Now We Have This Information

What Do We Do With It?
Financial Benchmarks

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The data which was gathered from the SEC Benchmarks Project is based on annual figures for 2009. However, for this presentation, the data will be shown monthly, from July 2009 through December 2009.

We will show you how to gather the data for each of the 5 benchmarks and create graphs specific for your Pediatric Ophthalmology practice.

These graphs will help you compare your practice to other practices. More importantly, it will help you track your own practice trends to allow you to make changes (such as increasing patient volume, profit margin and staff efficiency).

DON’T PANIC. We will go through each benchmark individually to help you.
No-show rate = number of patients that did not show for a scheduled appointment (for any reason) divided by the number of patients scheduled.

**No-Show Rate**

![Graph showing no-show rates from July 2009 to December 2009. The graph indicates a trend of increasing no-show rates over the period.]
Patient Visits Per Physician = \frac{\text{number of completed patient visits, including post-ops}}{\text{number of physicians}}
Profit Margin

Profit Margin = profits before any MD/OD salary or draws
              total collections

Graph showing the profit margin from July 2009 to December 2009.
COST PER PATIENT VISIT

Cost per patient visit = total annual practice costs before MD/OD costs, optical/CL costs, & depreciation number of patient visits per year

Cost per patient visit

<table>
<thead>
<tr>
<th>Month</th>
<th>Cost per Patient Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-09</td>
<td>$110</td>
</tr>
<tr>
<td>Aug-09</td>
<td>$120</td>
</tr>
<tr>
<td>Sep-09</td>
<td>$90</td>
</tr>
<tr>
<td>Oct-09</td>
<td>$130</td>
</tr>
<tr>
<td>Nov-09</td>
<td>$80</td>
</tr>
<tr>
<td>Dec-09</td>
<td>$90</td>
</tr>
</tbody>
</table>
Collection per average patient encounter ("average ticket") = \frac{\text{total collections}}{\text{total patient visits, inclusive of post-ops}}
HOW TO MAKE A SPREADSHEET & GRAPH

We will be using the “Profit Margin” as the sample graph

1. Open up a new spreadsheet in Excel
2. Click on cell A3, type “Profits before any MD/OD salary or draws”
3. Click on cell A4, type “total collections:
4. Click on cell A5, type “profit margin”
5. Click on cell F2, type “July 09”, follow straight across with the months ending Dec. 09. You should end on cell K2. Gather your practice Profits before any MD/OD salary or draws and Total collections to proceed to the next step (remember to use the Item Descriptions and Definitions to assist you in getting the correct amounts)
6. Click on the appropriate cells and insert the appropriate dollar amounts per category through Dec. 09
7. Click on cell F5, in the white formula bar at the top type =(F3/F4), a percentage will show up in the cell
HOW TO MAKE A SPREADSHEET & GRAPH

- Highlight cell F5, right click, copy, highlight G5 through K5, right click, paste. Percentages should be listed in all cells.
- Highlight cells F2 through K2, right click to copy, move cursor down to F7, right click to paste (months will be listed)
- Click on cell A8, type “Profit Margin”
- Highlight F5 through K5, right click, copy
- Move cursor to F8, right click, paste (the percentages will now be shown)
- Highlight both rows of the entire cells beginning with F7 and F8, click on insert at the tool bar, lick on charts (lower right hand corner), pick the graph style you want, click ok,
- Graph will appear.
The 2 previous slides provide detailed guidelines on how to make an Excel spreadsheet and graph. For assistance, please call Mitzi at (970) 254-4603.

You will find the Item Descriptions and Formula Definitions we have discussed for the five benchmarks on the link provided at the end of the session.

Once you have mastered the spreadsheet, you can track any data you want.
In closing, we have focused on five important benchmarks.

By following these simply guidelines, your practice can create your own unique Excel spreadsheet and graphs.

Practices may choose to review this data on a monthly or quarterly basis, or even just once a year.

