit and loss statement for the practice and its various operating segments. These various tools should be closed out at the same time, to the extent possible, and be in agreement. Only a minority of practices actually tie their disparate financial reports together in this fashion. Those that do can better spot sloppy entries and inappropriate write-offs.

33

Track the Volatility of Your Average Collections, Average Charges and Other Graphs

You may not pay particular attention to the financial details, but you can at least grossly monitor the stability of your practice's financial pulse by graphing each month, or 24 months or more, the monthly collections and charges divided by the number of patient visits. Obviously, the average charge per patient will be more stable than the average collections per patient visit because in the latter case, you are collecting for services rendered 30 to 60 days or longer ago. However, any excess swings and volatility in these graphs that are not explained by similar wide swings in vacation time are warning signs that can be tracked down to their source.

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“Payer, May I?”

It's a very complex variation on the children's game, “Mother may I,” that managed care payers play with doctors and their staff. Lack of referral and treatment authorization leads to untracked millions of dollars in lost fees to ophthalmologists annually. In the hum and flow of the typical urban practice, it's not practical, nor expected that you will win the game 100% of the time. Just like back in kindergarten, you are going to lose concentration and slip up on occasion. The best remedy is to have sufficient staff and sufficient training to be able to cover the best efforts of payers to not pay (which is of course the way that *they* win the game.) Like any game, you need to have and study a copy of the rules. You need to make sure that all the players know the rules. And every time you lose the game by slipping up, you need to huddle with the rest of the players on your team know how many points you've just lost and run through the ways this can be prevented in the future. That's the generic advice, at least. Obviously, the regional variations on

this frustrating game is something you simply have to learn by experience in your own setting. When in doubt, always check. Create a grid by payer, memorized by all staff and doctors, showing what services are allowed by what providers in your practice, after what pre-authorization steps are taken. Always be suspicious with payers you don't serve often. And along the way, be sure to keep the patient (the unfortunate pawn in this game) as educated as possible. Unfortunately, unless otherwise informed, they are going to blame you, not their carrier, for any limitations on their access to your services.

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Did This Test Really Happen?

Biometry, visual field and similar testing equipment that print out results should be checked periodically to make sure that the printed reports reflect the correct date. Failure to show the correct date, in the event of an audit, could lead to some embarrassing explanations as to why the chart date conflicts with the print-out date. Add this to your monthly or weekly checklist in the office.

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Are you Sure?

A similar "picky, picky detail" problem can occur with special tests that require followup reporting or interpretation by the ordering doctor. If this reporting is absent from the chart, then the relevant service cannot be billed. Develop a protocol in your office to make sure that all special testing has been subsequently interpreted. This can be done by comparing the written log for the special testing equipment (or the patient accounts print-out) with the contents of each subject chart. If periodic audits show you are following up 100% of the time, you can reduce the audit frequency. If your practice has an intractable problem with this, it may help to establish a routine where all special testing printout destined for interpretation are clipped or stapled to the front of the chart, and not filed away until the interpretation is completed.

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More Detail Work to Catch Billing Gaps

It's quite easy, in the heat of battle, to forget to document special testing or treatment on the superbill. Here are a couple of quick cross-audits. First, the number of A-scans should be roughly the same as the number of cataract surgeries in any one month. Second, every unit of testing and treatment equipment should have a use log showing date, patient name and appropriate utilization records. If you compare the gross number of yag lasers on the log for last month, with the number of yags charged out in the same timeframe, the numbers should match exactly.

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Getting Paid For a Needed Patient Service

On what portion of your cataract surgical patients do you perform intraoperative or postoperative relaxing incisions? Although new lens materials and smaller incisions have markedly reduced induced astigmatism, a small percent of patients go to cataract surgery with innate astigmatism, the correction of which will not be reimbursed by Medicare. You can approach such patients with the option of performing limbal relaxing incisions at a typical cost of about \$300 per eye.

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Differential Collection Ratios as a Marker for Billing Snafus

In a multi-physician practice, it may be very revealing to look at the collection ratio by doctor. Of course, there will be an expected variance based on practice patterns and patient mix. Pediatric ophthalmologists and Lasik surgeons in the same practice will have markedly different ratios for obvious reasons. But for two general ophthalmologists/cataract surgeons in the same practice, the collection ratio should be essentially the same. When it's not, look for both the obvious and the subtle disparities. Is one doctor the sole contractor for a low-paying contract? Or does one doctor's behaviors (like hoarding charts after surgery and not dictating or coding the case for several weeks) explain the difference. One source of this kind of problem that we've seen is when the patient accounts team gives the senior doctor's accounts the VIP treatment because he signs their checks, and pays less attention to the open accounts of junior doctors. Harness the natural competitive feelings within a practice to optimize everyone's revenue yield.

