Better Business, More Money

Administrators of three physician practices offer insight into the financial and efficiency benefits of moving to an integrated PM/EMR system.

*By Richard R. Rogoski, Contributing Editor*

When it comes to investing in a practice management (PM) system, practice managers want to see gains in efficiency and fatter bottom lines. Even if they choose a PM system that's coupled with an electronic medical record (EMR), their primary goal is to boost their practices' efficiency through more accurate and speedier billing, resulting in faster reimbursements from payers. To achieve these goals, a growing number of practices, large and small, are deinstalling their old practice management systems and replacing them with systems that include integrated EMRs.

While many of these PM systems are still quite healthy and have been kept updated, installing a truly integrated system from a single vendor appears to provide physicians with faster access to clinical data and better documentation, while ensuring that all the pertinent data necessary for billing of patients encounters is quickly entered into the billing cycle.

"I am a big believer in EMRs because you can achieve a lot in the middle segment of the practice management process by using EMRs," says Bill Bysinger, director of Mercer Health Systems in Macon, Ga. "But I approach EMRs from a purely business perspective. How can I make not just the physician more productive, but the whole practice more productive? To really get a return on investment, a physician group must have this as an underlying goal.

"We wanted to have an EMR so it could accommodate our going directly to electronic posting," he continues. "We only looked at vendors with an integrated EMR," to assist the practice in its plan to go to paperless billing throughout the practice.

Another reason Bysinger began looking for an integrated system was because the older PM system Mercer had used was being sunsetted by the vendor, with no attempt to become or remain HIPAA compliant. Finding a system that would combine practice
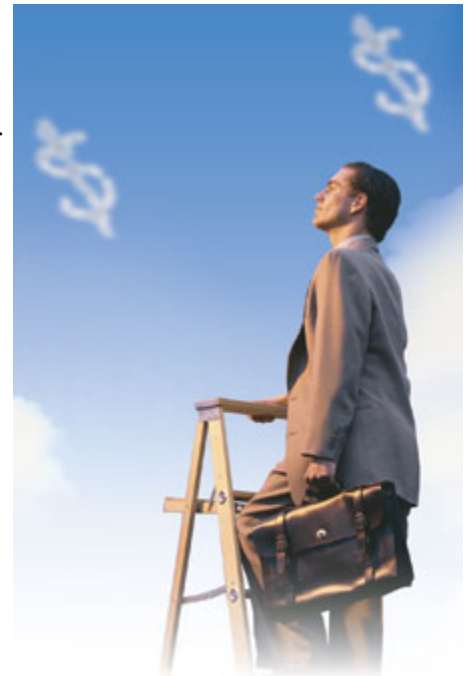
management functions with an EMR would not only expedite electronic claims submissions, but also would satisfy federal regulations.

Multiple Reasons for New Purchases
Bysinger is not alone in stressing the importance of an EMR as a major component of a PM system.

Graham Wright, general manager of Growing Child Pediatrics in Wake Forest, N.C., says that because providers are not coders, they view an EMR entirely as a documentation system. "But I look at it as a system to clinically document and bill," he explains. "Let's capture the services and interface that information back to the billing system. We must be able to use the documentation of the EMR and be effective at capturing codes. Then we must be effective at moving that data electronically into the billing system."

However, according to Bysinger, most physicians in private practice are now beginning to see how combining an EMR with a PM system is to their benefit. "Physicians are the ones who want to implement an EMR the least," he says. "They believe EMRs will alter the way they practice medicine. They believe it will cost a lot and slow down their practice. What providers care about is: 'How do my accounts look? How much have I billed? How much has been collected?'" As they ask and begin to answer these questions, the value of the EMR as an administrative tool takes shape in their eyes.

Not everyone who deinstalls a PM system in favor of an integrated system views the EMR solely as a vehicle to get clinical data electronically pushed into the billing department. Jim Stape, practice manager at the Gilbert Center for Family Medicine in Gilbert, Ariz., says his first priority was to find a workable EMR, because the EMR available from his PM system vendor would not be able to handle the demands the practice had in mind. "There are many solid practice management systems out there with all the features we were looking for, but the EMR is still in its infancy," he says. "Our EMR software search criteria demanded a single software vendor for the two programs."