That's the great thing....it's all up to you.
IMPROVING COLLECTIONS

Lance Siegel MD
Merrill Stass-Isern MD
Ways Not to Lose Income-Staff Duties

- Check eligibility + have authorization for codes with HMO/IPA
- If new code added, get authorization at time of service NOT retro
- Have current billing info/phone numbers
- Present insurance card at EACH visit
- Copy of valid license or ID allows you to make collect.
- Auto call/email reminders or both
- Consider billing for no shows or dropping pt
Ways Not to lose Income – Staff duties

- Schedule an effective clinic: payor mix
types of patients
no overtime

- Utilize physician extenders to increase visits:
  Optometrists
  Orthoptists
  Technicians

- Bill clean claims – have billing info right the first time
  reducing rebills and fixing errors are costly/timely
Collections

- ALWAYS COLLECT CO-PAY
- If self pay or “Routine Eye Exam” collect money BEFORE exam
- Consider all forms of payment: credit card debit card check payment plan
Collections

- Consider using a CHECK VERIFYING MACHINE –

Within this machine a check is read magnetically or by lasers.
The routing/account # are assessed via an internet link to assure validity of the info and the money is claimed electronically.
The check is printed with verification and returned to the customer; reducing paper load and a trip to the bank for a deposit.
Collections

- Bill electronically
- Consider taking a discount for cash at time of visit then have it bill the insurance company with remittance to patient. Common practice by dentists.
- If the pt has a balance at the time of a visit – COLLECT it or set up a payment plan
SCHEDULING

- Schedule effectively – new pt slots
  return slots
  post-ops
- Remember 1 new pt often equals 3-5 return pts
- Choose plans that meet your needs
- Payor Mix:
  Eg. PPO may pay well on office exams but not surgery
  Medicaid may have more difficult pts and no shows
SCHEDULING

- Private patients may be more difficult
- Remember more patients may not be more profits if you need more staff
CONTRACTS

• Review Contracts and their allowables
• Look at your most frequent procedures and how they pay.
• Watch for plans that do not allow certain codes – eg EYE CODES
• Can you still use consult code?
• Watch for bundling of Sensorimotor with comprehensive code
CODING

- Bill for refractions: be prepared to explain what a refraction is in writing; given to the patient before the exam. Also insure that your front desk personnel, technicians, and billing department understand what a refraction is and can give a patient an adequate explanation.
Coding

- Code EM or Eye codes ???
  The same exam may bill differently depending on carrier. With adequate documentation bill the code EM or Eye with the highest allowable.
- Always bill to the highest level supported by findings and DOCUMENTATION OR BY CONTRACT. (no documentation at all may be required with some contracts)
- Use sensorimotor (92060) and extended ophthalmoscopy (92225,92226) when appropriate and appropriately documented.
- If a pt comes in during their post op period for an unrelated problem you may bill for it (modifier 24)
CODING

- When doing a procedure in the office, use the modifier “visit with procedure” - modifier 25
- Remember modifiers may be specific to individual carriers (eg. LT, RT, 51, 50)
- When indicated perform OCT, B-scan, photos, VF’s pachymetry, gonioscopy, etc.
- Check your allowables from your contracted companies at least twice a year. Do not charge less than what you are allowed. (Don’t leave money on the table)
SURGERY BILLING

- Bill highest to lowest value, may be different for different Payors
- Notice if payor pays past 4\textsuperscript{th} procedure
- Take note of how payors pay for multiple procedures and add on codes
- Your biller needs to know that a vitrectomy is usually not bundled with a complex cataract code, and multiple procedures.
- Bill for forced ductions when applicable (92019)
- Ask not to apply multiple procedure discounts on unrelated procedures done at same time. Eg. EUA and cataract surgery
BE AWARE OF:

- Take backs
- Down coding, bundling or non accepted diagnosis
- Retro denials
- Embezzlement, missing collections
- Late rebilling or need for documentation support
- Partial payments = paid to amount of community standards
- Converting non contracted pay into usual and customary
- Don’t be paid by subsidiary/ancillary group at lower rate or evergreen rate
MANAGEMENT ISSUES

- Drop plans that do not pay and won’t affect physician referrals
- Don’t be afraid to call the plan if payment is wrong or delayed
- Understand risks and benefits of capitation if you accept it. Good for few patients. As referrals increase you see more patients for the same reimbursement
BETTER CONTRACT RATES

- You can negotiate with any plan for an increased rate. Be reasonable, know what you want, remind them you are not a general ophthalmologist. Without you they may have no hospital, ER or NICU coverage.

- If you are in a group make sure your biller is not just copying old patterns from partners that have not kept up or who do not understand bundling, modifiers etc.
OTHER WAYS TO INCREASE INCOME

- Have an optical shop (also good for the patients)
- Decrease Overhead
- ROP and on call contracts
- Clinical trials
- Outside consulting or lecturing
- Sell patches, lid wipes (this is also a convenience for your patient)
- Consider billing for copying charts (standards are usually set locally)
- Consider billing for tech time 99211 and filling out forms
- Rent out office when not being used.
- Satellite offices
Overhead Control

A Penny Saved is a Penny Earned

Eric A. Lichtenstein, MD
Robert S. Gold, MD
Overhead

- Capital costs
  - Construction and furnishing
  - Medical equipment
  - IT

- Recurring costs
  - Operational expenses
  - Debt service
  - Taxes
Capital costs

• Construction and furnishing
  • Physical plant: Rent vs. own
    • Low interest rates
    • Government grants (TARP, HPSA)
    • Shared common space with related practitioners
      • Peds ophth group, multi-ophth group, other peds specialties
  • Save with discontinued product lines
  • Consider maintenance costs
  • Get what you pay for (cheaper ≠ better)
Capital costs

- Medical equipment
  - Used if high quality and warranted
  - Cost/benefit analysis
  - Share with colleagues (do you need OCT?)
Capital costs

- IT systems
  - EHR incentives
  - Local phone/telecom network
    - FIOS, bundles
    - In-house phone system
Operational costs

- Payroll
  - Single-largest expense
  - Market forces prevail
  - Per AAOE:
    - 20-26% of overhead (net collections/gross staff wages)
    - $110,000-$160,000 revenue per FTE staff member
    - 6-8 FTE non-clinical per FTE MD
    - Techs work up 16-18 minutes (3.5 pts/hr/tech)
Operational costs

- Office maintenance
  - Cleaning
    - Daily staff responsibility
    - Janitorial service
  - Garbage disposal
    - Is there competition?
- IT maintenance
  - Network support contract
  - Software support contract
  - Replacement costs
Operational costs

- Insurances
  - Health
    - State society discounts, co-ops
    - Tax credits
    - Cost/benefit of NOT offering
  - Malpractice
    - Claims-made = Occurrence by year 7 or 8
    - Educational discounts
    - Affiliation discounts
Operational costs

- Debt service
  - Short term
    - Line of credit
    - Never use credit cards
    - Cost/benefit of cash vs. debt
  - Long term
    - Low interest rates = renegotiation
    - Cost/benefit of cash vs. debt
      - ? kill the bill
Operational costs

- Taxes
  - Corporate structure
    - S- or C- corp.
    - Affects liability and taxes
  - Retirement plan
    - Related to corporate structure
    - Tax deferred income
    - No SSI or Medicare (mostly)
    - Not earned income for employees BUT is a benefit
Operational costs

- Taxes
  - Retirement plans
    - Defined contribution: profit-sharing plan, KEOGH, SIMPLE
    - Defined benefit: MPP, pension
    - Hybrid contribution/benefit: CBPP
    - Combinations

