CHAPTER 2

Financial Management
What are the best financial ratios and reports I should use to monitor the financial health of my practice?

There are almost as many opinions on what the key financial ratios are for medical practices as there are calculations. Also, there are ratios and reports that need to be monitored on a monthly basis, while others are part of the year-end report and review. The ratios you choose to analyze regularly will depend on the type of practice (community health center, hospital owned, or specialty center) and its goals. By selecting a few key performance indicators to review frequently, you will be able to concentrate efforts on areas key to financial success and be able to observe trends or spot potential issues in a timely manner. Also, the indicators you choose for one period of time may not be as relevant in the future. Re-evaluate your key indicators from time to time.

David N. Gans, MSHA, FACMPE, has identified the key financial performance indicators applicable for most practice types:

<table>
<thead>
<tr>
<th>Revenue cycle indicators</th>
<th>Total accounts receivable per physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of total accounts receivable 120+ days old</td>
</tr>
<tr>
<td></td>
<td>Days in accounts receivable</td>
</tr>
<tr>
<td></td>
<td>Adjusted fee-for-service collection percentage</td>
</tr>
<tr>
<td>Financial performance</td>
<td>Total medical revenue per physician</td>
</tr>
<tr>
<td></td>
<td>Total operating cost per physician</td>
</tr>
<tr>
<td></td>
<td>Total medical revenue after operating cost per physician</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Total operating cost as a percentage of total medical revenue</td>
</tr>
</tbody>
</table>
Medical groups identified by an MGMA survey as better performers typically generate the following reports monthly and annually to evaluate financial performance:

- **Financial reports:**
  - Accounts receivable aging report;
  - Cost reports by department, provider, and location;
  - Income statement;
  - Balance sheet; and
  - Statement of cash flow.

- **Practice management reports:**
  - Collections system summary analysis;
  - Untracked encounter forms report;
  - Unbilled revenue report;
  - Billing summary;
  - Procedures analysis; and
  - Managed care plan profitability (capitation analysis).

You may choose to develop a dashboard or flash report to present to physicians and staff. These one-page reports will show key indicators in a format that is easy to understand. Along with key financial information (revenue, expenses, A/R, available cash, and so on), it will also include key performance indicators, such as number of visits, procedures, or work RVUs.

The key to successful financial management is using the reports and indicators effectively. Besides benchmarking with other practices, they should enable you to compare the practice’s status with annual budgets and organizational goals.

**Sources:**


I am analyzing the accounts receivable for my practice. How does my A/R compare with other practices?

You are right to be concerned about accounts receivable (A/R); it is one of the key indicators of whether or not a practice is on the right financial track. The longer the accounts go uncollected, the more revenue is lost and the more your practice’s resources are spent in ongoing collection efforts. Accounts receivable aging and days or months outstanding should be included in a monthly key indicator financial report.

However, knowing your practice’s A/R doesn’t help without knowing how your numbers compare with other practices. To compare your A/R numbers, refer to the annual MGMA Cost Survey Report or the Performance and Practices of Successful Medical Groups Report.

MGMA uses the following definition for calculating A/R in its two reports:

A/R is the summation of the amounts owed to the practice by patients, third-party payers, employer groups, and others for fee-for-service (FFS) activities before bad debt or contractual adjustments. Assigning a charge into A/R begins at the time an invoice is submitted to the payer or patient for payment.

Months of gross fee-for-service charges in accounts receivable = 
\[
\frac{\text{(Total accounts receivable)}}{\text{(Gross FFS charges)}} \times \frac{1}{12}
\]
Accounts receivable key performance indicators

<table>
<thead>
<tr>
<th></th>
<th>Percentage of total A/R 120+ days</th>
<th>Months gross FFS charges in A/R</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Better Performers</td>
<td>All Respondents</td>
</tr>
<tr>
<td>Primary care</td>
<td>10.34%</td>
<td>19.17%</td>
</tr>
<tr>
<td>Medicine specialties</td>
<td>9.52%</td>
<td>16.12%</td>
</tr>
<tr>
<td>Surgical specialties</td>
<td>9.02%</td>
<td>16.55%</td>
</tr>
<tr>
<td>Multispecialty practices</td>
<td>10.23%</td>
<td>17.76%</td>
</tr>
</tbody>
</table>

Note: FFS = fee for service


If your accounts receivable numbers do not compare favorably with the better-performing groups studied in the MGMA report, you should investigate aspects of your payment and collection processes to identify problem areas. Steps might include:

- **Analyzing collections by payer.** Which payers are slower to pay and which ones have more denials?

- **Assessing collections from patients.** Is the practice collecting all the copayments, prepayments, and outstanding payments at the time of service? Is the payment process explained to patients before or at the time of service? Some practices employ a financial counselor to advise and assist patients.

- **Calculating the frequency of errors that delay collections.** Repeated errors in gathering patient data, coding, billing, or in other processes are signs of where changes need to be made.

- **Investigating means to leverage the practice management or billing program.** These systems should have automated means of notifying staff when accounts are past due or follow-up steps should be taken.
I would like to get the bad debt for my practice under control. How can we manage our bad debt to ensure it is not out of line with the industry average?

There are two kinds of bad debt: (1) bad debt from commercial payers (health insurance, for example) and self-pay patients, and (2) inappropriate contractual write-offs and denied claims by payers (denials are discussed in Question 13). The MGMA benchmarks for bad debt from commercial payers and patients follow.
Bad debts due to fee-for-service activities per FTE physician

<table>
<thead>
<tr>
<th></th>
<th>Better performers</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care practices</td>
<td>$5,535</td>
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</tr>
<tr>
<td>Medicine specialties</td>
<td>$14,035</td>
<td>$19,564</td>
</tr>
<tr>
<td>Surgical specialties</td>
<td>$15,888</td>
<td>$27,977</td>
</tr>
</tbody>
</table>


If your practice is experiencing higher bad debt than the benchmarks, you will need to identify the source of the problem and then implement solutions. To identify the source, you will need to review several operational issues and financial ratios.

Start by analyzing the bad debt and your A/R. Is the chief culprit self-pay patients or payers? Is there one payer that leads the pack for denying payments? (See Question 11 for help with A/R.) If the bad debt is related to payers, what are the reasons for the lack of payment? Review the contract, claims completion and submission processes, and reasons for denials and rejections.

If bad debt is largely caused by self-pay patients, is it related to inaccurate patient information or inadequate steps to ensure payment? Review front-office and billing-department procedures to identify improvements in collecting copays, coinsurance, deductibles, and noncovered charges at the time of service. For larger payments, meet with patients to discuss payment options (including cash, checks, credit and debit cards) and payment plans. Do you offer installment plans? Include employees in suggestions and training to increase time-of-service payments. For instance, encourage employees to ask, “How would you like to pay today?” instead of “Would you like to pay now?”

Bad debt may be caused by little or no follow-up to claims, whether or not the payer is a managed care company or patient. What processes are in place if a claim is denied, rejected, or otherwise not paid within a designated period? Are there adequate personnel to follow up on claims, and do they have the training and resources needed to complete the process?
If your practice has insufficient resources for adequate follow-up or has exhausted its abilities to collect, you may choose to turn over outstanding accounts to collection agencies. The older an account is, the less chance that it can be collected even by a collection agency. After 90 days, a business has only a 69.6 percent probability of collecting its money. By six months, the odds drop to 52.1 percent. Develop policies specifying at what age an account will be sent to collection agencies, and streamline the process to minimize delays and expenses.

A CLOSER LOOK . . .

Forty-eight percent of the better-performing practices collected more than 90 percent of their patient copayments at the time of service, compared to 35 percent of the other responding practices.


Sources:


My practice is suffering from an increasing number of claims being rejected by payers. Do you know what the average is for the percentage of claims denied? What can I do to reverse this trend?

A LOOK AT THE NUMBERS . . .

The ideal is to have claim denials at 5 percent or less of the total claims submitted. Better-performing groups typically had 4 percent of claims denied on the first submission, according to the MGMA Performance and Practices of Successful Medical Groups: 2010 Report Based on 2009 Data.

The cost of reworking a denied claim is approximately $15 per claim including staff time, interest, and overhead, according to Deborah Walker Keegan, Elizabeth W. Woodcock, and Sara M. Larch in The Physician Billing Process: 12 Potholes to Avoid in the Road to Getting Paid, 2nd Edition (MGMA, 2009).

Many practices choose to ignore denied claims with the idea that they aren’t worth the effort to follow up. You are smart to realize that accepting rejected claims is denying money that your practice is due. There are several steps you can take to assess and correct the issue:

Step 1. Study the Explanation of Benefits to determine the reasons for denied claims. This involves deciphering the explanations and codes used by different payers and Medicare.

Step 2. Categorize the reasons for denials and tabulate the totals by category. Separate the data by payer and department or even by physician. Identify the most frequent reasons for claim rejection and whether specific payers, departments, or physicians have higher rates than others.

The most frequent reasons for denied claims are

- Patient registration errors, including missing data;
- Lack of insurance verification;
➤ Inappropriate code or modifiers;
➤ Incomplete information relating to referrals and pre-authorizations;
➤ Duplicate bills for the same services;
➤ Medical necessity claims and documentation;
➤ Incomplete documentation for the medical services provided; and
➤ Incorrectly bundling services.

**Step 3.** Set up processes for resubmitting claims. Denied claims should be adjusted based on the reason for the denial and then resubmitted. When resubmitting the claim, include a letter to the payer explaining the reason for the second submission. Identify the claim and include additional documents to support the claim, providing information or data not included with the first submission.

Identify one or two employees who will lead the effort, and ensure that they have adequate training to understand the billing processes and payers’ techniques and have the right resources to accomplish the goals. The employee should be familiar with correct coding policy, including Medicare’s National Correct Coding Initiative (NCCI). Leverage your practice management or billing system to automate as much as possible.

If claims are denied a second or third time, learn about the payer’s appeal policies and other options. Medicare’s policy is available at www.cms.hhs.gov/OrgMedFFSappeals.

**Step 4.** Use the reasons for rejected claims to correct errors within practice operations. Minimizing the problems before claim submission will decrease the number of rejections and increase practice efficiency and revenue. If patient registration errors were a major reason for denials, how can front-office efforts be improved to minimize errors? If lack of documentation is a problem, include a step or checklist prior to claim submission to ensure that all documentation is in place. Problem payers may require a telephone call or face-to-face meetings with company representatives.
Step 5. Keep on it. After processes are in place to minimize rejections, don’t assume the problem will go away. Continue to monitor denial rates and implemented changes to ensure the rates decrease and the corrective measures remain effective.

A CLOSER LOOK . . .

Total Account Ownership — Elizabeth W. Woodcock, practice consultant and speaker, proposes another option for managing claim submission and follow-up: total account ownership (TAO). Employees are assigned by payer to handle claims from start to finish — reviewing and submitting claims, posting payments, making contractual adjustments, correcting and resubmitting rejected claims, and transferring claim responsibility to second parties or patients if appropriate. Employees are assigned one or more payers, depending on the number of claims and difficulty of working with that payer. The advantages are the in-depth knowledge and sense of ownership the employee has of the claims and the payer. Supervisors can easily review data to assess payer and employee performance but must ensure that the workload is equitably distributed.


Sources:
QUESTION 14

I need to renegotiate some payer contracts that have not been in our best interest. What steps can I take prior to and during the negotiation process?

A regular review and comparison of your managed care and other health plan contracts is a good idea. It’s often too easy to renew a contract without an in-depth analysis of the payer’s performance and the contract’s terms. Allow several months for adequate time to gather and review data and negotiate the contract prior to the termination of the current contracts.

Step 1. Pull together your current contracts and develop a matrix with the following information:

➤ Payer name;
➤ Termination clauses and termination or anniversary date;
➤ Notification period prior to giving notice to terminate or renegotiate a contract;
➤ Representative’s contact information; and
➤ Reimbursement terms.

Step 2. Analyze the current reimbursement by payer. Record the actual reimbursement (contractual allowable, not the payment) and frequency for at least 20 of your practice’s most common procedures (the more the better) from the last 6 to 12 months. Using total RVUs and allowables for the selected procedures, divide the sum of the allowables by the total RVUs to arrive at a frequency-weighted reimbursement per total RVU. Divide this number by the current Medicare conversion factor to determine the payers’ reimbursement as a percentage of current Medicare. You will then be able to compare reimbursement for all of your payers regardless of the terms of the contract.

Step 3. Compare your charges with the usual, customary, and reasonable (UCR) charge data and Medicare rates. (See Question 15 on fee schedules for UCR data sources.) Ensure that you are within expected ranges, keeping in mind that the UCR can be
as high as 250 percent to 350 percent above Medicare for some specialties.

Analyze the denial or rejection rates, and quantify the administrative costs for claims follow-up or unique authorization, documentation, and carve-out or coding rules.

**Step 4.** Assess your practice’s and the payer’s position in your market. How does your practice stand out compared to others? Look at the access, specialties, services, and procedures you offer. Gather data on your market share and quality measurements. Look at the payers’ data for your marketplace, including

- Contracted hospitals;
- Number of insured in your area;
- Other contracted physicians in your area; and
- Contracted employer groups in your area.

**Step 5.** Start the negotiation process by submitting a written notice asking for a new agreement. Ask for one medical group agreement so you don’t have to deal with several agreements. Research the payer’s rate increases to employers in your area. Don’t accept delaying tactics; set deadlines during the negotiation process. For underperforming payers, you might want to include an intent-to-terminate notice if new terms aren’t agreed upon. This will provide you with more leverage. If the payer refuses to negotiate, evaluate its percentage of your net revenue, factor in the extra expenses related to managing its claims, and determine if you are willing to cancel the contract. You may be able to increase revenue by seeing more patients from better-performing payers.

**Step 6.** Review the contract and its language with your attorney. Confirm state regulations regarding offset rules, timely payment requirements, periods for notifying payers of errors, and other health insurance regulations. MGMA member Cecelia Bartz has an extensive contract checklist that she has found useful:

- The carrier’s rates compared with Medicare’s rates and the practice’s procedure costs. Don’t accept rates based
on current or prevailing Medicare rates in case of future Medicare reductions;

➤ Termination clauses;

➤ Amendment clauses (Are they mutual, or do they allow amendments to be made only by the carrier?);

➤ Policies for billing noncovered services to identify whether you can have the patient sign a waiver agreeing to pay for services the plan won’t cover;

➤ Hold-harmless clauses (replace these with “responsibility for own acts” clauses);

➤ Timely filing limits (should be at least 180 days);

➤ Timely payment provisions (review state requirements);

➤ Denial appeal limits;

➤ Time allowed to recoup overpayments (one year is recommended from the date of service, and require 45 days’ notice before the “take-back” date);

➤ Precedence (What’s the priority reference — the manuals or the contract?);

➤ Compliance with CPT guidelines;

➤ Adherence to NCCI edits;

➤ Opt-in and opt-out provisions;

➤ Practice locations covered by the contract;

➤ Time limits for providing notification about claims that are ineligible for payment and why; and

➤ Quality-of-care requirements (or replace these with “Physicians shall endeavor to provide care of the same quality that prevails in the community”).

Also, watch out for terms regarding binding arbitration or other means of solving disputes. The payer may require that you not join any class-action lawsuits. Another red flag is multiyear agreements without adequate increases in the following years. Ensure they’re based on industry indexes, such as the Consumer Price Index or medical cost index, from the U.S. Bureau of Labor Statistics.
A CLOSER LOOK . . .

New Trends

The U.S. healthcare industry is changing based on demand for reduced costs and increasing quality leading to new reimbursement methods. The “pay me right” concept coordinates the efforts of payers, financial leaders, and providers to ensure coordination with clinical management and contractual and financial processes. The goal is to reduce costs while offering rewards for premium performance.

Many payers are following Medicare’s lead and developing pay-for-performance (P4P) reimbursement methods. Negotiating contracts based on P4P will require an understanding of the selected quality measures, the reimbursement methodology based on those measures, and the processes within your practice for tracking your quality measures. See Question 76 for more P4P information.

Sources:


A CLOSER LOOK . . .

Payer Lawsuits

A class-action lawsuit against Aetna, CIGNA, Prudential, Anthem/WellPoint, and Humana led to a 2007 settlement. The lawsuit, known as In re. Managed Care Litigation or Multidistrict Litigation (MDL), required the insurance payers to comply with fairer business practices including

➤ Improved payment schedules and processes;
➤ Adherence to the American Medical Association CPT;
I have been hired as an administrator of a new practice. How do I ensure that the fee schedule will optimize revenue for the practice?

There are several techniques and resources for medical practice fee schedules. Since you are new to the practice, a comprehensive review of the schedule is called for, but subsequent reviews should occur on an annual basis.

The first step is to investigate if your current fee schedule actually covers the costs of providing the procedures. To compare costs
with your charges, select the most-frequently used codes in the practice and those that bring in the most revenue. Use RVUs to calculate and compare the cost per CPT code and the net or gross charges per procedure. If the net or discounted charges don’t exceed the costs, it’s time to adjust your fee schedule. Keep in mind that it is collections or net revenue, not charges, that pay the overhead expenses and providers. Adjusting charges upward to cover costs may be an answer, but you may also have to look at improving your payer contracts and/or reducing expenses.

The Medicare physician fee schedule can be used as a basis for your practice’s fee schedule. The schedule, based on the resource-based relative value scale (RBRVS), is published annually in the Federal Register or is available online at the Centers for Medicare & Medicaid Services Web site: www.cms.hhs.gov/physicianfeesched.

**A CLOSER LOOK . . .**

The Medicare fee schedule is based on the concept of relative value units (RVUs), defined as the “relative units of measure that indicate the value of healthcare services.” They assign relative values or weights to medical procedures for determining reimbursement. The resource-based relative value scale (RBRVS) was implemented in the Medicare payment system in 1992. The scale is based on an RVU of 1.0 for CPT 99213, and all other RBRVS values are determined relative to 99213.

RBRVS values are comprised of three components:

- **Work RVU** — “The relative time, effort, and skill needed by a provider in the provision of a procedure or service.”

- **Practice expense RVU** — “The costs associated with maintaining a practice, such as rent, equipment, supplies, and staff.”

- **Professional liability insurance or malpractice RVU** — Incorporates the relative level of risk in performing any given procedure.

To adjust for regional differences in health service costs, geographic practice cost indices (GPCIs) are used for each of the three RVU com-
You may need to set your fees at a certain percentage above the Medicare schedule to ensure that your costs are covered. Also, the RBRVS tends to place a relatively higher value on the E&M services, giving lower values to procedures. If your group performs many surgical procedures, you may want to use another system or set a higher conversion factor for surgical services.

You will also need to compare your charges with the reimbursement you have been receiving from insurance companies. You may want to increase your charges if you’ve been receiving full reimbursement from any payers; your charges should be above their reimbursement rate to ensure that you are receiving the maximum allowable. If the payer’s fee schedule is based on Medicare’s, find out if they use the current year’s conversion factor and how geographic locale is factored in.

Most payers are now using their own fee schedules, which payers may not release to you in their entirety. Request information from the payer starting with the CPT codes with the greatest volume or charges. You may need to submit several requests until you have enough codes to conduct an adequate comparison of charges versus costs. Conduct this analysis for every payer and type of service, including E&M codes, medicine, and surgery.

Whatever method you use to set your fee schedule, review it and payers’ reimbursement on a regular basis, annually or biannually, to ensure that your fees reflect changing costs and reimbursements.

ponents. The conversion factor (CF) converts the RVU into a dollar figure, and it is announced for each year. The reimbursement amount for each CPT code is calculated by:

\[
\text{reimbursement value} = \left( \frac{wRVU \times wGPCI}{wRVU \times wGPCI + peRVU \times peGPCI + mRVU \times mGPCI} \right) \times CF
\]

A LOOK AT THE NUMBERS . . .

What is the primary method you use to establish and/or maintain your fee schedule?

a. Ratio of Medicare = 46.2 percent
b. RBRVS = 20.3 percent
c. Based on payer contract amounts = 11.9 percent
d. Surveys and published lists = 6.8 percent
e. Other = 9.9 percent
f. Cost plus markup = 2.9 percent


FOR MORE INFORMATION . . .

Detailed steps for calculating costs and charges can be found in *RVUs: Applications for Medical Practice Success, 2nd Edition*, by Kathryn Glass (Englewood, CO: Medical Group Management Association, 2008).

There are many consultants and businesses that provide information on average fees or will consult with you to develop a fair fee schedule for your practice and location. The following list contains a few contacts:

<table>
<thead>
<tr>
<th>Contact</th>
<th>Web site</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ingenix</td>
<td>Ingenix.com</td>
<td>800.464.3649</td>
</tr>
<tr>
<td>MagMutual Healthcare Solutions</td>
<td>Coderscentral.com</td>
<td>800.253.4945</td>
</tr>
<tr>
<td>Practice Management Information Corporation</td>
<td>PMIOnline.com</td>
<td>800.med.shop</td>
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<td>EMC Captiva UCR Databases</td>
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<td>858.320.1100</td>
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<tr>
<td>MGMA Health Care Consulting Group</td>
<td>MGMA.com</td>
<td>888.275.6462</td>
</tr>
</tbody>
</table>

Sources:


We are trying to decide if we should centralize our billing when we merge with another practice. What are other practices doing?

A frequent question in medical practices is whether or not to have centralized or decentralized billing and business offices. The issue is becoming complicated with the increasing number of merging practices and physicians aligning with hospitals.

Advantages of the centralized business office include

➤ Economies of scale to reduce costs;
➤ Standardization of processes, data collection, and reports;
➤ Centralized compliance monitoring;
➤ Development of expertise with increased employee specialization;
➤ Opportunities to share knowledge in one office;
➤ One location for managing patients’ requests; and
➤ Leverage to purchase and manage one information system.

Advantages of a decentralized office include

➤ Closer relationship with physician and nonphysician providers;
➤ Easier communication among staff with diverse functions within one practice;
➤ More ownership of processes with closer connections to physicians and patients;
➤ Improved collections from patients; and
➤ Opportunity for more direct communication with patients.

Many practices have adopted hybrid models that centralize some functions but decentralize others. Those at the locations where patients are seen can easily handle charge entry and time-of-service collections. Claims submission and payer follow-up may be handled in the central office.
Elizabeth W. Woodcock, MBA, FACMPE, and Loc Nguyen compared the operating costs and collections of practices with centralized billing offices to those with decentralized billing offices (see the following table). Those with centralized operations had lower business office expenses than those without. However, collections took longer in centralized offices, and the collection percentages were mixed. Their conclusion was that a hybrid centralized/decentralized billing office may be best, “allowing the practice to capture the economies that are possible while retaining the relationships, communication, productivity, and control that are essential to success.”

**Comparison between decentralized and centralized billing offices**

<table>
<thead>
<tr>
<th></th>
<th>Decentralized</th>
<th>Centralized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business office expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(median per physician)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single specialties</td>
<td>$22,571</td>
<td>$17,455</td>
</tr>
<tr>
<td>Multispecialties</td>
<td>$19,962</td>
<td>$16,873</td>
</tr>
<tr>
<td><strong>Collection percentage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single specialties</td>
<td>96.02%</td>
<td>97.59%</td>
</tr>
<tr>
<td>Multispecialties</td>
<td>98.50%</td>
<td>97.56%</td>
</tr>
<tr>
<td><strong>A/R days outstanding</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single specialties</td>
<td>56.0</td>
<td>57.5</td>
</tr>
<tr>
<td>Multispecialties</td>
<td>52.8</td>
<td>57.4</td>
</tr>
</tbody>
</table>


Factors that will affect your decision include your practice’s current situation. If you’re a recently merged practice, you may want to centralize at least part of the billing functions to contribute to the sense of unity within the new practice. For integrated delivery systems (IDS), the decision will depend on the model: directly employed physicians frequently transfer the billing function to the hospital’s centralized business office or office specific to managing the practices. Subsidiary models may continue to operate the business office within the practice or adopt a hybrid model with some functions within the practice and others in the IDS’ centralized office.
Nick Fabrizio, MGMA healthcare consultant, describes the potential benefits for hospital-affiliated practices to modify their billing processes, especially for primary care practices with large Medicare populations. Switching to a provider-based setting enables the hospital to bill Medicare for the hospital facility payment as well as for the physician services. The total may be higher than if the practice billed as a separate clinic. Prior to moving in this direction, you should research current Medicare regulations and definitions for provider-based billing, the reimbursement rates for the two options at your location, and the processes for notifying patients of the change.

If the decision is made to centralize or partially centralize billing operations in a merged system, the difficulty is in the transition. Form a work group with staff members from all of the involved organizations to review current procedures and structure. Identify the final structure that is desired and develop a transition plan, including training. Establish performance and communication expectations and accountability standards. Monitor after implementation to ensure a successful and complete transition, and monitor procedures and training as needed. During transition, a claims clearinghouse or billing service might be used to provide a central location and identification number for the different offices until the new office is operational and IDs are in place.

Sources:

### A LOOK AT THE NUMBERS . . .

<table>
<thead>
<tr>
<th>Practice’s billing function structure</th>
<th>72.58%</th>
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</thead>
<tbody>
<tr>
<td>Centralized</td>
<td></td>
</tr>
<tr>
<td>Decentralized</td>
<td>11.37%</td>
</tr>
<tr>
<td>Both/Hybrid</td>
<td>13.04%</td>
</tr>
<tr>
<td>Other</td>
<td>3.01%</td>
</tr>
</tbody>
</table>


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**Case Study**

St. John’s Clinic, with 110 offices in southwest Missouri, uses a hybrid collection model. Each location is responsible for collecting patients’ copays and self-pay balances at the time of service. The centralized business office (CBO) processes and collects payments from insurers. The CBO enables patients to discuss billing issues at any location. Collecting from patients at individual clinics increases collections as the number of self-pay and high-deductible plans increases.


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**QUESTION 17**

What is the best method of measuring the productivity of my billing office? Are there benchmarks for billing staff activities?

Comparative staff productivity data are difficult to locate and should be used wisely. Each practice is unique in terms of payer mix, staff mix, and business office functions. Therefore, staff productivity will vary. You should also benchmark your practice with MGMA survey data to compare the number of business office staff and expenses, gross charges, accounts receivable data, and other financial data. If you are within medical practice norms, your staff productivity may be acceptable.
Medical practice experts Deborah Walker Keegan, PhD, FACMPE, Elizabeth W. Woodcock, MBA, FACMPE, CPC, and Sara M. Larch, MSHA, FACMPE, provide the following figures for billing office staff workload ranges. They recommend that you review and emphasize the quality of the work, not just the quantity. The ranges are based on seven hours per day, assuming one hour for breaks and interruptions.

<table>
<thead>
<tr>
<th>Staff activity</th>
<th>Per day</th>
<th>Per hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge entry encounters (without registration)</td>
<td>375–525</td>
<td>55–75</td>
</tr>
<tr>
<td>Charge entry encounters (with registration)</td>
<td>280–395</td>
<td>40–55</td>
</tr>
<tr>
<td>Transactions posted manually</td>
<td>525–875</td>
<td>75–125</td>
</tr>
<tr>
<td>Account follow-up:</td>
<td>n/a</td>
<td>6–12</td>
</tr>
<tr>
<td>• research correspondence and resolve by telephone</td>
<td>n/a</td>
<td>12–60</td>
</tr>
<tr>
<td>• check status of claim and rebill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-pay follow-up</td>
<td>70–90</td>
<td>10–13</td>
</tr>
<tr>
<td>Patient billing inquiries</td>
<td>56–84</td>
<td>8–12</td>
</tr>
</tbody>
</table>


Note: Workload may depend on your information systems, Internet access, facility, flow of work (e.g., documentation required), additional tasks assigned, specialty(ies), and other variables.


If the billing staff workload is below the above ranges, and your practice financial ratios are below MGMA benchmarks, you should investigate possible reasons and ways of correcting the issue:

➤ Are you using the practice management system to its full capabilities? Have staff members received adequate training, and are they using the program with maximum effectiveness? You may want to work with the system vendor to identify additional efficiencies.

➤ Ask the business office employees for ideas to improve the department’s productivity. Can they identify issues that impede their work?
Develop an incentive program based on increasing the group’s billing efficiency and financial ratios. Make the employees vested in increased productivity, lowered accounts receivable, fewer patient complaints about bills, and so on.

I’d like to conduct a chart audit but don’t know how to proceed. What advice can you offer me?

Correct coding and complete documentation are important in many ways: It’s the basis for ensuring the practice receives reimbursement for services performed, it reduces the number of denied claims, and it protects the practice against malpractice suits and investigations for fraud and abuse. A chart audit can also be used to identify whether physicians are following best practices and quality indicators that are becoming increasingly important as healthcare moves from quantity to quality reimbursement, including P4P. If the coding in your practice has never been audited, you may want to hire an experienced consultant or coding professional to conduct it.

When conducting a first-time audit, you will want to gather as many charts as possible to have a large representative sample of charts for different physicians, procedures, diagnoses, and service locations. Cindy Dunn, MGMA healthcare consultant, recommends 10 to 15 charts per chosen diagnosis per physician to evaluate for indicators of quality care.

Review the documentation and check for correct application of E&M level and use of procedure codes, modifiers, and diagnosis codes. You can also benchmark the coding levels among your practice’s physicians or use the CMS data, especially for E&M coding. (MGMA.com has an online tool with E&M coding data by specialty available under Member Benefits Communities/Benefits and Tools: //www.mgma.com/WorkArea/DownloadAsset.aspx?id=40977). Keep in mind that CMS data are primarily populated by Medicare patient claims, which are for an older population. If coding discrepancies are found, correct the
claims that haven’t been submitted. For claims that were already submitted, you may want to discuss voluntary disclosure requirements with your legal counsel.

Physicians tend to undercode, often called “safe coding,” especially the E&M codes. Although this may lessen their concerns about being investigated, it decreases the practice revenue and physician income. Develop training sessions on the proper use of E&M codes, discussing the factors for determining the codes and documentation to support it. Provide benchmarking data to show nationwide use of the codes.

EHRs can be utilized to provide computer-assisted coding. Providers should work with the EHR vendor’s staff to ensure the templates and documentation fields will lead to accurate coding and supportive documentation. Auditors should conduct an initial review of EHR records for accuracy in coding and providers’ utilization of the templates to document provided services.

After the initial audit, pull several records each month (consultants recommend 3 percent of each month’s records) to monitor for any ongoing issues. Provide regular training on correct coding practices and new issues in coding. This will be especially important as the ICD-10 implementation date approaches. Accurate coding and documentation should be factors included in employee and physician performance reviews. As always, the key to continued success is communication: Ensure that physicians and coders are freely communicating so that correct coding is a team effort.

**A CLOSER LOOK . . .**

Who is responsible for setting the CPT and diagnosis codes?

Some coders believe they have the expertise and so should be held responsible for setting the codes, and physicians may relinquish the responsibility to them. However, it is the physician whose signature is at the bottom of the chart. Therefore, physicians are advised to work in direct concert with the coder or code the services keeping in mind the coder’s advice and/or direction.
## ADDITIONAL CODING RESOURCES

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td><a href="http://www.cms.gov">www.cms.gov</a></td>
</tr>
<tr>
<td>Specialty societies</td>
<td>various Web sites</td>
</tr>
<tr>
<td>American Academy of Professional Coders</td>
<td><a href="http://www.aapc.com">www.aapc.com</a></td>
</tr>
<tr>
<td>American Health Information Management Association</td>
<td><a href="http://www.ahima.org">www.ahima.org</a></td>
</tr>
<tr>
<td>MGMA’s books, articles, consultants</td>
<td><a href="http://www.mgma.com">www.mgma.com</a></td>
</tr>
<tr>
<td>American Medical Association</td>
<td><a href="http://www.ama-assn.org">www.ama-assn.org</a></td>
</tr>
</tbody>
</table>

Sources:


### QUESTION 19

I recently read about an accountant embezzling thousands out of a local medical practice. How can I make sure I have controls in place to prevent embezzlement or employee theft?

Unfortunately, embezzlement or theft in medical practices is not an unusual event. An MGMA survey found that nearly 83 percent of respondents had been affiliated with a practice that was a victim of employee theft or embezzlement.
Theft or embezzlement scheme reported by MGMA survey respondents

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
<th>Percent of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash receipts (stealing cash either before or after it is recorded on the books)</td>
<td>335</td>
<td>44.7%</td>
</tr>
<tr>
<td>Cash on hand (stealing cash, such as petty cash, kept on hand at the books)</td>
<td>73</td>
<td>9.7%</td>
</tr>
<tr>
<td>Disbursements (forging a check, submitting false or personal invoices)</td>
<td>134</td>
<td>17.9%</td>
</tr>
<tr>
<td>Expense reimbursements (submitting fictitious or inflated business expenses)</td>
<td>27</td>
<td>3.6%</td>
</tr>
<tr>
<td>Payroll (creating a fictitious employee, unauthorized bonuses, or inflated pay rate or hours)</td>
<td>46</td>
<td>6.1%</td>
</tr>
<tr>
<td>Noncash (stealing cash assets such as supplies, equipment, or patient financial information)</td>
<td>56</td>
<td>7.5%</td>
</tr>
<tr>
<td>Other</td>
<td>78</td>
<td>10.4%</td>
</tr>
</tbody>
</table>

To find out if your practice is at risk for embezzlement or theft, ask the following questions from the MGMA Theft and Embezzlement Risk Assessment:

➤ Before hiring new employees, do you conduct extensive personal interviews or use any sort of employee integrity or background tests?

➤ Do you systematically assess the morale of your practice at least quarterly?

➤ Have you made it clear to every one of your employees or future hires that you believe honesty and integrity are essential for the success of your mutual interests in the practice?

➤ Do you have a written policy that explains the consequences of being found guilty of stealing?
➤ Is it practice policy to terminate employment immediately and prosecute for employee theft?

➤ Do you have safeguards built into your practice to protect you from embezzlement and theft that do not depend on the perpetrators themselves reporting the true state of transactions?

➤ Do you have an independent accountant/bookkeeper audit your business or your practice on a regular basis?

The questions address several keys related to preventing theft. Knowing your employees and their morale alerts you to any potential concerns. Cases often involved long-term employees who found temptation hard to pass up or had changes in personal financial situations.

The best protection is to remove temptation and opportunities by implementing internal controls that limit any one employee’s opportunity. Controls should include

➤ Conduct financial background checks for all employees who have financial responsibilities.

➤ Ensure these employees are bonded. The bonding agency may require even more in-depth background checks.

➤ Segregate job responsibilities related to receipts, postings, and deposits. Consider cross-training and rotation of duties to spread the responsibilities. Conduct bank reconciliations yourself, and have someone else manage the general ledger.

➤ Check the charges daily to the sign-in or appointment schedule, and use direct deposit whenever possible.

➤ Occasionally review the checkbook and checks for possible illegitimate activities.

➤ Hire an outside accountant to frequently review the ledger and work of the practice’s staff.

Segregation of responsibilities is probably the single most important control for limiting theft. Cash-receipts theft was reported most frequently in the MGMA survey and occurs when one
person taking cash also can take payment, delete an appointment record, report a “no-show,” write off an account, and/or take complaints. This is the reason receptionists were involved in 26 percent of the reported theft cases in the MGMA survey.

Cash-disbursement schemes were also fairly frequent and often involved paying personal bills with company funds by using business checks or credit cards. Internal controls should include limited access to company credit cards and checks and having an auditor or second person reviewing credit card statements, bank statements, and checks.

To decrease theft of supplies, particularly pharmaceutical supplies (discussed in more detail in Question 75), use locked cabinets and check-in/check-out logs with two employees monitoring the cabinet.

Your employees are your highest concern, but they can also be assets. Encourage employees to watch for warning signs or report if they have suspicions. You can set up an anonymous reporting structure but double-check whatever is reported.

Sources:


