Introduction to Practice Data and Pivot Tables

Get access to some data, learn a tool, and do some analysis and get some insight. And don't let the perfect be the enemy of the good in getting started.

Play with some date and learn some things about your practice. You know what? If you learn pivot tables and start putting your practices data in pivot table, Like a partner meeting or a board meeting, or whatever else, you'd better bring dinner.

Because they're gonna have questions, because they've never seen it before. They go, I didn't know you could do that, and then it just goes on and on.

If you can get access to your data, on a tool like pivot tables, build into Excel, if you have Excel you'll have pivot table, it's not an extra thousand a month or any awful thing, just plain data.

That's what, try that at home. Try that. Welcome to Medical Money Matters, the podcast where you can find experts, answers, and resources so that you achieve mastery over the financial and business aspects of your practice.

Welcome, everyone. Today on Medical money matters, I am joined by someone who has probably forgotten more about medical group data analytics than most of us will ever learn.

Because I'm old, Drew. But thankfully you still teach it, so that's good for all of us. So Nate Moore is the founder of Moore Solutions and one of those rare people who can walk into a complex medical group, take a look at the data stack, the org chart, and the comp plan, call schedule, governance structure, within 15 minutes or so say, ah, here is a real issue.

Nate has a particular genius for helping medical groups untangle compensation models, governance drama and operational chaos and turning them into systems that actually work for physicians instead of against them.

He has been called a magician, a data guru and a next level guy. All true. I am going to add Pivot Table Master to the list. If you've ever thought there has to be a better way to run this group, you're going to love this conversation.

Nate, welcome to the podcast. Thanks, Jill. If a third of that was true, that'd be great. I'm going go with a hundred percent of it was The business of medicine has changed.

Why Medical Groups Need Better Analytics

The good old days of, hey, run a couple reports, charges, payments, adjustments, AR, call it a day. It's not cutting it in today's medical practice environment.

We've had this conversation. And hopefully we can talk a bit today about… what I've seen groups do and what groups you're doing to push back against the shenanigans payers are up to, or trying to keep all these physicians happy and physician, cop, and I think I'm a CPA by training.

I am a dating nerd. If I can put good data in front of the practice, in for the practicing ministers, for other docs or whatever, and help them run their practice with data, that's really what I try to do.

And there's a bunch of examples out there that we could talk about. I mean, the current way, you've seen the down-coding thing with the groups you work with.

The payers are just randomly saying, I know you build a 99214, we're making it a three because we can. We

wouldn't recommend patient on the street, but we know what happened in that exam room and we are going to down code it.

Yeah. Number one, you can't look for a manual. You just can look manually. If you're a group of any size at all, You need something that's automated that is going to find these things.

And if you could do… with the groups I work with, I spend a lot of time looking for exception reports. I don't want to see every single 99214. What I want see is the one fours got billed to one three, or the 05s that got down-coded to an 04, whatever it is.

And I find those kind of things, show you an exception report, and then give you the ability to act on it. bank on the fact that you don't have enough bandwidth, your practice doesn't not have bandwidth to deal with all the shenanigans they're trying to do, whether it's down-coding or random denials and we'll do enough time to appeal, whatever.

And if we can find a way to take on an ocean of data and just kind of narrow it down to what we really need to see. Anyway. Yeah, that's fantastic. And I'm just reflecting on your down-coding comments, given what we know about the number of visits that are already undercoded by physicians out there that aren't getting full credit, aren' taking full- credit for what they've done.

When they do code a four or a five that United or Cigna or somebody else is going to come along and just randomly down code, and that makes my blood run cold.

But you're absolutely right. You've got providers in the first place that are nervous about, oh, I did afford, but I only get a bill of three, because whatever.

And then to get down-coded on top of that. Jill, you know this better than anybody. Medical practice is under a lot of pressure. I mean, costs are going up, and revenue is not.

Yes. Yeah. But I don't have to be a CPA to that, right? Yeah, yeah. To get what's happening with the margins. Everybody is getting squeezed. Yeah, so I love just seeing the work that you do with groups and the fact that we have so many groups that are really like drowning in data, but it's like there's no information anywhere to be data.

