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Meet the Presenter…

Maxine Collins
MBA, CPA, CMC, CMIS, CMOM
Faculty
Practice Management Institute

On the topic:
Financial Management: Monitoring Your Practice Vital Signs
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Financial Management
Monitoring Your Practice’s Vital Signs

Brought to you by: Maxine I. Collins
MBA, CPA, CMC, CMIS, CMOM
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What Physicians Want to Know

• The “bottom line”:
  – How much are we billing out? Charges?
  – How much are we collecting? Cash?
  – Which services are receiving higher reimbursement? Comparative income possibilities?
  – What can we expect to collect from outstanding Accounts Receivable? Collections?
  – What is it costing us to provide services? Costs?
  – Why am I working harder and receiving less? Co efficiencies?
  – What are my alternatives to increase profitability and work less? Choices?
  – What is changing in the future? Changes?

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Goals of Session

- Set practice goals to ensure "Best Practices" for your entity. Be the best!
- Build on your knowledge and challenges of “crunching the numbers” to analyze and evaluate revenue and expense efficiencies that lead to profitable operations.
- Understand that no matter what position you serve in the medical practice or clinic, you have the opportunity to continue to learn and impact the "bottom line" and quality of care, as well as the ability to advance your own professional career in the process.
- Refresh your knowledge in “benchmarking” your practices ranking in relation to similar offices and specialties.
- Reviewing the most useful “stats” that can indicate where the practice is excelling and identify areas where it is needed to employ problem-solving techniques.
- Understand what information for those dozens of computer reports you should monitor on at least a monthly basis.
- Learn to have fun with numbers for more effective decision making and improvement opportunities.

Revenue Cycle Management

Patient Registration → Eligibility Verification → Capture Charges

Remittance Posting ← Charge Entry ← Diagnosis & Procedure Coding

Denial Management → Accounts Receivable Update → Generate Reports

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What You Need to Know

- What are the goals & philosophy?
- Is your team working together to monitor the practice’s “vitals”?
- What does it cost to see a patient or perform a procedure?
- What costs are relevant for decision-making?
- What is your average cost or variable cost per patient?
- What is your average revenue or collections per patient?
- What is your gross collection ratio?
- What is your net collection ratio?
- What is your average overhead %?
- What is your payer mix?
- What is the average # of days in A/R?
- Which payer plan is the most profitable for your practice?
- Where are your managed care contracts?
- Do you have a budget in place?
- Do you receive/review monthly financial reports?

The “ABC’s” of Finance

- **A** – **Assets** – Resources owned by the Practice such as: equipment, buildings, cash, accounts receivable, inventory of supplies, etc.

- **B** – **Balance Sheet** – A listing of the Resources owned by the Practice less the value of liabilities or debts owed by the Practice = the Owner’s Equity in the Practice

- **C** – **Capital** – Often referred to as the Owner’s Equity or Capital
  
  Also, refers to Equipment or Resources expected to have a life over one year and which is used as an investment in the Practice to be utilized to earn a profit stream for the entity.

Think of your personal “balance sheet.”
Additional Financial Terms

- **Liabilities** – The debt or what is owed to others such as: Accounts payable, loans from banks or other creditors, salaries and wages, etc.

- **Revenues** – Inflows of cash received in exchange for services, products, or other sources such as fees collected from office visits, procedures, medicines, drugs, etc.

- **Expenses** – Outflows of cash for purchase of goods and services consumed in operating the practice such as rent, utilities, supplies, salaries.

Think of your personal income, expenses and debts.

“Show Me The CASH”

- **Cash-basis Accounting** – a method of recording Revenue only when collected and deposited into the Bank; and recording Expense only when payments are made for the goods and services necessary to operate the Practice. (Often used by Physicians due to Federal Income Tax issues)
“Charge It”

- **Accrual - Basis Accounting** – A method of recording Revenue in the period in which it is earned or charged regardless of when collected; and recording Expenses in the period in which the purchase is made rather than when funds are distributed for payment. (Would have to estimate an allowance for Uncollectibles and Expenses related to the Current period but remaining unpaid at the end of the period.)