  - Always maximize deferred income
    - To fullest extent you can afford today
    - Especially if your future tax bracket is likely to be lower
Taxes: Profit-sharing plan (PSP)

- fully deductible to corporation
- profit-sharing ≠ “profitable”
- defined contribution
  - 25% of W2 (up to $49,000)
  - employees must receive ≥ 1/3 of employer benefit
    e.g.: owner = 25% W2, employees receive 8.3% W2
  - BUT employees can opt out
  - could receive cash bonus instead
- can have several tiers
- waiting and vesting periods
- can be rolled over into an IRA
Taxes: PSP

- Example: S-corporation, net revenue $400,000
  - Option A
    - $W_2 = $400,000$
  - Option B
    - $W_2 = $200,000$
    - Dividend = $200,000$
  - Option C
    - $W_2 = $200,000$
    - Dividend = $151,000$
    - PSP = $49,000$
Taxes: PSP

Option A: W2 = $400,000
- $25,057 FICA Medicare: 2.9% W2 earnings ($11,600)
  + $132,000 Federal (33% $400,000) = $157,057

Option B: W2 = $200,000, dividend = $200,000
- 19,257 FICA Medicare: 2.9% W2 earnings ($5,800)
  + $132,000 Federal (33% $400,000) = $151,257

Option C: W2 $200,000, Dividend $151,000, PSP $49,000
- $19,257 FICA
  + $115,830 Federal (33% $351,000) = $135,087
Taxes: PSP

- **W2 $400,000**
  - $157,057 FICA + Fed

- **W2 $200,000, Dividend $151,000, PSP $49,000**
  - $135,087 FICA + Fed
  - Save $24,000 in taxes (pay $25,000 for $49,000 value)
  - grows tax free
Taxes: Cash Balance Pension Plan (CBPP)

- Defined benefit
  - Benefit paid out during retirement (pension)
  - Can be rolled into IRA
  - Can be lump sum

- Contribution limits (2010)
  - Age 40  $101,000
  - Age 55  $165,500
  - Age 65  $230,500
Taxes: Cash Balance Pension Plan (CBPP)

- Corporate deduction (as in PSP)
- Simpler administration
- Full vesting in 3 years – less control than PSP
Taxes: No plan vs. PSP vs. CBPP

- **W2 $400,000**
  
  AGI $400,000 = $157,057 FICA + Fed

- **W2 $200,000, Dividend $151,000, PSP $49,000**
  
  AGI $351,000 = $135,087 FICA + Fed
  
  Save $22,000 in taxes (pay $27,000 for $49,000 value)

- **W2 $200,000, Dividend $100,000, CBPP $100,000**
  
  AGI $300,000 = $119,257 FICA + Fed
  
  Save $38,000 in taxes (pay $62,000 for $100,000 value)
  
  Tax = $19,000 on $200,000 beyond W2
Retirement Plans vs. Bonuses

- Employees can opt-out of PSP or CBPP
  - Can not be coerced or induced
  - For PSP, contribution formula maintained
  - For CBPP, benefit formula must be maintained
  - Can opt, instead, for bonus
    - eg - $5,000 into PSP/CBPP or $2,000 bonus
  - Can not go “back and forth”
Taxes: 401(k)

- In ADDITION to CBPP
  - Deferred salary – withheld from W2
    - employee option
  - SS but no Medicare taxes (partial FICA exemption)
  - personal deduction for recipient
    AND corporation gets payroll deduction
  - allowed: 6% W2 to max $16,500 (+ $5,500 age 50+)
  - safe-harbor rule: 3% W2 for employees
    - eliminates complicated formulas
Example

- $400,000 earnings
  - W2 $200,000
  - CBPP $100,000
  - 401(k) $16,500
  - 6% safe harbor $12,000
  - Tax deferred income beyond W2 = $128,500
  - Fed tax exposure = $71,500 (on $200,000)
  - Tax = $23,600 on $200,000 beyond W2
INCREASING OFFICE VISITS PER PHYSICIAN