So I'm curious when you go into a group newly, like what do you help them look for specifically? I mean, you just said exception reports, what kinds of things do see?

Let's, based on what you said, Jill, let's throw it a different way for a second. If you forget to create or distribute or whatever, a weekly report or monthly report, or wherever, and your docs don't say a thing, that's a bad sign.

That's the bad sign, you know what I'm saying? And if you're doing the same reports that your predecessor did, that their predecessor didn't, it's been that way for 20 years, I am here to tell you that medical practices have changed in that interim and we've got to change the things we look at and the changed things that we looked for and if your going to measure what you want to manage.

We've got to change what we're measuring if we are going to and you don't tell them about X, Y, and Z until a month later, or two months later or three months, you're not going to impact behavior.

What you need is something that's automated, that simple, it says, hey, your on track to be 10% under your work RVUs or your collections or whatever your physician comp plan is.

I want to tell you that on the 15th of the month. So you can say, oh, I can open up a Friday afternoon or there's another surgery slot I could fill or wherever.

You know, the data's got to be actionable and as close to real time as you can get it. And our historical approach of old data when we get around to it and a stack of reports.

Using Exception Reports to Catch Underpayments and Denials

It's just not going to do it in today's environment. Yeah, spot on. And I remember the days of running the reports. They came out with the little tractor feed on the side of the paper.

Those were great, all those reports, they would stack up really neatly too when you were done printing them. You're working AR off the dot matrix guy, right?

Exactly, exactly. By the time you get to the Cs and Ds, payments have come in and more charges have Now it's only a start over again. And what we need are tools that can help us deal with, to your point, a mountain of data and say, yeah, I got a amount of the data, but here's what I'm going to act on today.

Yes. Here are the Blue Cross is secondary and it over 90 days and the balance is over 500 bucks and there are 15 of them. That's why I want you to work today if we can do that rather than dot matrix.

I am surprised by the number of groups that don't even have that level of sophistication in their revenue cycle follow-up. I have my report and I just go down the list and it's not sorted in any kind of intelligent way.

They've assigned the same level to a $35 claim as a 35,000 dollar claim and they're just going down a list. Yeah, to your bandwidth. Good discussion. If you got this many yard of work or appeals or whatever else, what you need is some history and some things to say, all right, if I appeal this code to United and this coded and then this go to the blues, the one that's going to respond, I'm going get dollars per.

appeal back on in the, I'm not picking on somebody, but let's say for my practice, response to appeals and I get X cents on the dollar and it's three X more than I give for the blues or for, you know, the local payer or whoever it is.

If I can get some of that information and say, yeah, know I got too many appeals to deal with. But I know that these are the ones I had to prioritize because I've taken the time, If I do a hundred appeals of the blues, I'm only going to get X, but I know a 100 appeals event.

I might get why I want to do 100 peels of and every time that if I have to really go back to the Blues or whatever. Right, right. Not telling you not to appeal stuff.

But what I am is if you're pressed, like so many practices today are pressed. Prioritize and prioritize smartly, not the way you've always done it. Yeah, no, that's great.

What's thinking a little bit about that? What, like how many practices do you go into where you see that they have good prioritization and they're actually kind of slicing and dicing the data in an intelligent fashion?

Is that like 10% of them, 80%? That's a good question. And I don't know what your experience is. I think most of the practices that engage me are savvy.

They're the smart ones that see the value, they get the ROI, that know, hey, if we just had one more thing that did this or one thing they did that, or kind of start the process, and then they'd get it and roll from there.

I help somewhat like some medical practices consultants, kind folks like you. They get some folks that are in deep trouble, then we help them with some basic reports and get back.

But most of the folks I work with are the 18, the folks that get what they're trying to do. I'll give you an example. There's orthopedic practice that I've worked with for years.

And they said, you know what? We know we're getting underpaid. We got to find a way to figure out and beat the system. So we built a process to go through.

Essentially, what we did, Jill, is we adjudicate the claims the way we understand the contract. You got our

contracts. Just a pair of contracting friends will tell you.

Yeah. You have the contracts versus you write. Load your contracts. This group was savvy enough to say, all right, we've got our contracts, and we know we're being underpaid to figure it out.

And we caught a local care, probably 30 orthopedic surgeons and another 30 advanced practitioners in the group. six figures, and it wasn't one or two in front of the six figure.

It was serious money that we were able to recoup because, oh, we didn't love the contract, right? And we did recognize some of those kind of things. Oh, yeah.

can recognize some of those issues and that will put the resources behind the data to act on the kind of things I tell them. And they can really pull with it, if that makes sense.

Absolutely makes. Yeah, and this is the magic that you have that I love to see when you come in and work that kind We just had a local group here, a smaller number of clinicians, and they had about a third of the amount of money that you just stated on a contract that didn't get loaded.

And it went on for quite a while, but then they uncovered it, thankfully. But yeah, it's just those kinds of things happen. We assume good intent from the payers.

Whether or not that's a good assumption is another whole conversation. Sometimes you get it back and sometimes they get timely filed or whatever their bad excuse is or whenever.

And boy, you got to act on this stuff before it's too late. Yeah, because they're very quick with those timely filing. I mean, that's it. But I think it is our friends, Kem and Taya have said to me many times, the statistic is about 65% of denials are never followed up.

And the payers know that. Oh, do they? And you know, Jill, it's a great point on a broader scale. You know what? The payors are going to have the data.

They're going know. Right? Mm-hmm.

Prioritizing Appeals and Revenue Cycle Work

And if you've got savvy competitors, they're gonna have data and they are gonna know and to try to compete in that environment where your revenue stream is based on folks that know more than you do around the There's no more than you do around the data.

That's two strikes against you. Yeah. So what do you recommend for groups like that? Other than hire Nate, which is a great answer, what else do say to groups where people are listening and they're saying, okay, he's making a good point.

How do they handle that. I think sometimes what I'll do, sometimes there is pushback from the physicians saying, and I'm sure you see this too, Jill, saying I am not sure we're ready to hire somebody either, either an outside consultant or another FTE or whatever it is.

And they don't sense the need or they feel the cost pressure or whenever. Sometimes what'll I do is the first project will be the one that physicians or the board or whoever is focused on and solve their problem.

In the process of solving their problems, build a system, build work flow, built a culture that says, we're going to act based on data. We're gonna make our decisions based data, and so here's something that the board was interested in, maybe it's physician comp or whatever their issue is, And maybe the ROI is here, but we built something, right?

We built structure, a foundation. And now we can leverage that foundation and say, all right, now let's go after where the real is. The board is focused on that.

But your issue is its appeals. It doesn't take much to get me off on a tangent. I love the conversation. You've probably seen in my presentations, you have seen the slide I showed years ago.

One of my biggest clients is in foreign Indiana, I live in Utah. The way to from foreign Indian is to fly Delta. From Delta you fly Fort Wayne to Detroit, and Detroit back to Salt Lake.

Detroit's a hot Salt Lakes now, that's what you do. And I was outside the airport, this is probably eight or 10 years and return to the rental car, ready to go back, flight to Detroit.

And I get a message from Delta saying, oh, we're about 30 minutes delayed. Pretty soon it was 60 minutes and pretty soon, it were several hours. The drive from Fort Wayne to Detroits, like two and a half, three hours, so everybody, the locals who had to be there, just plain drove.

So by the time it's nine o'clock at night, I show up at the Fort Rain airport and there are two pilots, one flight attendant and me. And I've got a picture.

You've probably seen the picture in my presentation. Delta does not like me that much, Jill Arena, let me tell you. But they had to have the plane further into Michigan that night, so they flew.

And the point I tell from that story is Delta lost money in that flight, but they knew they did. They look at the plan, it's obvious. I think a lot of the times practices have unfilled open appointment slots that they can't see that or worship the roping off slots on the plane because, you know, we'll hold these and if we fill the morning, then we will open the afternoon or, all this worry.

orthopedic surgeons, neurosurgeons, you know, sometimes what they want is blonde hair, blue eyes, 23 years old with knee pain. And if you don't read our criteria, then you can't fit the- You can have this appointed slot, no?

And what we need to do is if I can show you, hey, did you that you've got X amount of unfilled appointment slots last week, last month, whatever the metric is, and here's your wait list.

We got people trying to get in the door. Your compensation model is work RVUs or collections or whatever it is that's driven by folks coming in the door, and you're not opening the doors and not letting people in.

And if we can see that kind of data and change things to say, all right, maybe not blonde hair and blue eyes, but just blonde here and knee pink, can we let, you know what I'm saying?

Stretch those requirements a little bit, yeah. You know what? We're going to flag this, and we're gonna automatically flag it. And we'll let anybody and their dog in within 48 hours of the appointment, because we want them to fill out a slot.

Yeah. Those kind of things, can we see those kind things ahead of time and fill them, to do this? I don't know why you see it with your practices, but if I have a no-show within 24 hours, how many of your practice can fill that slot?

What do you think? Very few, very few. If I were to cancelation, I shouldn't say no, cancelations within 24 hours, cancellation within 48 hours. How many of your practices can fill that slot?

Very few. We don't see a lot that are actively either actively or in an automated sense managing any kind of waiting list, although they all would have a waiting lists if they created that as a possibility.

And can you, I've seen software that will like text out five people and first one to respond get the slot and I have seen things where you have to try to fill slots.

But if you can see some of that and see it coming and then act on it. Yeah. whether that's unfilled deployment slots or whether, how can I fill, I did this for a group in the Dallas area years ago, and they were dermatology.

Appointment Data, No-Shows, and Scheduling Strategy

And the deal is, let me back up one step, they're dermatologists and we plotted their no-show rates on a chart. Y-axis going up and down was your no show rate, 2%, 4%, 8%, whatever.

The X-Axis going across was how long in advance was was your appointment schedule. So if I scheduled on two weeks out or whatever, what's my no-show rate if they scheduled a day out, 14 days out?

Or however many days? By charting that for dermatology, no show rate doubled after a couple of days. The rash went away, or they found another provider, they wanted to be seen, and the no share rate double within a few days, so what we said was, we've got to do everything we can to minimize that window.

Okay, can we get a patient in 48 hours? Can you give me 24 hours?" How do we even find them in the first place? And we build a bunch of workflows around that to say, okay, we're going to get people in that door if we'd get an unfilled appointment.

We're gonna see unfill appointment slots up front. But with their cancellation, we had reports going during the day that said, We want to find them, and we want them to fill slots and drive revenue to the practice.

Because those extra couple of appointments a day, Jill, they go straight to bottom left. It really adds up, absolutely, because you've covered all the costs already.

Yeah. Other than physician comp or whatever, most of your costs are fixed. And you can capture that. Adam, I'm always fascinated when you go in and you sort of look at what the setup is, especially around the schedules and practices, and, you learn a lot about their culture that way.

And exactly what you're saying, if the physicians and clinicians relate to the schedule as sort protection from, like, I need a protected hour to do this or that, and they don't really relate to it like this is my bread and butter, this my cash flow, every one of these slots is extraordinarily valuable.

And we had a group, a single specialty group a few years back, when they went in to a system upgrade and conversion, they had 93 appointment types. in their system.

They could not keep from office staff because 93 appointment times, you know, and it was to your point, it wasn't, yeah, blonde hair, blue eyed within this very narrow age range and knee pain.

Yeah. And that's all they can have Tuesday at two. So it, was, I, It was fairly freeing. I made the bold statement going into the system change that, we probably need to aim for, six or eight appointment types and you can see everybody swallow.

Let's see what we can do. The physicians I've most enjoyed working with over the years will say, I'm going to be here at eight. I'll try to leave here around five.

Put some patients in for me, will you? I don't care how you do it. Maybe I will have some lunch in the middle. And I get the notion of trying to have a bit of a sane work day in your profession.

But yeah, 93 appointment tax was the record for us. And that was only across like 15 positions. So that, yeah. I want to come back to appointments in just a second.

Because appointments, they drive the revenue cycle. We're going to go back that bit. You're based in the Portland area. The Pacific Northwest Conference, this is several years ago.

And somebody raised their, and we were talking about reducing no shows and managing appointments in unfilled appointments, lots of stuff like that. Some of the backs that I used to work, it was kind of like answer for a friend, Joe, but I use to worked at a university that had a thousand appointment types.

I mean, there's just no way. Yeah. And so let's talk about appointment types for a minute and why that might matter. I think you can, and you've probably heard me say this in the end of presentation before too.

If Target knew who was coming in tomorrow, what they were going to buy, when they weren't going come and those kind of, they had all that data there. Target would, that changed their hours.

They would change their inventory levels. That stock differently. Did do all kinds of things because they knew exactly who's coming and what run their inventory and their operations accordingly.

We're so happy the claim gets paid. Wait, throw away all that data. I mean, we know who's coming in tomorrow, for the most part, right? Right. Next week, For the last part.

Yeah. And how can we plan and do some of that? You're familiar with the claims, Trevor. Before you send the client to the door, you run tests to make sure you're going to get paid before it gets denied.

Then you get an appeal and it's another 60, 90, 120 days before you pay. For groups that I work with I built an appointments forever show me all my future appointments And I've got a list of all the things that might go wrong that means you don't need the patient You know took time off work got daycare drove, you know 45 minutes to see me whatever it is and they show up and They can't be seen because they've gotten old insurance and we don''t take that insurance anymore or you Know they're in the global period in it.

This is not an argument Don't if you need to patient the Global period see it seen them But know they're in the global period that you're doing this and not this is an appointment that was created three or four months ago and then we had back there near a knee surgery a week ago.

And now, you know, just know that they are in there. Do I have insurance issues? Do they do I even know what the copay is to collect? Is there a patient balance that I had to click before they come in?

There's all kinds of things that. You could know about the future because appointments kick off your revenue cycle. Yeah. If you follow up appointments up front, your group with 93 appointment types or whatever else, it should downstream.

Oh, yeah. It just gets harder. Yeah, and we were doing revenue cycle for that group that had 93 appointment types. And so our team was busy mopping up on the other end and also moping up from the fact that they couldn't keep front office staff.

So there was all this turnover. Like 30% of the last number I saw from MGMA. 30%. Every year from the desk, yeah. Every, so a third of your staff in a medical practice every year.

I can't even imagine, I mean, the cost of that. There's so many different ways to estimate the costs. Sure. And there's some many non-monetary costs of turnover as well.

We could probably quantify the dollars, but so, many things just in terms of reputation and relationship and all of the things that get lost when you have that- I agree.

It does fascinate me how the, I'm sure you find it, getting into systems and looking at the data is a bit like an archaeological digging, right? And then you're just in there.

One of the challenges lately is more and more practices are saying I don't want to deal with the IT and the PHI and HIPAA and all those kinds of things.

So I put my data in the cloud.

Owning Your Data and Learning from Pivot Tables

The challenge is now you have to say, Mother, may I, and pay to get your data out of the cloud so you can do something with it because most of that canned reports are still charges, payments, adjustments, they are right where we started, right?

Those saying, you know, this is what we're doing and it's not the level that we need to be doing. And if your date is held hostage in the Cloud, it makes it even harder to run the kind of course or to automate the kinds of things.

Just show me what I need to see. Tell me everything else is running great, but I needed to these five appointments tomorrow or these 20 next week or whatever.

Help me with these and it's hard to get that if you're paying to access to your own data out of the cloud. Yep, that's well put. We've run into a lot of groups that really don't have control over their revenue cycle data.

Like they'll have to control their chart, but not the money side. And that always fascinates me. Why would you abdicate control of the information that is about your money to anybody?

There ought to be a strategic advantage, right? I mean, target in a million years, and pick your favorite retailer or your least favorite retailers, whoever it is.

In a billion years it's not going to give away access to a strategy advantage like medical practices do every day. Oh, yeah. It is fascinating, isn't it?

I mean, just all of the things. This is a question that has nibbled at me for a long time, and I'd love your thoughts on it. I can observe that health care in general and medical practices specifically lag probably 10, 15, maybe 20 years behind in terms of deployment and utilization of technology.