“SOAP IT”

**SUBJECTIVE: Ask the pertinent questions:**

- Do we want to increase productivity?
- Do we have the space to do so?
- Do we have the staff necessary?
- Are we taking care of our current patient load?
- Does the proposed new service “fit” in with our practice and practice goals?
- Do we have the Capital to invest?
- Do we have the time?
- Will the new procedure be profitable?
- Do we know the necessary information about our current operations?
- Have we performed an internal audit?
- Do we review practice stats at least on a monthly basis?
- Do we know our collection ratios?
- Do we know our current overhead ratio?
- How do we compare to published statistics for our size, area, and specialty?
Monitoring Your Practice For Success

- It is also important to track productivity. Considerations:
  - Unbilled encounters
  - RVU production by provider
  - Items in “hold” category or unclosed
  - Average number of days from date of service to posting date – Normal benchmark should be less than 7 days.
  - % of clean claims to total # of claims – Normal benchmark greater than 95%
  - Claims payment first pass pay rate – Normal should be 85%
  - Posting of cash & contractual allowances – Normal benchmark should be less than 24 hours
  - Denials overturned – Normal benchmark should be 95%
  - Length of time since Encounter form Master has been reviewed and updated – Should be annually; maximum of 2 years.
  - When were managed care contracts last reviewed? Should be a minimum of annually.
  - Compliance plan should be reviewed and auditing of charts performed – quarterly or at least annually

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Evaluation & Management of Practice’s Financial Statistics

- Objective: Examination - let’s look at the facts:
  - Gross collection ratio = Collections + Gross Charges
  - What % of the total charges put on the books are you collecting?
  - This should be monitored on a monthly basis to note any significant variations.
  - Net collection ratio = Collections + Gross Charges – Adjustments
  - What % of the net charges (after adjustments) are you collecting?
  - This will be a more accurate calculation to determine future collections from Accounts Receivables.

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Collection Ratio Examples

- **XYZ Medical Clinic – Average Monthly Billing Stats for 2015:**

  Collections = $180,000
  Gross charges = $311,693
  Adjustments = $ 90,050

- Gross Collection Ratio = $180,000/$311,693 = 58%

- Net Charges = $311,693 - $ 90,050 = $ 221,643

  - **Net Collection Ratio** = $180,000/ $ 221,643 = 82%

  ****************************************

- Review the information on the Medical Practice on the next slide and formulate a summary of what you see happening in the practice from the prior year.

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**“FLASH” Report**

- Physicians (2 Physicians) Financial Information: 12/31/15 compared to 12/31/16

<table>
<thead>
<tr>
<th>PROFIT/LOSS SUMMARY</th>
<th>YTD 2015</th>
<th>YTD 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collections (+ 8.1% from 2014)</td>
<td>$ 6,595,000</td>
<td>$ 6,100,000</td>
</tr>
<tr>
<td>Expenses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non – Physician Providers</td>
<td>900,000</td>
<td>700,000</td>
</tr>
<tr>
<td>Staff Expense</td>
<td>1,950,000</td>
<td>1,750,000</td>
</tr>
<tr>
<td>General Overhead</td>
<td>2,500,000</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Interest Expense</td>
<td>8,000</td>
<td>6,000</td>
</tr>
<tr>
<td>Total</td>
<td>$ 5,358,000</td>
<td>$ 4,456,000</td>
</tr>
<tr>
<td>Income Before Physician Cost</td>
<td>$ 1,237,000</td>
<td>$ 1,644,000</td>
</tr>
</tbody>
</table>

| Overhead to Earnings Ratio | Without Non-Physicians | 53.8% | 61.5% |
|                           | With Non-Physicians    | 61.4% | 73.0% |

**Accounts Receivable Statistics**

- Gross Charges YTD thru June $1,602,500
  - Average Monthly Gross Charges per month 267,083
- Accounts Receivable at 06/30 650,000
- Average Months/Days in A/R:
  - Balance in A/R divided by Average Monthly Charges:
    - $ 650,000 / $ 267,083 = 2.43
    - 2.43 x 30.4 average days per month = 73.9 days
- Prompt Pay law in your state?
  - MGMA (Better Performers Benchmark) = 37.0 days