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Options to 100% ASC

Development and Ownership

What should you do if you don't have the necessary cataract case volumes or risk tolerance or management coverage to develop your own surgery center? There are basically three options:

1. You can join in the syndication of a group ASC. This may be an ophthalmic-only center, or a multi-specialty center. Your costs and risks will be much lower, but keep in mind that your returns are likely to be lower, too, in percentile terms...especially with a multi-specialty center. Such facilities typically have only a 15-25% profit margin compared with dedicated eye ASCs at 35+%.
2. You can turn to a development/management company such as NovaMed or AmSurg to carry the ball. This allows you to own (and be responsible for) half or less of a facility, and may help to diffuse difficult local politics of bringing other partners into the deal.
3. You can rent facilities and staff by the day from an appropriate local facility, and have the benefits of your own private space, but with no investment outlays or capital at risk. This approach can be a potential bridge to developing your own dedicated facility (when your numbers slowly rise)...there is no non-compete agreement in place, as there would be with options 1 and 2.

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Basic Capitation

Contract Caveats

As this book goes to press, capitation contracting continues to wane for ophthalmology and for Medicare beneficiaries. Strong pockets of pre-paid care continue to hold on in selected markets, and one can forecast that with health costs continuing to escalate at a double-digit pace, some HMO-like products will find their way back onto the market and into your billing office. Here are some very basic issues and warnings related to such contracts:

- Look carefully before leaping...what may seem like a great way to trump the competition may end up leaving them time and the inclination to redouble efforts to get higher-paying patients.
- Review the covered services in the contract. Especially check to see if you will be responsible for subspecialty care. If so, and you don't have in-house subspecialists, the cost of such care with outside providers will be subtracted from your payments. This is an easy way to "blow your cap." Try, in most cases, to have outside subspecialty care paid for by the HMO directly.
- What starts as incremental income for your practice, for selling unused incremental time, can turn into major time commitments that edge out better-paying patients. Make sure that any one contract (except Medicare) never exceeds 15-25% of your total collections.

- It is typical for HMOs to withhold 10-20% of the capitation fee to cover any losses due to over-utilization. In evaluating your go/no-go with a potential contract, base your decision on the least amount are assured of receiving, not the most. You must also review the contract closely to assure that you will not be obliged to cover any over-utilization losses that exceed the withheld amounts.
- Beware of accepting pre-paid contracts for small beneficiary pools. The actuarial statistics work for large pools, but break down with smaller groups of patients.
- Negotiate, if you can, capitation payment increases indexed to any increases in premiums charged by the HMO to employers.
- Capitation payments are made monthly, accompanied by a statement showing the number of beneficiaries. Watch this statement for adverse trends, especially any trends that reduces the beneficiary pool down to a size that invades the actuarial soundness of your capitation payment. Negotiate in advance if possible to be guaranteed a minimum number of assigned patients.
- Medicare cap rates are obviously higher—often 4-6+ times higher—than cap rates for commercial-aged patients due to the much higher utilization rates of older patients.
- Remember that accepting your first capitation contract in a group practice obliges a close review of the compensation model. Compensation directly based on utilization (RVUS, visits, surgeries) will cause doctors to increase their utilization (in order to get a larger share of the cap fee pie), which decreases the profit per unit of service rendered. It's more rational to divide capitation fees based on assigned patients, so that each doctor's incentives (to not over-treat) are aligned with the HMOs payment methodology.

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Are Multiple Fee Schedules Allowed?

If you are a typical ophthalmic practice, most of your revenue comes from Medicare. Maintaining just one fee schedule for all payers generally works well. Keep your total fees about 20% to 30% above allowable Medicare rates, but be sure that you match or exceed the fees paid by any commercial payers. If you are receiving from Medicare 100% of any of your charged fees, it may mean that Medicare's allowable fee is higher than your charge. Fee reviews should be annual to make sure you're keeping up with changes. Keep in mind that patients see your fee on their explanation of benefits statement, and may misperceive your high fee as an attempt to overcharge Medicare. To avoid this, and to avoid large write-offs and an inflated A/R, some practices will have two fee schedules: one for Medicare and one for all other carriers.

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Documentation Basics

The following is a basic checklist, abstracted from a Medicare carrier newsletter. Compare this list to documentation standards in your own practice:

- Medicare expects documentation to be generated at the time of service or shortly thereafter
- Delayed entries (within 24-48 hours) are permitted for clarification, error correction, or the addition of data not initially available
- The medical record cannot be altered. Corrections must be lined out legibly, dated and initialed.
- Delayed written explanations cannot be used to retrospectively support services billed or their medical necessity.
- All entries must be legible to another reader to a degree that a meaningful review can be conducted.