In detailing the challenge his practice faced, Stape explains, "The old software database was UNIX-based and lacked easy accessibility for independent queries. The software lacked features we wanted, like direct connection with third party payers, claims scrubbing and scanned insurance cards imaging." Plus, the practice was planning to install a wireless network and to triple the number of workstations as part of a plan to go paperless. It needed to interface a new PM system with cart-mounted wireless tablets that would be used in the 10 exam rooms.

Careful Planning
The Gilbert Center for Family Medicine has a staff of two physicians and four nurse practitioners and tallies about 2,500 patient encounters per month, so a lot of planning went into selecting a new PM system and deinstalling the old one. By 2003, Stape

Advanced planning also paid off for Wright at Growing Child Pediatrics. With six locations and nearly 20 providers, the practice is gearing up for even more growth as the area continues to explode with new residents. In the first half of this year, the practice had 32,500 patient encounters and an active patient list of 18,000.

> **"We tried to have everything set up and thought out before going live, but in the first three hours of operation, we reinvented many of our procedures."**
>
> —Jim Stape
> Gilbert Center for Family Medicine

That's a lot of paper. Since many patients are apt to visit multiple locations, that also is a lot of faxing and phone calls between offices, according to Wright. The old PM system used proprietary software, making it extremely difficult and expensive to build interfaces to other systems. "When you have an open system, the price goes down dramatically," he says. In November 2003, the practice deinstalled its former PM system and installed the HealthMatics Ntierprise and EMR system from Cary, N.C.-based A[4] Health Systems.

For a large practice like Mercer Health Systems, finding the right system was critical. The practice has 44 physicians and practitioners who see roughly 800 patients a week. There are five separate clinics in the organization; three community clinics specialize in family medicine, internal medicine and psychiatric/behavioral health, and two student clinics in Macon and Atlanta serve students enrolled at Mercer University.

All clinics, however, are affiliated with Mercer
University School of Medicine, and all physicians serving the clinics also teach at the school. Between 55 percent and 60 percent of all patients are on Medicare or Medicaid. In trying to find the most effective integrated system for the diverse practices offered through Mercer, Bysinger says, "We sent out requests to 10 to 12 vendors and got four or five responses. Then we narrowed it down to two." In the spring of 2003, Mercer Health Systems installed the Companion PM system and, in the fall, installed the Companion EMR, both from Columbia, S.C.-based Companion Technologies.

Facing the Challenges
Deinstalling a major information system and installing a new and integrated system is not

without challenges, and each of the three practices had their share. Before the conversion, Mercer had been submitting about 40 percent of its claims electronically. Now it is up to about 90 percent. "But it wasn't easy to get there. It took us more than a year to achieve this," Bysinger says.

Problems began to arise in dealing with transaction sets, payers and clearinghouses. "When HIPAA cut over, a lot of payers and clearinghouses had hiccups," Bysinger recalls. "We had the software and the software worked, but the payers and clearinghouses weren't ready. It caused some serious collection issues in the first six months." Bysinger credits the size and stability of Mercer Health Systems for being able to sustain cash flow during this time period, a luxury many small practices may not have.

Also, problems resulted from the conversion of payer and patient data. "If we were going to do it again, we would not convert data from the old system to the new system," he continues. "We converted three times more payers than we were dealing with. For about 40 percent of our payer information, we found that we no longer had patients covered under those plans. That meant every time we searched for something, the system had to search through all that unnecessary data."

> **"We must be able to use the documentation of the EMR and be effective at capturing codes. Then we must be effective at moving that data electronically into the billing system."**
>
> ——Graham Wright
> Growing Child Pediatrics

Plus, Bysinger says the practice converted data on old patients that it hadn't seen in a while, noting that three-years' worth of patient data were transferred to the new system. "We really should have determined which patients we had seen only in the last year."

He also adds that the entire billing process should have been considered as part of the conversion. "We made the tragic error of automating the old process with the new system. We brought in a new system, but didn't change our billing process. The system worked well, but we should have reassessed our financial and billing processes to customize the new system first. The hard part is trying to get people to understand that they have to change their behaviors to use the new system." Relying on old behaviors and old processes while running a new system inevitably caused frustration among the billing staff. He says everyone expected to reap benefits in 90 days or less, but measurable system benefits emerged after about a year.

Still, Bysinger says, "We pulled the plug on the old system after eight months and used it only as a data repository of old data, adding nothing to it since going to the new system." He admits he gained much insight from the conversion experience and is able to offer advice to other practices that may be thinking about completely deinstalling their old PM

system and installing an integrated system. "You need to be cautious," he warns. "Don't convert too much. Have the vendor articulate what the best process is and make sure everybody buys into the reasons for making the change."

Lessons for Future Efficiency

At the Gilbert Center for Family Medicine, Stape learned similar lessons, although he says the data conversion was easier for him. "Our data conversion consisted only of patient demographics, patient status and appointment scheduling information. We did not bring forward any billing or insurance data. Each patient was essentially treated as if he had new insurance. We transferred discharged patients' demographics and their status so we wouldn't find ourselves re-established with patients who were previously severed from the practice." Stape also lucked out in finding someone locally who would analyze and convert the data from the old UNIX-based system to the new Windows-based system for a tenth of his original data conversion estimate.

Approaching each patient as if he had new insurance, however, did tend to slow down the initial visit process at the front desk, because the staff now had to process insurance information and then scan in insurance cards. The first few weeks were hectic.

"Our staff was struggling to become efficient with the new software and with navigating new responsibilities," he notes. "Insurance cards needed to be scanned, insurance information entered, responsible parties established and demographics updated. We hung signs on the office door and in the waiting room asking our patients for patience. We tried to have everything set up and thought out before going live, but in the first three hours of operation, we reinvented many of our procedures," he continues. In restrospect, Stape says the practice should have booked half the normal patient load for the first three or four hours of operation on the new software.

In time, the staff developed a rhythm to deal with the patient flow. Dealing with payers was a slightly different story. The conversion required setting up a new clearinghouse, Stape says. "Getting Medicare to reply in a timely fashion" also became a problem. "We went about two weeks into the program holding Medicare charges," he says.

Stape says the Gilbert Center for Family Medicine pulled the plug on its old system the day before going live with NextGen EPM, but continued to work the old accounts receivables from the old software for about 12 months. As for advice to other practices, he advocates diving in. "Don't wait. The benefits we gained were astronomical." But practices should be aware that reaping the benefits will take time. Stape says it took about nine months before everyone in the practice felt they were more efficient than they were before going paperless.

Another objective that requires time is working out the payer-related kinks. "Updating the third-party payer fee schedules is a timely necessity," says Stape. "There's no reason to input old, outdated data, so updating the fee schedules is part of the process. This takes

three to six months, depending on how diligent you are in pestering the insurance provider reps."

Benefits of New, Clean Data
Knowing beforehand what data needs to be transferred to the new system also saved Growing Child Pediatrics' Wright from conversion headaches. "The only thing we brought over was patient demographics," he says. "We had six years of payer information, but we brought over only our top 25 insurance companies."

To establish electronic patient records, all patients were treated as new patients. The fact that the new encounter form looked like the old one simplified the process, but front desk staff still had to scan in everybody's insurance card. "For several months we did a lot of card scanning," says Wright. Initially, this work was a burden for office staff, but Wright says that after three months, they began to experience benefits from the new system.

"It was worth it, because all the eligibility and plan data that went into the system went in clean. We weren't sorting through and sifting out and changing old data." The practice also decided not to import old appointments. "That meant we had nearly 2,000 appointments we had to reschedule as we changed systems," he says. "I underestimated the time it would take to get this done, but that, too, was the right decision." The extra time, in fact, gave staff an opportunity to make some major changes. "We asked ourselves, 'Do we like our appointment categories? If not, let's change them.' So we got rid of certain categories and simplified things."

Prioritizing played a significant role in bringing up the integrated PM/EMR system at Growing Child Pediatrics. "We implemented the new billing system first because we have multiple locations," Wright says. "We had to bring everybody up at the same time." In the beginning, the practice ran both old and new systems in tandem. Now, the old system serves only as a reference.