A Large Practice Perspective

Jorie Jackson, CO
Houston, Texas
Establishing Efficient Practice Patterns

- Office Environment
  - What are your limiting factors?
- Provider Time Management
- Scheduling
- Marketing
- Physician Extenders
  - Orthoptists and Optometrists
Self Assessment of Office Environment

- Is it the physician?
- Are there enough patients scheduled?
- Are the patients scheduled efficiently?
- Is it the staff?
  - Are they well enough trained to help you move patients through the exam process efficiently?
- Is it the flow of patients?
  - Consider re-designing the office, adding more lanes, adding a dilating area, expanding the waiting room
- Is it the EMR?
  - May need a scribe
- Is it the check in/ check out process?
  - Improve pre-registration (website)
  - Centralized Scheduling
Provider Time Management

- How many patients can comfortably be seen each day?
- Can some of your responsibilities be delegated to office or technical staff?
  - Patient Education
  - Triage
- How much time do you spend with each type of patient?
  - Pre-op
  - Amblyopia follow ups
  - Adults
Clinic Operations: “Red zone/Green zone” Alerts

- “Green zone” is when provider is running on time
- “Red zone” is when provider is behind
  - Establish trigger for calling a red zone
  - Determine who can call a red zone
  - Have a visual signal that is readily apparent to key personnel
- How does the doctor and staff performance change when in the red zone?
Scheduling

- Are you scheduling enough patients?
  - Know the max number of patients you can see
  - Improve your show rate
- Do you run an efficient schedule?
- How far out are the appointment openings?
  - Consider an “open access scheduling model” where patients are scheduled at max one month out or less.
- Are there more patients that could be scheduled?
  - Marketing
- Are you getting in every kind of patient you could?
  - Are you on all insurance plans available?
  - Can your patient base be expanded?
  - Can you offer other services?
Efficient Scheduling

• Base daily schedule capacity on no-show rate

• Needed information:
  • Current average visits daily
  • Your current patient visit capacity
  • No-show rate
Scheduling Example

- 25 patients per day are seen
- 30 patients can be considered max capacity
  - Current capacity is 83% (25/30 x 100%)

- How many patients do I need to schedule to accomplish a goal of max capacity?

- No-show rate is 20% (show rate is 80%)
  - Includes same-day cancellations and reschedules,
- Need to schedule 38 patients (30/80%) to be at max capacity
Open Access Scheduling

- Appointments do not open for scheduling until a short time prior to appointment day
  - Can be one week or one month prior
  - Can be the entire schedule or only a percentage of the appointments
- Works best for an established practice
- Effective because the show rate will be higher
- Leads to happier families because they are getting quicker access
Marketing to New Patients

- 2-3% of cash flow is the typical amount of money that you want to spend
  - An older, more established practice that is at or near capacity may spend less
  - A younger, growing practice may want to spend more

- Marketing techniques:
  - Website
  - Outreach programs
  - Community education
Marketing

- Large Practice: In house Marketing/Public Relations Team
  - Salary for this department is paid by those who utilize the services
    - If working for the group, the time is shared by all partners
    - If working on something for a particular physician, time allocated to them

- Referring Physicians
  - Physicians within a larger practice
  - Local and regional pediatricians
  - Local and regional ophthalmologists & optometrists

- Community Programs
  - Community Outreach (eye screenings, health fairs)
  - School Nurses

- Advertising
Website

- Use a local marketing firm to help you develop an attractive, informative, and user friendly site
  - Links to AAPOS website
  - Check your web hit count monthly
  - Make sure that your firm regularly updates your site to keep it from becoming stagnant
- The same firm can design brochures and business cards along the same theme of your website
Monthly Referral Report

- Pay attention to your referral sources
- Generate a monthly referral report by noting the specific referral source when a new patient is scheduled
- Review this report monthly and take action if any referral sources are dropping out
- Consider graphing the number of different doctors referring to the practice each month- a great measure of outreach effectiveness
Utilize Physician Extenders

Orthoptist

- Stable strabismus follow ups
- Time consuming adult patients
- Amblyopia follow ups
- Sensorimotor pre-op and post-op exams
- Patient education
- Glasses check

Optometrist

- Contact lens patients
- Annual stable patients
- Amblyopia follow ups
- Stable strabismus follow ups
Example of Utilizing an Orthoptist

- Work up patients
  - Dilate
  - Retinoscope
  - Refract
- Co-Manage and release stable patients
- Run a private clinic when the MD is out of the office
- Run a private clinic along side the MD while they are in the office
  - Screen new adult diplopia patients
  - Post-operative sensorimotor exams
  - Strabismus measurements for the pre-op patients
- Scribe as needed to get patients moving and assist in patient education
Example of Utilizing an Optometrist

- Work up patients and screen for the MD
  - Refract
  - Dilate
  - Fundus Exam
- Co-Manage and release stable patients
- Private clinic while the MD is in the office or out of the office
  - Contact lens patients
How we do it at Houston Eye

- 40-45 patients currently seen a day
- Team consists of:
  - 1 full time, well trained COA/surgery coordinator
  - 1 full time scribe/secretary
  - 1 part time (70%) orthoptist
    - Could see 60 if we added one more full time well trained COA
- Serve 2 different locations each have 4 exam lanes
How we do it at Houston Eye

- Open access scheduling of 1 week appointments
  - 10% of our schedule
- Triple book Medicaid patients
  - Schedule majority on one ½ day a week
- Limit 2-3 new Adults a day
- Pre-ops spread evenly throughout the schedule
- ROP exams done at 800 AM or 1245 PM before the afternoon starts
- Procedures all done at the end of the day
Summary: Tips and Advice

- Know your limitations and make changes accordingly
- Create an efficient schedule that is going to work for you
- Know your referral base and market yourself in every aspect of the community and outlying communities
- Train your staff well and delegate components of the exam to them
- If you have reached your max potential, think about hiring a physician extender, such as a certified orthoptist.
The No-Show Problem

- No-shows cause a significant decrease in productivity of a practice
  - Lost revenue
  - Underutilized “empty” time
  - Staff time to call and reschedule patient

- This is not a new problem in pediatric medicine
  - Sending letter increased show rate from 48% to 64%
No-Show Statistics

- In 2000, the national no-show rate was 5.5% according to MGMA.
- Pediatric ophthalmology typically is at 8-20%
- The AMA policy states a physician may charge a patient for a missed appointment or for one not cancelled 24 hours in advance, if the patient is fully advised the physician will make such a charge.
Legal Risk of No Follow-up

- Liability occurs when patients:
  - Fail to follow-up
  - Do not respond to the follow-up reminder cards
  - Do not respond to the follow-up telephone calls
  - No-show
  - Cancel without rescheduling
  - Repeatedly cancel appointments – delaying care
    - Keeping track of cancellations is often difficult
  - Call in with a problem and an appt is recommended but not made
  - Call in and speaks with on-call doctor who recommends follow-up
  - Call in and answering service inappropriately handles call

- Need protocols -- document, document, document!
Real Reasons for No-Shows

- Medical
  - Acute illness
  - Failure to comply with treatment: patching, atropine, other drops, glasses, etc.
  - Does not fully understand the significance of the diagnosis and importance of treatment
- Financial
  - Past due balance
  - Insurance/HMO authorization problems
  - Inability to pay co-pay
- Transportation and weather issues
- Family issues
  - Overscheduled families
  - Child-care problems
  - Other family issues – e.g. divorce and 2nd parent doesn’t want care
General Strategies—Reducing No-Shows

- Modify scheduling
  - Make follow-up appt before the patient leaves the office
  - Let patient suggest appointment time
    - Better show rate with patient suggested vs. scheduler suggested time
    - Schedule at a time that actually works for the family
  - Limit long-timeframe scheduling
    - Show rates decrease with longer delay between time of scheduling and time of appointment

- Overbooking
  - Be strategic with double-slots
    - Put during slow times or times of frequent no-shows
    - Overbook by the expected number of no-shows
  - Be ready for the super-busy “all show” day

- Use waiting list
General Strategies—Reducing No-Show Rates

- Reminders
  - Call
    - 24 vs. 48 hours prior
    - Decreases no-show rate by increasing cancellations
    - Automated calling
    - Consider requesting additional information or call back

- Postcards and letters
  - Good for new patients and long-timeframe follow-ups
  - Mail at least 2 weeks in advance
  - Make new patient information package
General Strategies—Reducing No-Show

• Pre-appointment interaction
  • Having new patient come to fill out paperwork at least the day prior to appointment
    • decreased no-show from 40% to 5% in one retina practice

• Examine your practice
  • Do you respect your patients’ time?
    • Frequency of bumping appointments, running behind
  • Do your patients understand why your treatment and monitoring are important?
  • Do you and your practice have an accepting attitude?
    • May feel embarrassed to cancel or unable to ask questions about care
After the No-Show—Protocol

- Rapid follow-up to no-show
  - Call when 15-30 minutes late, may be able to reschedule that day
  - Reinforces significance of examination
- Pull all no-show charts at end of the day
- Call all no-show patients
  - Make new appointment
  - If no answer leave message
- Develop a form to be used when patients no-show so the provider is quickly informed by the staff
  - Include the number of no-show appts for this patient
  - Helps physician make an informed decision on whether to terminate the patient
After the No-Show Protocol

- Send no-show letter and keep copy for the chart
  - Consider having several versions
- Call after a month if no response to letter
  - sooner if medically necessary
- Send non-compliance letter
  - Send certified letter with mail-return receipt and by regular mail if risks serious vision loss
  - Send copy to PCP
  - Keep copy for your records
- Discharge the patient if necessary
Dear Parent,

Your child had an appointment on xx. You did not notify our office and you failed to keep this appointment. In addition, your child has an important medical problem and is now past due for evaluation. Your child’s condition requires monitoring and it is possible that permanent damage could occur resulting in possible visual loss. We encourage you to continue care for your child’s eye condition and recommend that you please call our office as soon as possible to reschedule.

Our office policy requests 24 hour notification of cancellation. It is also our policy to charge $xx for failed appointments.

Enclosed is a copy of our financial policy which you have signed and acknowledged. Please make arrangements to pay this balance so that we can reschedule your child’s appointment.

Please call immediately if there has been an error on our part.
Dear Parent,

We are performing an audit of our charts. We have brought your chart to the attention of Dr. X and he/she has asked us to send you this last reminder notice. Before placing your chart with our inactive charts, we want to contact you to be sure that you know that you are past due for an appointment. Please call our office immediately to make your appointment. Unless we hear from you in the next 30 days we will assume that you are seeing another physician for your continued eye care and will not be returning. Please know that we have enjoyed caring for you in the past and look forward to seeing you again. Please do not hesitate to call our office if you have any questions.

Date of last appt: xx-xxxx  
Advised next appt: xx-xxxx
Advanced Techniques—Repeat Offenders

- Identify chronic no-show patients
  - Many practices have a small group of patients that repeatedly no-show
  - Inform the patient of their status and risk of poor medical outcomes
- Probation strategies/behavior modification
  - Offer only end-of-session appointments
  - Work-in appointments only
    - Show at beginning of session, seen when able
  - Put on “Dr. No-show” schedule to be worked in
    - Double-booked with regular appointment, but seen second
    - If no-show, physician doesn’t waste time
  - Can return to regular appointment once behavior improved
  - Dismiss from practice if necessary
Advanced Techniques

- Penalties
  - Guilt
    - Some patients are used to clinic/ER model
    - Stress appointment is time for them, and “we missed you”
  - Financial
    - May not be possible with certain insurers/benefit plans
    - Define no-show appointment (e.g. cancellation within 24 hours or more than 15 minutes late)
    - Make no-show policy clear, especially if charging fee
      - Written policy for staff
      - Written notification for patients
No-Show Policy Examples

• We work hard to see patients on time. If you are unable to keep your appt, please call us as far in advance as possible so we can offer the time reserved for you to someone else who needs it.

• If you must cancel or reschedule your appointment, we require 24 working hour notice (48 hours for two children). We will charge $ xx for appointments missed or canceled with less than 24 hours notice. Generally, we can not fill appointment spots with less than 24 hour notice - thus your missed appointment makes the delay time longer for others to get an appointment.

• If you need or cancel or reschedule you need to give more than 24 working hours ahead of time or there will be a $ xx charge to reschedule and a $ 2xx charge for weekend or evening appointments.

• As a courtesy to other patients and to avoid a $ xx missed appt fee, please call us 24 hours in advance if you need to change or cancel this appt
No-Show Fee

- Post a notice at the front desk where patients check-in (inform them of the charge, if any)
  - Include in new patient welcome package
- Add a notification to your financial form that new patients sign if you charge a fee
- Obtain credit card information when appointment is scheduled
- If you chose to charge a fee, have a protocol in place for your billing department and supervisors
  - Who can waive the fee?
No-Show Fee Waiver

- Make list of acceptable and unacceptable reasons for no-shows to help decide if fee should be waived

- Acceptable
  - Sudden illness
  - Major traffic accident/breakdown
  - Adverse weather (snow, tornado, earthquake, volcanic eruptions)

- Unacceptable
  - Conflict – made a different appt at the same time
  - Unexpected sports practice called by coach
  - Patient doesn’t want to come
  - Doesn’t want to be dilated
  - Too much homework
OMIC Letters

- Available letters:
  - Missed appointment letter
  - Non-compliance letter
  - Termination of care letter

- Available at:
  http://www.omic.com/resources/risk_man/medOffc_patSafety.cfm
Challenges In Multispecialty Practices

- Practice guidelines may not be suitable for your pediatric practice
- My worst clinic day ever
  - 15 patients scheduled
  - 10 no-shows
  - 0 patients showing between 1:15 and 3:00 pm

- What happened?
My Strategy For Improvement

- I identified how my pediatric patient population was different from the adult practice patients that could cause a worse no-show rate
- Modified day-prior reminder calls
  - Found over 50% were left messages
    - More left message patients no-showed than if spoken to in person
  - I now have our late-stay receptionist re-call after 5pm
    - Increases contact rate and decreases no-shows
- Obtained improved demographics
  - Practice traditionally defaults to home phone number
    - Many elderly patients exclusively use land-lines
  - Instructed our receptionist to specifically ask for cell phone number
    - Increases the contact rate
Why a No-Show Rate of 8-20%

- Why do so many of our patients no-show?
  - Is it because our dilated exams take so long and the blur interferes with so many activities?
  - It is because we are only “providers”?
  - It is because insurance companies are the middle-men?
  - Is it because we deal with kids?
  - Is it because we deal with a lot of Medicaid?
Why a No-Show Rate of 8-20%

- Why do parents think that it is a higher priority to attend a changed sport practice for an 8 year old than to keep a doctor's appointment?

- Are we perceived as busy or rich, so it doesn't matter if they no-show?

- It is because it seems like we and/or our staff don't care/don't give enough time? Do our patients feel that they are being treated in a factory?

- Is the waiting room always a "zoo" with long waits so that they feel we don't respect their time and figure it wouldn't matter if they no-show?

- What can we do to regain our authority?