

# Your Healthy Practice



Medical practices are continually looking for ways to reduce overhead as they face a steady decline in reimbursement. For most medical practices, staff is the single largest overhead expense.

In addition to wages paid to employees, there are also payroll taxes, insurance premiums, workers' compensation insurance and retirement plan contributions that make up the total personnel expense for the practice.

As part of any analysis of personnel costs, physicians need to ask themselves two very important questions:

- ① Does the practice employ the right number of staff members?
- ② Does the practice pay wages and provide benefits that are competitive in the local market?

The cost of turnover is significant, and turnover is disruptive to the practice, because of the need to recruit and train new team members. So, keeping your current staff happy is vital to running a smooth practice.

Whenever practices have a problem, the usual answer is to hire more staff. More staff isn't necessarily the answer.

Research can help you find out how many full-time equivalent staff members you need to run your practice efficiently. The practice should do a staffing analysis and carefully evaluate the results.

To do the analysis, you need to calculate or obtain the following information:

- ▶ Total patient revenue generated by the practice
- ▶ The number of full-time equivalent (FTE) employees in your practice broken down by job function (number of hours divided by 2,080 hours per year – assuming that 40 hours per week is full-time)
- ▶ The number of FTE physicians and nonphysician providers
- ▶ Total compensation paid to staff
- ▶ Total cost of payroll taxes, benefits and retirement contributions for staff

This information will allow you to determine:

- ▶ Salaries and benefits as a percentage of revenue
- ▶ Number of FTE staff per FTE physician
- ▶ Average total compensation per FTE staff member
- ▶ Average salary per FTE staff member

Medical Group Management Association and many specialty societies have benchmarks by specialty that can tell you if your practice is operating with an appropriate number of staff members

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Nov. / Dec. 2011

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A financial and management bulletin to physicians and medical practices from:

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# 2012 incentive program changes bring some relief

Any day now, the Centers for Medicare & Medicaid Services (CMS) will release its final ruling on the 2012 physician incentive programs.

Providing some needed program flexibility, provisions covering the Electronic Prescribing (eRx) Incentive Program should, for the most part, remain as proposed in July.

Notably, in 2012, eligible professionals will be able to use either a qualified electronic prescribing system that meets the original eRx program criteria or electronic health record (EHR) technology certified for meaningful use. Since some certified EHR systems did not match the eRx program requirements, allowing providers to use certified EHR technology eliminates a major source of frustration for physicians.

## Act now to avoid 2013 penalties

For individual professionals and group practices that were unable to – or chose not to – participate in the eRx program in 2011, a 1.5 percent reduction in 2013 Medicare Physician Fee Schedule (PFS) payments is looming. If you are among them, the good news is that you will have another chance to sidestep the 2013 payment adjustment.

CMS has added a second reporting period in 2012 and 2013 to give practitioners more time to meet requirements before penalties are imposed in 2013 and 2014, respectively. To avoid a reduction in payments in 2013, individual practitioners must report the eRx measure's numerator code at least 10 times during the six-month period from Jan. 1, 2012, through June 30, 2012.

Group practices with 25 to 99 eligible professionals must report the eRx measure's numerator code at least 625 times during the six-month period to avoid lower 2013 payments. Those groups with 100+ eligible professionals must report 2,500 times.

For purposes of the payment adjustment, you can report the measure's numerator for any Medicare Part B PFS service provided during the reporting period, regardless of whether the code for such service appears in the denominator. To be eligible for an incentive payment, the numerator must be reported in connection with a denominator-eligible visit. The numerator identifies whether a clinical-quality action was performed, while the denominator defines the patient population on which performance is being measured.

## More physicians qualify for exemptions

The new rules also provide more professionals who are eligible with an opportunity to request a hardship exemption to avoid a payment adjustment. Categories include eligible professionals who:

- ▶ Cannot prescribe electronically because of local, state or federal law (e.g., those who prescribe a large volume of narcotics)
- ▶ Prescribe fewer than 100 prescriptions during a six-month, payment-adjustment reporting period

- ▶ Practice in areas with few pharmacies for electronic prescribing
- ▶ Practice in rural areas with limited high-speed Internet access

Because G-codes previously have been established for the last two categories, you can request an exemption by reporting the appropriate G-code at least once on claims for services rendered during the six-month reporting period.

You must make all requests for hardship exemptions by June 30, 2012, to avoid the 2013 payment adjustment. CMS is developing a Web-based tool to accept requests for exemption.

## Learn the other eRx program changes

Practices consisting of two to 24 eligible professionals are no longer eligible to participate in the eRx group practice reporting option (GPRO). To participate as a group, a practice must include 25 or more eligible professionals billing Medicare under a single tax identification number (TIN).

Members of group practices with fewer than 25 professionals can participate as individuals by simply beginning to report the eRx measures for 2012.

To participate in 2012, groups must notify CMS of their desire to participate in the eRx GPRO no later than Jan. 31, 2012. Those groups comprised of 25 or more eligible professionals who previously participated in the eRx Incentive Program are automatically eligible to participate in 2012.

## Meet incentive requirements

As in previous years, to receive an incentive payment for 2012, your Medicare Part B charges allowed for the eRx quality measures during the reporting period must be at least 10 percent of your total charges allowed by Medicare Part B.

An eligible professional must report the eRx quality measure's numerator associated with a denominator-eligible visit at least 25 times between Jan. 1 and Dec. 31, 2012.

To receive an incentive payment, a group practice comprised of 25 to 99 eligible professionals must report the electronic prescribing measure's numerator for at least 625 unique visits – 2,500 unique visits for group practices comprised of 100 or more eligible professionals.

For 2012, the Current Procedural Terminology and Healthcare Common Procedure Coding System codes in the denominator will remain the same as in 2011. CMS will post the final electronic prescribing measure specifications for the numerator on its website at [www.cms.gov/ERXIncentive](http://www.cms.gov/ERXIncentive) by Dec. 31, 2011. – Irene E. Lombardo



# Compensation perspective: Half empty or half full?



**M**ore than three-fifths of physicians were dissatisfied to some extent with their income last year, according to a 2011 survey by the physician search firm Medicus. Whether you see the glass half empty or half full depends on your specialty.

Numerous compensation studies show a mixed bag with respect to 2010 income levels. However, for most physicians, average earnings were relatively unchanged between 2009 and 2010, given the weak economy and the need to keep a lid on healthcare costs.

“Stagnant reimbursement is likely to continue, especially from commercial payers,” says Jeffrey B. Milburn, MBA, CMPE, of the Medical Group

Management Association (MGMA) Health Care Consulting Group. Commercial payers are standing on the sidelines waiting to see how healthcare reform will play out.

Milburn sees hospital employment of physicians and the growth of integrated delivery systems (IDSs) as other major trends affecting physician compensation. An IDS is a network of healthcare organizations, such as physician groups and hospitals, delivering a broad range of health services, usually under a parent company.

## Primary care in demand

Hospital employment of primary care physicians has been rising and is expected to grow. Merritt Hawkins, a healthcare staffing organization, reports that its searches for hospital-employed physicians have more than doubled, rising from 23 percent in 2005-2006 to 56 percent in 2010-2011.

Increasing demand combined with a shortage of physicians has helped to boost primary care earnings. But primary care remains well below specialties like cardiology, orthopedic surgery, urology and radiology.

The MGMA 2011 Physician Compensation and Production Survey showed that, between 2006 and 2010, median compensation increased by 15.47 percent for family practice (without obstetrics), 13.35 percent for internal medicine and 10.30 percent for pediatrics. By comparison, increases for higher-paying

specialties, such as urology and radiology, lagged behind at 4.15 percent and 5.54 percent, respectively.

## Landscape in flux

Much of the demand for primary care physicians stems from the systemic shift in how health care will be organized, practiced and delivered because of reform.

In its 2011 survey summary, Merritt Hawkins says “hospitals are seeking to align with physicians in response to healthcare reform, which is promoting the use of Accountable Care Organizations (ACOs), bundled payments and other physician-aligned and integrated delivery mechanisms.”

In addition to hiring physicians directly, large health systems are acquiring practices as part of a strategy to remain competitive. At the same time, practices are mulling over the decision to stay independent, align with a physician-led model or be swallowed by a hospital system.

Accenture Health predicts the rate of independent physicians employed by health systems will grow by an annual 5 percent over three years. The company expects that less than one-third of physicians will remain truly independent by 2013, compared with 57 percent in 2000.

Under the new delivery systems, the traditional fee-for-service compensation model gives way to “pay for performance” principles or value-based mechanisms, using relative value units and quality metrics that measure outcomes.

“IDSs generally pay a base amount and offer 5 percent to 10 percent additive bonuses that can be earned based on meeting multiple targets,” says Milburn. “Some are paying bonuses of 15 percent to 20 percent of physician compensation.”

Milburn believes that healthcare reform will eventually evolve into a dual system, featuring fee-for-service mechanisms and/or capitated integrated delivery systems, as well as ACOs formulated on a risk model – either partial or total risk.

## Elephant in the room

Come Jan. 1, 2012, all physicians face a 29.5 percent decrease in reimbursement under the Sustainable Growth Rate (SGR) formula Medicare uses to set its annual Physician Fee Schedule. However, Congress is expected to act to avert the cut as they have done in previous years.

Nevertheless, as the federal government struggles to contain the country’s debt, it must come to grips with the rising cost of entitlement programs like Medicare. How that will affect physicians remains to be seen. – *Irene E. Lombardo*

## Staffing *continued from page 1*

in comparison to your peer group. By looking at average total compensation per FTE staff member, practices can tell if they are paying an appropriate amount to their staff.

Also, practices should survey other physicians in their area to determine what they are paying for different job titles. It’s difficult to offer medical assistants \$10 per hour when all the other practices in your area are starting medical assistants at \$12 per hour.

Practices that have too many employees can reduce their overhead by reducing their work force and eliminating unnecessary

salaries and benefits. Alternatively, if your practice volume is growing, you may need a larger staff to manage patient care.

Finding the right number of full-time employees to run an office efficiently is not an easy task. Striking the right balance so that you remain profitable as well as able to handle the patient traffic of your office takes time and research.

Fortunately, there are tools and benchmarks you can use to help calculate the proper number of employees needed to run your practice. – *Deborah R. Mathis, CPA, CHBC, and Michael S. Lewis, MBA, FACMPE*

# Online eligibility checking gives scoop on billing

Practices today need to exhaust every opportunity to ensure that they are paid for the services they provide.

In the current economy, many patients have lost jobs. Others may avoid or postpone medical care because of higher copayments and high-deductible health plans.

The process typically followed by many medical practices is to request each patient's insurance card at every visit. The front-desk receptionist either makes a copy of the card or checks it against the records of the practice. This process has many limitations and can lead to rejected claims.

With rising premiums, employers change health insurance plans more frequently, and patients may not receive new identification cards on a timely basis. Out of habit, they may present their old cards at the medical office. The copayments and deductibles may have changed.

The only way practices can be sure they have correct patient insurance information is to use online eligibility checking. Many of the newer practice management systems have some type of eligibility checking integrated into the software.

The more sophisticated systems allow both immediate eligibility checking and checking one to two days in

advance. Advance checking provides the practice with a list it can use for follow-up prior to the patient's appointment.

If a practice is not using a management system that offers eligibility checking, it can access websites to check eligibility. Many insurance carriers have banded together to provide information on a single website.

Online checking has multiple benefits for practices:

- ▲ Elimination of claims rejection due to coverage not being in effect
- ▲ Ability to collect the correct copayment or deductible at the time of service
- ▲ Elimination of waiting on hold to contact insurance carriers by telephone
- ▲ More detailed information than is readily available by phone, including:
  - ❖ The selected primary care physician
  - ❖ The lab and ancillary service providers to use

Some of the eligibility modules also allow the practice to both submit and accept online referrals for patients. – *Deborah R. Mathis, CPA, CHBC, and Michael S. Lewis, MBA, FACMPE*

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The technical information in this newsletter is necessarily brief. No final conclusion on these topics should be drawn without further review and consultation. Please be advised that, based on current IRS rules and standards, the information contained herein is not intended to be used, nor can it be used, for the avoidance of any tax penalty assessed by the IRS.

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