ams biweekly report
Applied Management Systems
Dedicated to Excellence in Health Care Management • Trusted in Interim Management

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AMS PRODUCES PHYSICIAN PRODUCTIVITY REPORT CARD

When physicians and clinics need a formal analysis of their productivity, the question always comes up, when is the right time?

Based on AMS recent experience and project commitments, now is the right time. An AMS team of four consultants has conceptualized an approach and developed a three-dimensional strategy to be employed up front with the physicians and clinic leadership. For physician buy-in, this approach includes collaborating on a methodology, effectively communicating throughout the process, and mutually establishing expectations.

The first strategic element is to decide the approach. There are many external data sources that AMS references to look at the provider utilization within the practice in terms of RVU data from organizations such as the Medical Group Management Association (MGMA). This data coupled with AMS proprietary Paid Hours Per Visit (PHPV) benchmark data for the clinical and clerical support staff, yields a 360 degree analysis leaving no stone unturned. When developing the methodology, AMS expertise in this area becomes apparent with the consideration of hours spent by providers and staff with EHR documentation, patient health maintenance follow up, and workload associated with the "virtual patient" or those inquiries coming into the practice via the patient portal.

The second strategic element is communication. Since the physicians are not often familiar with comparing their own performance to. comparative data, AMS is able to walk through this sensitively but knowlegably to communicate the results through a graphical presentation in a simple "A-B-C" process, with grade A being the number of providers achieving and exceeding the 90th percentile. AMS also accounts for part time providers by converting them to full time equivalants to normalize the comparison.

The third strategic element is to mutually establish expectations. This includes having AMS frame what the data says into process improvement recommendations so that providers understand how change correlates with improved productivity. For example, a recommendation to develop a physician champion role to guide peer physicians on data interpretation. This overview of the AMS approach is just a snapshot of how we can assist practices improving operations. For more detail, contact Shari Robbins, Vice President, at srobbins@aboutams.com or Tom Souliotis, Vice President, at tsouliotis@aboutams.com.

FDA Approval Will Increase Home Health Productivity

Back in the day, Home Health was almost always through the Visiting Nurse Association (VNA) and so the traditional label of "visits" were a key factor in the evaluation of productivity and establishment of a benchmark. A visit was defined as a patient encounter, usually in the patient's home, but could include a clinical appointment in another setting. With the advancement of telehealth a decade ago it is common for Home Health to now include an advanced home monitoring service for patients diagnosed with specific medical conditions, along with specific medical devices in the patients' homes. Monitoring and intervention can be done remotely eliminating the need for a visit.

VNA services will continue to be greatly impacted by technological innovations. For example, on Monday, November 13, 2017, the Food and Drug Administration (FDA) approved the first pill with a sensor that can track if patients have swallowed it. Now, a patient takes all their pills including this one, and a technician is alerted if there is an issue. This helps increase productivity, eliminate the need for an on-site home visit and minimize the health care navigator's role with a patient. For more information on Home Health operational diagnostics, contact Pat Abrami, Principal, at pabrami@aboutams.com or Michael Foley, Principal, at mfoley@aboutams.com.

What Family Physicians make in the US and UK

Following up on *"The Changing Demand for the ED"* story in the January 8, 2018 Biweekly that mentioned United Kingdom Mobile Alcohol Recovery Units, we were curious about physician compensation. According to **Modern Healthcare** (December 18, 2017) US family practitioners (GPs) earn an average of $237,369 a year. There are 624,434 physicians in the US, and about one-third are general practitioners who would have a payout of $489 billion in the last year according to the Agency for Healthcare Research and Quality (AHRQ).

There are 55,000 full and part time general practitioner physicians in UK's National Health Service (34,014 FTE GPs in 2016). According to **The Times (**December 29, 2017, issue 72,418) who filed a Freedom of Information request to obtain salary data, the average GP makes $119,000 and that salary has been falling since 2010. The top salaries went to only 200 of that 34,000 with 193 general practitioner physicians paid between $275,000 and $400,000 a year, and 7 more earning up to a million. Big picture, the NHS paid $11.75 billion to 7,763 GP practices last year.

