*ACMPE Paper*, October 2011

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This case study manuscript is submitted in partial fulfillment of the requirements for election to Fellow status in the American College of Medical Practice Executives

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Using Benchmark Data to Evaluate Overall Practice Position

Submission April 6, 2011
Resubmission July 6, 2011
STATEMENT OF PROBLEM

With previous experience in obstetrics and gynecology, the new administrator of a medium-sized nephrology practice had challenges ahead. Upon initially meeting the physician partners, the administrator was charged with “making the practice better”. The administrator asked questions such as: What are the current accounts receivable? Is the practice overstaffed or understaffed? When was the last coding audit? What was the outcome? However, the physician partners had very little input because there was no historical data to reference other than financial statements. They had been evaluating themselves based on annual profits for years. They wanted their practice to be better, but had no idea how they were going to achieve it.

The administrator was new to the specialty and was not in a position to offer detailed information regarding the nuances of nephrology-specific revenue streams, such as Erythropoietin and dialysis. Recognizing that benchmarking is important to measure many areas of the practice, such as planning, staffing, and revenue, the administrator wanted an in-depth report that compared the practice’s overall performance to similar practices both nationally and within the region. In this way, the administrator could determine whether the practice was thriving or failing based on comparison information. In addition, the administrator could prioritize any potential issues brought to light once the analysis is completed.

Periodic benchmark comparison is vital in analyzing current practice performance and reviewing the accuracy of presumed success. Measuring success on financial gains alone may put the practice in a position to miss out on additional prospects for financial growth. Using benchmark data would allow an opportunity to thoroughly examine each element of the practice and identify
areas of improvement not otherwise recognized. Because they had not previously performed this analysis, the physician partners were unaware of changing industry trends and national policies within nephrology. Although the specialty is small, the administrator looked for comparison data to determine what measures are important to benchmark and which standards to measure against. This case study will outline the administrator’s journey to obtain the benchmark data to compare and evaluate the practice, and report back to the physician partners.

OPTIONS CONSIDERED

An analysis would need to be performed to give the administrator the information needed to make informed decisions moving forward. A clear set of goals and objectives would be developed based on the findings. Varying methods of data gathering would need to be evaluated to determine which would be most effective. The methods are outlined below.

1. The practice had a nationally recognized practice management (PM) system with access to information from physician practices from coast to coast. The PM system vendor could complete the analysis based on its stored data. This method would offer a decreased workload to the administrator while capitalizing on the vendor’s vast resources. However, the vendor’s ability to legally perform the analysis based on the confidentiality agreements with its current clients was an issue. After contacting the vendor, the administrator discovered that the vendor did not offer comparative analysis as a service to its clients.

2. The administrator could prepare an analysis based on benchmark data from a professional association such as Medical Group Management Association (MGMA). This method would be more time consuming and potentially would stall other projects taken on by the new administrator. However, it would put the practice in a position to learn additional information about the performance of new and existing nephrology practices. Unfortunately, the administrator discovered that nephrology not as well represented
within MGMA. Upon review of the catalogue of resources offered, the administrator determined that the organization lacked printed material with benchmarking information on nephrology-specific practices. The administrator then turned to the Renal Physicians Association (RPA), where a benchmark survey was published recently. The RPA Business Benchmarking Survey offered an abundance of detailed information on nephrology-specific practices as well as key comparison points to reference.

**CHOSEN SOLUTION**

The physician partners agreed to purchase the RPA Business Benchmarking Survey so that the administrator could use the data to evaluate and report the practice position as compared to other nephrology practices. With assistance from a RPA practice management committee member who assisted with the survey creation, the administrator reviewed the survey data and performed an in-depth analysis.

The administrator reviewed key information about the survey data to determine comparability to the practice.

- Data pool size
- Geography (national versus regional)
- Practice size

The RPA practice management committee member confirmed that 212 nephrology practices across the country participated in the survey. The survey contained both regional and national information on practices with 2 to 7 FTE nephrologists or medium-sized nephrology practices. The survey also featured comparison data points, such as accounts payable and evaluation and management coding patterns, which were ideal for comparison and analysis.
Once suitable benchmarking data was obtained, the administrator needed to determine whether practice data could captured effectively for comparison. The PM vendor was contacted to verify whether specific practice data could be captured from the system. The vendor walked the administrator through the various reports needed to obtain the requested information on evaluation and management coding patterns and accounts payable. Then the administrator consulted with the practice accountant to determine whether comparison data could be pulled from QuickBooks, the accounting software, to compare information on salary per FTE nephrologist, operating expenses per FTE nephrologist, and total revenue. The accountant was able to find Profit and Loss Statements as well as a Balance Sheet which targeted the information needed to perform the analysis.

Over four weeks, the administrator gathered the practice data and performed the comparative analysis. The administrator would present the findings to the physician partners for review and discuss next steps.

IMPLEMENTATION

The administrator generated a Microsoft excel spreadsheet which included the following comparison points:

- Established and New Patient Office Visit Codes
- Accounts Receivable Aging
- Staff per FTE Nephrologist
- Charges per FTE Nephrologist
- Payer Mix by Charges
Based on all practices surveyed in the January 2007 RPA Business Benchmarking Survey, specific practices were selected as “benchmark practices” and their comparison data used. These successful practices reported:

- Net income greater than the median before physician expenses per FTE physician, and
- Total operating expenses per RVU less than the median.

Over 25% of the “benchmark practices” were within the Eastern region and were listed in the 25th, 50th, and 75th percentiles. The administrator used the 50th percentile data (practices surveyed January 1, 2007-December 31, 2007) for comparison.

The accountant was able to pull the 2008 fiscal year profit and loss report from QuickBooks. This information was used to populate the income and expense per FTE nephrologist comparison point on the spreadsheet. To correspond to the survey, the accountant divided the expenses into personnel expenses, occupancy expenses, medical supply expenses, and general administrative expenses. Total physician compensation (salary and benefits) was added to the Income and Expense per FTE nephrologist worksheet for comparison.

The administrator compiled a list of all staff and practitioners and grouped them into five categories.

1. Physicians
2. Clerical Staff
3. Clinical Support Staff
4. Nurse Practitioners/Physician Assistants
5. Administrative/Management Staff

This information was used to determine Staff per FTE nephrologist, and to help calculate Income and Expense per FTE nephrologist and Charges per FTE nephrologist.
The administrator obtained the current accounts receivable aging as of January 2009 from the practice management system. Also, the administrator ran a report of physician office visits by current procedural terminology (CPT) code for each practitioner from January 1, 2008-December 31, 2008. Using a pivot table in excel, the administrator separated, counted, and grouped CPT codes by specific physician/clinician based on their coding in 2008. All CPT codes were counted per physician, and a percentage of usage was determined by each physician per CPT code. The percentages were then inserted into the spreadsheet to compare with the benchmark data. The practices total charges for 2008 were also obtained from the practice management system and separated by specific payer. In accordance with the survey, payer information was categorized under Medicare, Medicaid, Commercial (non-managed care), Managed Care, Charity Care, Self-pay, and Other. The charges were separated, counted, and grouped by specific payer, and the percentage of charge per payer was determined and documented on the spreadsheet. Once the benchmarking and practice comparison data were obtained, the administrator performed a detailed review, prepared a report, and presented the findings to the physician partners.

FINDINGS

- Established and New Patient Office Visit Codes

  On average, the practice’s established visit code usage was no more than 10% from the benchmark standard. However, for individual physicians, improvement was needed. In some cases physicians billed the mid-level office visit code, 99213, 87% of the time while only billing the higher level code, 99215, 1% of the time. The physicians indicated that the 99213 was right in the middle so that they did not bill too much or too little. Practices that consistently bill higher level visit codes are likely targeted for an audit. As a practice, new patient visit codes were also consistent with benchmark data. However, individual physicians were still using the mid-level consult code too liberally (almost 94% of the time).
Accounts Receivable (A/R) Aging
Initially, the administrator viewed accounts receivable aging as a top priority but surprisingly the practice fared well against the benchmark data. Twenty one percent of the practice’s A/R was over 121+ days. The practice was 6 percentage points from the benchmark standard, which is not statistically significant.

Staff per FTE Nephrologist
Interestingly, the practice had less staff than the average benchmark practice. Clerical staff was 22% lower, clinical staff was 9% lower, and management staff was on target per FTE physician.

Charges per FTE Nephrologist
Gross charges for the practice indicated that benchmark practices charged 1% more per FTE physician than the practice.

Payer Mix by Charges
Based on the findings, the practice had 8% more Medicare patients than the benchmark practices and 6% more Self Pay patients. This payer mix could explain the jump in the aging of 121+ days due to the inability to collect self pay balances.

LESSONS LEARNED
Based on the findings, which provided a clearer perspective on the practice, the administrator:

- Scheduled coding training for all providers and semi-annual coding audits
- Evaluated staffing to determine if the practice was understaffed based on similar practice staffing
- Was able to give the physician partners the proper perspective on the acceptable number of days in Accounts Receivable
- Will perform this benchmark analysis bi-annually in accordance with when the RPA survey is released

The administrator also became a member of the RPA’s practice management committee which determines the questions and facilitates survey data. New data sources for nephrology continue to become a goal specifically within MGMA. Fortunately the members of the RPA’s practice management committee are also active members of MGMA and they organized a nephrology roundtable at the 2010 MGMA conference.

In conclusion, benchmark data offered a clear method for evaluating the practice. The physician partners were able to set clear and realistic goals for the new administrator and the practice, ensuring success for both parties. In her article titled Benchmarking in healthcare organizations: an introduction, Eleonor Anderson-Miles states that "...business survival is defined as long-term economic viability achieved through excellent performance. To maintain the excellence needed for survival, however, business enterprises must find a way of consistently measuring and improving their performance." She goes on to say that in a changing market consistent benchmarking and provisions to implement change as a result ensures success.

Benchmarking is used by all levels of practice managers, from looking at standard co-pay collection percentages to long term strategic planning (which involves advanced analysis of data). This case study has shown one way that benchmarking was used to identify and helped this practice identify a solution to a problem.

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1 Anderson-Miles, Eleanor. "Benchmarking in healthcare organizations" Healthcare Financial Management 1 September 1994