- All notes should be dated, preferably timed, and signed by the author; initials are acceptable in an office setting where the author can be easily identified by initials. If the initials or signature are not legible, a printed version should also be recorded.

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When Should You Collect Co-Pays and Deductibles?

Each office I go to has strong opinions about when co-payments, deductibles, refraction fees and any other patient responsible amounts should be collected. Most of this conforms with local custom, the experience of each practice and the policy to which your patients have been habituated. The most aggressive practices, especially those in rural southeastern markets where “tricking the doctor” seems to be a community pastime, office managers get the money up front as often as they can...before the patient is allowed to see the doctor. Any past-due amounts from prior visits are also collected with a vengeance. This may seem mercenary, but really is indicated in some settings. At the other, ‘Yankee’ end of the spectrum, there are practices that collect nothing at the time of service. Zip. They end up having to chase after patients with three letters and a phone call for a \$10 co-pay. In the average setting, both of these extremes are skipped in favor of payment at the time of checkout.

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Refraction Fee Trends

It’s not that long ago that only a minority of practices charged a refraction fee, or what they charged was more of a nuisance fee than a reasonable exchange for the value conveyed to the patient. Recently, that has changed. The typical refraction fees we see now are in the \$20-35 range, and a few bold practices are charging in excess of \$40. The highest-priced practices report, somewhat cynically, perhaps, “Whoever is going to complain about a refraction fee is going to complain, no matter what we charge...so we decided to charge a premium, which offsets fee cuts a bit, pays us a fee that induces us to provide a superior level of care, compensates us for the tongue-lashing we get from a very small number of patients. No one else seems to mind”

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Give Yourself As Many Second Chances As Possible

Most practices and most surgeons really don’t try very hard to *make the sale*. The gentility of the average surgeon (and by abstraction, their management team) is not in synch with the increasingly difficult cash flow environment we’re in today. Here are just some examples:

- Practices that let patients walk their glasses prescriptions out the door without making a follow-up call to learn why the patient didn’t buy glasses in their dispensary, and to offer them a 30-day coupon for \$25 dollars off to prove that you do the best job in town.
- Practices that send out information to prospective LASIK patients without then making a series of follow-up calls to ask the patient to take the next step and have a consultation.
- Surgeons who send patients home with a pat on the shoulder, saying, “Well Mrs. Arnold, you think about that cataract surgery and call me if you have any follow-up questions”...instead of saying, “Well Mrs. Arnold, you think about that cataract surgery and in about a week I’ll have my chief medical assistant Mary give you a call to answer any followup questions. Meanwhile, here’s a free videocassette on cataract surgery you can share with your husband and daughter.”

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Aging Report Pearls

The standard vanilla-flavored aging report lumps all payers together and only has aging buckets for current, 30, 60, 90 and 120+ day accounts. Consider generating your reports by carrier so you can spot adverse trends associated with slow payers. Also, if your computer allows, consider expanding the buckets to allow 121-160 day and 161 and over categories. As a doctor-owner, or administrator, you should meet with your patient accounts staff monthly. Ask about the status of individual patient line items. If your staff can recite from rote (or at least from their notation fields) the status of high-balance/older open accounts, you can have some assurance they're on top of the details.

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What is a "New" Patient?

It all depends on what you're using the data for. In the world of practice marketing, a new patient is just what you would expect—a patient who has never been a customer before. However, with respect to reimbursement, Medicare defines a new patient as one who has not received services from you or another doctor of the same specialty within the same group practice within the past three years...which means you can bill for a new patient visit.

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Learn in a Flash

Let's face it. Most patient accounts work is mind-numbingly dull. If marketing is the sizzle of practice management, billing work is little more than scrubbing the frying pan. But it's obviously equally important or more so. So how can we get doctors, techs and others in the practice who need to know coding and reimbursement details cold up to speed? It may help to develop a set of flash cards. These can be specific to the needs of your individual practice, and prepared at a simple or more complex level depending on the skills of your people. You can prepare a basic set for all staff, and more advanced versions for staff who need a higher level of mastery.

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Portable Brains

Of course, no matter how much you study coding and charting and reimbursement, there are going to be dark corners that you never commit to memory, especially if you don't work with billing daily. Consider laminating in plastic one or more cards with a "cheat sheet" of relevant details that can be kept handy in a lab coat pocket, and refreshed periodically.