Again-Information on Massachusetts Payment Integrity Compliance Reviews

The printed version of the last Biweekly referred to an insert on conducting payment audits and compliance reviews being for "Massachusetts Readers Only." That insert is included again with this Biweekly with the new titles.

MASSACHUSETTS PAYMENT INTEGRITY COMPLIANCE REVIEWS

CHANGES IN BEHAVIORAL HEALTH PAYMENTS

Payment Denial to providers that they were previously compensated –

AMS is aware of the increasing and more stringent audits by third party payers pertinent to behavioral health and reimbursement (Evaluation/Management Codes).

Beacon Health Options (Beacon) published a bulletin on December 17, 2017 with findings from their 2017 "Payment Integrity Compliance Reviews."

- Results of this review were highly negative to providers and included findings from the simple (failure to use black or blue pen) to more complex (lack of documentation, incomplete documentation, documentation spread over multiple entries).
- Beacon temporarily broadened acceptable documentation standards for authentication and duration of services for Massachusetts providers only. Beacon will accept "progress notes, psychotherapy notes (redacted to meet HIPAA requirements), encounter forms, and billing sheets to authenticate the services and to confirm the duration of services reported on claims submissions services" for services provided through December 31, 2017.

AMS thinks this appears to contradict the Federal Register 2007, 72 CFR 66789, which states there are no coding standards for ED facility codes. The regulation, further, states hospitals "should continue using their own internal guidelines to determine the appropriate reporting of different levels of clinic and emergency department visits until formal guidelines are developed."

This temporary accommodation will end on February 1, 2018 and providers will be expected to meet documentation requirements for authentication and duration of services on the progress notes. Extraneous documentation will not be accepted.

AMS has staff members who are very experienced in coding/documentation audits for all health care entities (i.e. hospitals, medical staff offices, clinics, EDs, ambulatory centers) in all aspects (i.e. facility, staff) of Evaluation/Management coding, documenting and auditing for all services including behavioral health. Our "day to day" experience includes "hands-on" coding, management of coding services, denials coding, pre-denial coding (billing departments), teaching coding/documentation requirements to coding/medical staffs, auditing/coding compliance and creating/implementing documentation tools to ensure proper documentation.

There is much more background and information on this that AMS has to share. Contact our HIMC vice presidents Linda Mancini at lmancini@aboutams.com or Jeanne Beando at jbeando@aboutams.com.

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QUALITY, RISK MANAGEMENT HEALTH INFORMATION MANAGEMENT AND COMPLIANCE

NOT JUST INTERIM MANAGEMENT, BUT CHANGE AGENTS

(January 2018) With the Recent Successful Completion of long term assignments in the above areas, AMS has two experienced vice presidents available to help your organization handle the transformational changes needed in health care. AMS interim leadership will provide the expertise to hold people accountable and match resources to their changing workload demand.

A Summary of AMS Capabilities to assist in Interim Leadership and Management-

The AMS approach through interim management is to perform an operational analysis while providing leadership and oversight. Each department has its own individual dynamics and challenges, but in all cases workflow analysis resulted in more efficient processes. In addition, projects were completed ahead of deadline, and staff morale was improved through recognition of accomplishments achieved.

These are recently completed assignments-
-Academic Medical Center and Teaching Hospital (multiple)
-University Health Service
-Community Hospital and Critical Access Hospital
-Behavioral Health Hospital on a two hospital campus

Prior to the above AMS has completed long term assignments-
-Two Hospital System Emerging from Bankruptcy
-Teaching Hospital Being Sold
-Rural Hospital

For more information on AMS capabilities, please contact Alan Goldberg, Principal, at agoldberg@aboutams.com, or Jeanne Beando, Vice President, at jbeando@aboutams.com or Linda Mancini, Vice President, at lmancini@aboutams.com.