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**Financial Calculations**

<table>
<thead>
<tr>
<th>Assumptions:</th>
<th>Balance in A/R</th>
<th>$ 180,000</th>
<th>Collection/year</th>
<th>$ 392,500</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Billed for month</td>
<td>$ 60,000</td>
<td>Total expenses</td>
<td>$ 637,500</td>
</tr>
<tr>
<td></td>
<td>Adjustments</td>
<td>$ 13,000</td>
<td>Total salary</td>
<td>$ 150,000</td>
</tr>
<tr>
<td>Collected</td>
<td>$ 38,000</td>
<td></td>
<td>Pts/month</td>
<td>462</td>
</tr>
<tr>
<td>Average Monthly Charges</td>
<td>$ 62,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Gross Collection Ratio:**
- Total Collection $ 392,500
- Total Billing $ 637,500
- Collection Ratio = $ 392,500 / $ 637,500 = 0.61

**Net Collection Ratio:**
- Total Collections $ 382,500
- Total Billings - Adjustments $ 60,000
- Collection Ratio = $ 382,500 / $ 60,000 = 0.64

**Length in A/R:**
- Total A/R Balance $ 180,000
- Monthly Billing $ 62,000
- Collection Period: Length in A/R x 30.4 = 2.9 x 30.4 = 88.3 Days
- Billing Per Patient: Total Billing (Mo. or Yr.) = $ 60,000
- Total # Patients (Mo. or Yr.) = 425
- Revenue Per Patient: Total Collections (Mo./Yr) = $ 382,500
- Total # Patient (Mo./Yr) = 2,550
- Expense Per Patient: Total Expenses (Mo./Yr) = $ 637,500
- Total # of patients (Mo./Yr) = 2,550
- Salary Rate: Total Salary (with or without benefits) = $ 150,000
- Total # Patients = 2,550
- Salary per Patient = $ 58.82

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An Example of a Possible Primary Care A/R Dashboard

Benchmarking Your Accounts Receivable for Success

Source: https://cecilelaine.wordpress.com

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Measurements & Monitoring Outcomes – Setting Goals!!

• **S – Specific:** Be clear and unambiguous when setting your goal. Don’t leave room for guessing.

• **M – Measurable:** Set a goal that allows you measurement toward your goals progress.

• **A – Attainable:** Ask yourself, “Is this realistic and attainable?” If not, back to the drawing board.

• **R – Relevant:** Create a goal with importance and meaning. Make sure the effort is worth it to you.

• **T – Time-bound:** Commit to a deadline. Open-ended goals tend to go forgotten.

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Key Performance Indicators for A/R over 120 Days

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>% OF TOTAL A/R in the 120+ DAYS BUCKET (BETTER PERFORMERS PER MGMA REPORT)</th>
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<tbody>
<tr>
<td>Primary Care</td>
<td>10.34%</td>
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<tr>
<td>Medicine Specialties</td>
<td>9.52%</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>9.02%</td>
</tr>
<tr>
<td>Multispecialty Practice</td>
<td>10.23%</td>
</tr>
</tbody>
</table>

## Analysis

- **Analysis of private carriers allowable as a percentage (%) of Medicare**

<table>
<thead>
<tr>
<th>CPT/ HCPCS</th>
<th>MCR ALLOW</th>
<th>AETNA ALLOW</th>
<th>% OF MCR</th>
<th>BCBS ALLOW</th>
<th>% OF MCR</th>
<th>CIGNA ALLOW</th>
<th>% OF MCR</th>
<th>UHC ALLOW</th>
<th>% OF MCR</th>
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</thead>
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<tr>
<td>99203</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>99213</td>
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</tbody>
</table>

## Analysis

- **Analysis of private carrier average reimbursement as a % of Medicare's average payment per code for (6 mo., 12 mo., etc.)**

<table>
<thead>
<tr>
<th>CPT/ HCPCS</th>
<th>MCR AVG PMT</th>
<th>AETNA AVG PMT</th>
<th>% OF MCR</th>
<th>BCBS AVG PMT</th>
<th>% OF MCR</th>
<th>CIGNA AVG PMT</th>
<th>% OF MCR</th>
<th>UHC AVG PMT</th>
<th>% OF MCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
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</tr>
</tbody>
</table>
Assessment & Plan

• If you don’t have a plan for your Practice in these turbulent times, you are probably planning to fail.
• We are continuing to see the cost of practice operations increase, while reimbursement is declining.
• If your Physician is working harder while collections are declining, it may be time to focus in on exactly what is going on in the Practice.
• If you do not have a good understanding of the ratios that we have reviewed as well as the RBRVS system and your Managed Care contracts - you may have trouble operating efficiently in the future.
• Preparing a Budget is a 1st step in organizing and planning - and it is challenging to forecast the future of the Practice.