As a cautionary tactic, the charge interface was not turned on for the first six months. "It took six months to get to the point where we understood what the physicians' intentions were, matching physicians' coding on the superbill to what we were pulling across the interface." Wright says staff proceeded like that until physicians were sufficiently comfortable that they didn't have to fill out an encounter form, and just put data into the EMR.

Although the conversion went very smoothly, Wright says he does have advice for others. "For a private practice, it's a real challenge to meet payroll. You have to be prepared for a decrease in cash flow for the first several months. Our accounts receivable days (A/R) soared for a few months. Before A[4], our A/R days were about 40. For the first months of the conversion, A/R days ballooned to 60 days. Now they are down in the 30- to 34-day range."

Timing also is important, Wright says. "You need to schedule when the transition will take place and allow yourself enough time to implement and train."

Weighing the Benefits
Although converting to a new PM/EMR system may be fraught with challenges, the gains in efficiency and income are worth the time and effort. "Our average charges have increased from $105 per patient in 2003 to $115 per patient in 2005," says Wright. "Our average payment has increased from $75 per patient in 2003 to $85 per patient in 2005. The main reason is due to the charge capture and charge interface functionality. We have been able to take the coding details out of the hands of the physicians by building in CPT codes, ICD-9 codes, modifiers and units," he continues. A change in coding protocol can be rolled out easily by substituting or adding to the current description in HealthMatics EMR.

"I approach EMRs from a purely business perspective. How can I make not just the physician more productive, but the whole practice more productive?"

—Bill Bysinger
Mercer Health Systems

That EMR, working in conjunction with practice management functionality, also gave physicians better access to more information and more time to spend with their patients. The new system also made the four FTEs in the billing office more efficient. "I have one person managing nearly 6,000 claims a month," says Wright. "Instead of charge entry, it's charge review in this office. Instead of keying data, she reviews batches of information from the EMR system, checking them for accuracy. There are maybe five or six things we may have to modify manually, but most of the time, the process takes between 10 and 20 seconds: Look at a bill for charges; review it visually; if it's correct, move on to the next one."

Wright says when he compares the practice to national averages, it can handle double the number of items that a billing specialist is expected to handle. Turning on the system's automated appointment reminder also should cut the no-show rate, thereby saving the practice even more money, Wright says.

At the Gilbert Center for Family Medicine, Stape has seen similar efficiency gains. The old system flagged patients who didn't pay or moved and didn't leave a forwarding address, but still allowed the front desk to schedule them for a new appointment. The new system can block problem patients and also has streamlined the entire billing process. "Charges are entered and elec-tronically sent the following day. Our average insurance payment is within 14 days of the patient visit, and our A/R is less than one month's charges," says Stape. He adds that claims rejections also have been drastically reduced and attributes that, in part, to the system's claims scrubbing feature.

In addition, dealing with payers is much easier now. "Analyzing third-party payers is a snap," he reports. "Individual fee schedules allow effortless monitoring, comparing and reporting on insurance payers by procedure, diagnosis or visit type. Fine tuning our insurance payer mix has never been easier or more accurate."

Bysinger also is reaping the benefits from his new system. "We are electronically processing 90 percent of our billings to our 500 payers," he says. "The top 12 are all electronically paid." Among the top 10 payers, claims are now being paid in less than 60 days, and some in less than 30 days.

With the practice becoming more efficient through electronic posting, Bysinger was able to save even more money by reducing his billing staff of 10 to 12 employees down to seven. He says that while Mercer's backend functions are now totally paperless, getting all clinicians and physicians to use the EMR does take a little time. But he remains undaunted, in part because he embraces the same business objectives as all practice managers and administrators. "Our goal in buying and installing the integrated system was primarily a business goal, so we are pleased."

When coming from a practice administrator—that's high praise.

For more information about **HealthMatics Ntierprise and EMR from A[4] Health Systems,**
www.rsleads.com/510ht-207

For more information about **NextGen EPM from NextGen Health Information Systems,**
www.rsleads.com/510ht-208

For more information about **Companion PM and EMR from Companion Technologies,**
www.rsleads.com/510ht-206

Richard R. Rogoski is a free-lance writer and contributing editor to HMT. Contact him at
rogoski@aol.com