What would you say are some of those causal factors of that? No, a lot of it is this is what we've always done at Joe. This is, you know, it's the way we always, and I think it.

It is hard to do. I mean, we talk about target or whoever your retailer is then after you have PHI, right? They don't have to be. And then, so there's some constraints there, but I.

Think it and it, I, think some of the physicians need to see the opportunity and the strategic advantage, the competitive advantage. in owning your data, in knowing what's going on, and be able to, well, you're pushing back against payers or your competitors or whatever.

I'll throw you one more example about knowing your, how knowing data might help. Physicians are typically competitive. The neurosurgeons and the groups I work with, I mean, they haven't been fifth at anything since kindergarten.

Right. Yeah, yeah, right. They were fifth in kindergarten, but yeah. And you can show them that, hey, Jill saw 100 patients and 38 of them were in surgery within six months.

Neurosurgery, right? Conservative care takes longer. And Nate saw a hundred patients, and 15 of him were surgery. So the first thing he says, I got all the, whoever it is, it's hard to pre-op, Blue Cross, United, our market, whatever.

But if you come back to the data and say, look, you saw a similar patient mix. You saw similar ages, similar diagnoses, and if physicians are trying to respond to data, if can show them that data.

And say all right, how'd Jill get 38 when I only got 15? What's Jill doing? Is it the way she's documenting the notes

she sends? The way we do the pre-author request or whatever it is.

If we can learn from that and use the date to learn we can drive a lot of change in our practice if we just don't have the data to do that. And you're going to get that from a canned report, right?

You've got to have a business intelligence team, doesn't it have to be me, but somebody that's looking at your data that can run some kind of reports and tell you, here's an opportunity.

Yeah, I'm glad you used the term business intelligence. I wanted to make sure that we wove that into this conversation because that's exactly what it is.

And it's one of the things I've always admired about you and your practice is just how you go in and ask those really intelligent questions and then how use the data.

to find the answers that really are actionable as opposed to charges, payments, and adjustments, which should be actionable, but then there's always dig deeper and find more answers.

So you and I could talk all day for three days probably about data. I would love to hear one pearl of wisdom from you to sort of help round out our episode here for physicians and administrators when they're sitting with those piles of data, So here's your try this at home, right?

This is what, try at this home. I think what I'd do is start small. Just get access to data you haven't looked at before. Find a way to get data out of your system and learn a tool to manipulate it, to play with it to ask it questions.

If you have seen pivot tables in Excel, like Jill says, I'm Pivot Table Guy on Twitter and YouTube and X and wow. It has a fabulous pivot table presentation.

if you're able to catch him live ever, you should do it. Bring your laptop or something. And on your website as well. And we'll put that in the show notes so everybody can go to your web site.

Get access to some data, learn a tool, and do some analysis and get some insight. Don't let the perfect be the enemy of the good in getting started. Play with some date and learn some things about your practice.

You know what? If you learn pivot tables and start putting your practices data in pivot table, If you had like a partner meeting or a board meeting, or whatever else, you'd better bring dinner because they're going to have questions because I've never seen it before.

I didn't know you could do that. And then it just goes on and on. If, if you can get access to your data and a tool like pivot tables, it's built into Excel.

You have Excel, and you have pivot table. It's not an extra thousand a month or any awful thing. She's playing data. That's what. Try that at home, Jim.

Love it. I love it, try PivotTable at Home. There you have it! All right. Nate, thank you so much for the time and the conversation and also just for contribution that you are to the medical community.

And this is a huge contribution to medical communities to do this, Jill. So more power to you for your efforts to educate and enlighten. It's just time to show folks, hey, there's another way, a better way you can do it this.

Thank you. Great to be with you! Thanks for tuning in to today's episode of the Medical Money Matters podcast. Before you go, let me ask you, are you ready to take your medical group's coding to the next level?

Because that's where code mastery comes in. Code mastery isn't just another coding program. It's the ultimate physician to physician training solution to maximize your revenue and empower your physicians with the skills they need to code confidently and win the coding game.

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