E & M Continued

• Some ways we can analyze procedures and services for our operations:
  – Cost sheets for each service
  – Analyzing the “revenue centers” of the practice
  – Using RVU’s to calculate cost per procedure
  – Using RVU’s to calculate your own “internal conversion factor”
  – Organizing, analyzing, and negotiating Managed Care Contracts
  – Know your “Payer Mix”
  – Preparing a Budget to monitor variances in revenue and expense items
Cost Analysis by Revenue Center

- Knowledge of costs within each revenue producing center essential to negotiate managed care contracts.

- Two types of costs that must be determined:
  1. Direct Costs
  2. Indirect Costs

Financially Speaking

- **Direct Cost** – Utilized in allocating cost to revenue centers to determine the profitability of that service or department. These costs are directly associated with the production of these services and would not exist if the Practice did not furnish this service and the department did not exist.

- **Example:** A Practice Lab
  Direct Cost: The salary of the Phlebotomist
  The Lab equipment
  The Lab supplies
Speaking of Costs

- **Indirect Costs** - Those costs that must be fairly allocated to a revenue center to determine the net profit from its operations. This would include allocating a portion of the building rent, utilities, administrative staff and expense to the department.

How Much Does It Cost?

- **Fixed Cost** – Those cost that do not vary in the short-term. If you are operating as a “going concern” that will exist whether you see one patient or 1,000 patients during the month. You can count on paying the building rent, insurance, utilities, telephone service, ---- each month that you are in practice. This cost will not vary, but will remain constant in the short-term.
How Much Extra Will It Cost?

- **Variable Costs** – Those costs that vary in direct proportion to the number of patients seen. These are costs such as medical supplies, administrative supplies that will increase as the number of patients served increases.

- In management decision-making, these are the relevant cost for making decisions such as adding new services, new providers, etc. The Fixed Costs will be there regardless, but the variable costs are the ones that we have to consider in making a decision.

Is The Service Profitable?

- **Contribution Margin** – This is the difference between the Revenue or Collections received for a pertinent period of time that is produced from the services of the Revenue Center less the Direct Costs of earning the funds.

- The amount left over is a margin of profit/loss that can be applied (hopefully) to the allocated Fixed Cost to finally determine the actual Net Profit from the service.
Let’s Look at the Formula

Lab Dept. statistics – February, 2016

Revenue(Collections) $18,000
Less: Direct Cost - 14,000
Contribution Margin $ 4,000
Less: * Allocation of Indirect Costs - 2,000
Lab Profit for the month of Feb.: $ 2,000

*Allocation based on Sq Footage of Space occupied by Lab.

Break-Even Analysis

- In order to make a profit, you must cover both the Fixed and the Variable Cost. This is the "Break-even Point."

- Example:
A kit can be purchased for $ 200. It can perform 100 test @ $ 2.00 ea.
Addtl Variable Cost for Test 8.00
Total Variable Cost $10.00

Fixed Cost have been calculated to be $ 2000.00.
How many tests do we have to perform to break-even if we charge $ 50.00 per test?

Calculation: $ 2000.00 Fixed Cost
DIVIDED BY: $ 50.00 (Price) - $ 10.00 (Total Variable Cost) or $40
= 50 tests to break-even
51 tests to make a profit

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Get The Picture?
Fixed vs. Variable Costs

**EXPENSE**

**VARIABLE COSTS**

**FIXED COSTS**

# OF PATIENTS SEEN OR PROCEDURES PERFORMED

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Put The “Pencil” To It
One Easy Calculation

Total Cost per Patient = \[
\frac{\text{Total Exp. (Annual)}}{\text{Total # Patients (Ann.)}}
\]

- Gives an average overall cost of providing services per patient
- Can be used for basic comparisons of Collections per Patient vs. Cost
- Can be calculated and monitored weekly/monthly/annually

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Analysis By Item/Service

- Create Cost Sheets for major procedures
- Complete for each and turn in with ticket
- Monitors the direct costs for procedure performed frequently
- Indicates areas of waste or inefficiency
- Create a Purchase Order system to save on costs – purchase in quantity, etc.
- Appoint someone to be responsible for monitoring and improving both quality and cost

Injection Charge Sheet

<table>
<thead>
<tr>
<th>Meds/ Supplies</th>
<th>Package</th>
<th>Dose</th>
<th>Used</th>
<th>Cost</th>
<th>Comments/Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atropine</td>
<td>1 mg</td>
<td>1.6 ml</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demerol</td>
<td>100 mg/ml</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenalog 10</td>
<td>400 mcg</td>
<td>2 ml vials</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Versed</td>
<td>5mg/ml (10 in box)</td>
<td>2 ml vials</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lidocaine</td>
<td>2% bolius</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterile water</td>
<td>50 ml vials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4x4 gauze sponge</td>
<td>10 in box</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Needle 3 1/2 &quot;</td>
<td>5 &quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Etc.</td>
<td></td>
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</tr>
</tbody>
</table>

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Analyzing “RVUs”

- Medical practices produce services that can be counted in “Relative Value Units”.

- RVU’s are non-monetary values that Medicare developed to represent the relative amount of physician time, resources and expertise to provide each service represented by CPT.

- **Example:** If a low level office visit = 1 RVU, then a mid-level visit might = 1.5 RVUs and a surgical procedure might = 20 RVUs.

Using RVU’s to calculate costs

- Can your practice generate a profit with the conversion factor that the Managed Care Co. is offering? Use the RVU’s to find out.

- Each time you perform a procedure, you produce a unit – an RVU. Produce a spreadsheet as follows:
  1. Column I - List all the CPT Procedure codes for the year. (99202, 99203,…….)
  2. Column II- Reports) Frequency each code was charged. (Can get from Computer
  3. Column III- Relative Value Unit for each Code. (Established by CMS)
  4. Column IV – Frequency x RVU = Units produced for the year for that procedure
  5. Add up all of the RVU’s the Practice produced = your production for the year.
  6. From your financial statements, determine the total costs of operating your practice for the year.
  7. Divide your total costs by your RVU production for the year. This gives you the Cost per RVU. This is your Conversion Factor.
  8. Compare this cost to the reimbursement (Conversion Factor) offered per RVU by the insurance company.

- If you accept a conversion factor from a managed care co. less than your cost per RVU, you will lose money each time you bill that Co. for that CPT.

- Can your Practice generate a profit with the fee schedule proposed in the Contract?
RVU Spreadsheet
For 12 Months Ending 12/31/XX

FREQUENCY CAN BE OBTAINED FROM COMPUTER REPORTS (EXAMPLE ONLY – RVU’S NOT EXACT)

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>FREQUENCY PRODUCTION</th>
<th>RVUs</th>
<th>TOTAL RVUs PRODUCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>x</td>
<td>.89</td>
<td>xx</td>
</tr>
<tr>
<td>99202</td>
<td>x</td>
<td>1.73</td>
<td>xx</td>
</tr>
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<td>x</td>
<td>2.56</td>
<td>xx</td>
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<td>x</td>
<td>3.92</td>
<td>xx</td>
</tr>
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<td>3.40</td>
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<td>Totals</td>
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<td>TOTAL RVUs PRODUCED</td>
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Let's See How It Works!

CPT code 99213 – Established Patient Office Visit –
Here is the calculation for payment (unadjusted by GPCI or locality):

RVU for Work x .97 x (GPCI of ?) = .97
RVU for PE, (Non-Fac.)= 1.01 (Fully Trans PE_ x GPCI of ?) = 1.01
RVU for Malpractice Ins.=.07 x (GPCI of ?) = .07
Total RVU's for 99213 (Unadj. For GPCI) 2016 = 2.05

**Each would be adjusted by the GPCI (the Geographic Adjustment Factor which makes the value of a 99213 different for various regions of the country.

THE TOTAL RVU’S ARE THEN MULTIPLIED BY MEDICARE’S CURRENT CONVERSION FACTOR OF $ 35.8043 X 2.05 = $73.40 (unadj for GPCI)

THE CONVERSION FACTOR CONVERTS THE RELATIVE VALUE UNITS IN ($).

THerefore, each time you provide the service for CPT code 99213, the practice produces 2.05 units worth $38.8043 each which would also vary according to your area.

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How Can We Use The Formula To Our Advantage?

• Important that we understand the current way we are reimbursed and any future changes.
• The government is determining what it costs our practice to perform our procedures.
• **Do you calculate what the actual costs are for each procedure you perform?**
• Many providers are paid based on RVU production.
• We can also use RVUs to compute our practice’s production. Dividing practice costs by total production will yield cost per RVU which can be used for comparison to the government’s conversion factor.

Fee Schedule Development

• How often do you review your Standard Fee Schedule?
• How is it developed?
• Do you have a worksheet that compares plans?
• Do you utilize a National Fee Analyzer?
• Do you have an Insurance Catalog detailing special features of each plan – a contact person, contact #, etc.?
• Do you review your fee schedule annually with your Office Manager/Administrator?
• Do you keep a log of denials or underpayments for each carrier?
• Do you analyze reimbursement on your top 25-50 procedure codes monthly?
• Do you know what happens in your office when you receive less than the allowable for the procedure performed? Is it written or adjusted off? Is there an adequate appeal process?
• Does your computer system have the ability to input each Fee Schedule?
• Are you pulling and analyzing the pertinent reports monthly?
• Do you analyze the adjustments that are being made on accounts and the average % of such adjustments monthly?
Understanding Leads To Knowledge

• Knowledge leads to $$$
• The more we understand about reimbursement, the more knowledge we will have to:
  – negotiate managed care contracts
  – read and understand fee schedules
  – implement procedures that will insure better reimbursement and more efficient operations

Fee Schedule Development and Maintenance

• Other considerations:
  ❑ Do you utilize Hassle Factor Logs to report carrier problems?
  ❑ Do you review the Federal Register?
  ❑ Do you have the OIG’s Seven Step Compliance Plan as published in the Federal Register in place in your practice?
  ❑ Are you aware of and utilize the appeal process for each carrier?
    Did you know that when a physician carries an appeal through all the appropriate channels to the Administrative Law Judge, that the provider prevails in these cases 60% of the time?
  ❑ Do you report plans that are not HIPPA compliant?
  ❑ Are you aware of the tools and information available on your local Medicare Carrier and the CMS website?

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It’s 10 A.M. – Do You Know Where Your Managed Care Contracts Are?

- **Why** is this so important for Office Managers and Billing/Front office personnel?
  - Because contract **provisions** affect **reimbursement**!
- A **contract** is a **legally binding document** – if breached, could be liable for “breach of contract law.”
- IPA’s, etc. are **no longer** as free to share information needed by doctor to make a decision on signing
- Many physicians sign without knowing provisions contained in the contract.
- Often we are duplicating efforts with appeals for denials for an item that is being denied because of contract provisions that we do not know about.
**Turn Negatives into Positives**

- Improve training
- Note changes in coverage's and guidelines
- Communicate and encourage cooperation among departments and with Providers
- Ongoing monitoring of claim denials and underpayments
- Make a Managed Care “Bible”
- Endurance – never give up on a denial or underpayment until all efforts are exhausted.

---

**The Problems/The Solutions?**

- Declining reimbursement
- Pay-for-Performance / Quality ratings
- Technology
- Increasing Practice Costs
- Complexities of managed care
- Aging population
- Growth of consumer-driven healthcare
- Increasing stress on providers, clinical and administrative staff as need for research and continual updates of information increases.
- Potential shortage of providers and nurses in some areas of the U.S.
Reimbursement /Billing/Payment Policies
Reviewing the Contracts

- What patients are you obligated to accept under the plan?
- Is the carrier bound to list you as a participating provider under the plan?
- Are there both HMO and non-HMO products under the plan?
- Do they have the right to introduce new plans not listed on the initial agreement?
- Does the primary care physician have to agree to schedule appointments with members within certain time frames for various types of complaints?
- What are the regulations as to how long a member has to wait for an appointment?
- What are the provisions in the plan for review of outcome of care, etc.?
- Is the provider appeals process clearly stated and reasonable?
- Are the billing guidelines readily available and clear?
- What is the time frame for payment of your claims?
- What are the pre-authorization, pre-certification guidelines?
- Do you have the opportunity to speak with a doctor concerning any disagreement concerning treatment or medical necessity?
- Does the provider have the right to bill the patient for “non-covered” services?
- Does the plan provide their definition of Medical Necessity?

Importance of the Budget

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Preparing the Budget

• If new in practice, prepare “Pro-Forma’s” indicating projections of cash in and cash out over the upcoming year.
• If practice has been in operation for a few years, use the last 3 years of income/expense information as a basis to note annual trends and factor in possible changes to come up with a budget for the upcoming year.
• The Budget provides a “map” or directions for the Practice based on past operational trends factored in with the goals for the future.
• Physician must “buy-in” and participate in the planning
• Regular, simple reporting is a must.

Is It in the Budget?

• Use the previous year’s financial information as a starting point
• Note the changes or “trends” from year to year.
• Develop forecast for the upcoming year:
  Revenue – Changes in volume
  Changes in Fee Schedules
  Changes in Specialty
  Changes in your area
  Changes in services provided
  Expenses - If changes in services, how will it impact expenses?
  Are staffing changes necessary?
  What about inflation/cost of living adjustments?
  Do we need to upgrade technologically?
  Is our space adequate?
  Do we need to re-negotiate any leases?
  What is the cost of providing our services?
• Capital Requirements?
Budget Worksheets

• An opportunity to “dig in” and look at individual items
• Where is the money going and for what?
• A time to step back and gain a new perspective
• Creates a rewarding challenge to find avenues for reducing cost and improving services

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Monthly Telephone Expense  Line #1

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After calculating some of the more important ratios, you can compare your indicators with some of the national benchmark comparisons.

- Medical group management association – has cost surveys available. For non-members, the cost could run around $450-$500.
- American Medical Association - produces information on physician characteristics and on medical groups. These publications will also cost around $150 - $300 for non-members.
- Practice Support Resources, Inc. – publishes "practice management stats quick reference" for individual specialties – also for a price.
- Of course, there are many variables that affect each practice and the "benchmarks" produces are for comparison purposes only. However, the comparison may point out areas where you could improve in efficiency or indicate that you are doing better than the average in your specialty. Either way, you may find areas that need further scrutiny.

SOURCE: AMERICAN ACADEMY OF FAMILY PHYSICIANS, "HOW MANY STAFF MEMBERS DO YOU NEED?, SEPTEMBER, 2002
Let’s Look At a Few “Benchmark” Abbreviations

- FTE = full-time equivalent employees
- Provider FTE = number of full-time equivalent providers
- FFS = fee for service
- A/R = accounts receivable
- RVU = relative value unit

Published “BENCHMARKS” for Some Specialties

### Total Medical Revenue, Physician Compensation and Benefits

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>TOTAL REVENUE PER FTE DR. (BETTER PERFORMING PRACTICES)</th>
<th>TOTAL REVENUE PER FTE DR. (OTHERS)</th>
<th>PHYS. COMP &amp; BENEFITS PER FTE DR. (BETTER PERF PRACTICES)</th>
<th>PHYS. COMP &amp; BENEFITS PER FTE DR. (OTHERS)</th>
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<td>ORTHOPEDIC SURGERY</td>
<td>$1,347,331</td>
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<td>$476,906</td>
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</tbody>
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### Nursing Staff per FTE Physician by Specialty

- **SPECIALTY**              **NURSING STAFF**
- CARDIOLOGY               1.54
- FAMILY PRACTICE          1.74
- INTERNAL MEDICINE        1.49
- OB/GYN                   1.68
- ORTHOPEDIC SURGERY       1.14
- PEDIATRICS               1.65
- GENERAL SURGERY          .83
- UROLOGY                  1.40

Financial Reporting

- Physicians are overwhelmed with patient care and the increasing documentation and quality of care guidelines.
- Physicians must now wear many “hats” – doctor, coding expert, financial expert, employer, etc.
- Physicians understand “cash in” and “cash out”; therefore, reports must be simple – monthly “flash reports” that will enable them to file away the important statistics in their mind.
- Reports must be timely, accurate and furnished on a regular basis.
- Reports must be meaningful and capture the important information your physicians want to monitor.
- Financial management is not boring! Learn to have fun with finance and improve your practice’s performance!
- Employees are the key in providing and monitoring internal controls that lead to greater practice efficiencies.
- You play an important role in achieving “best practices”!

Final Thoughts

- Be happy
- Smile
- Reach out to help at least one other person today and make this world a better one!
Questions

- Thank you for your attendance!
- PMI’s Discussion Forum: